Blue Cross Blue Shield of Rhode Island

provider update

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

January 2017

A patient needs an appointment with a specialist and consults our online directory—Find a Doctor—to locate a provider. The patient sees multiple addresses and phone numbers for a single provider. She calls several of the numbers only to be told there is no doctor by that name at that location or that the doctor doesn't see patients there. The patient gives up her search for that provider and moves on to another.

Unfortunately, the scenario described above is very real and one that patients face quite frequently. And, it's not a problem unique to BCBSRI or even to Rhode Island. The accuracy of provider demographic data is a problem in health plan directories around the country, as evidenced by two recent articles:

- ***New York Times***, "Insurers' Flawed Directories Leave Patients Scrambling for In-Network Doctors," *December 3, 2016*
- ***Kaiser Health News***, "Feds Find Doctor Listings Often Wrong in Medicare Advantage Directories," *October 24, 2016*

Both articles reference a 2016 audit of 54 Medicare Advantage (MA) health plans conducted by the Center for Medicare and Medicaid Services (CMS). Those results found that incorrect information was found for almost half of the 5,832 doctors listed in online MA directories (of those plans included in the audit). The most common errors? Providers with multiple offices that do not serve health plan members at each location listed, wrong phone numbers, and wrong addresses.

It goes without saying that this is unacceptable, and CMS has frequently pointed out that directories need to be viewed through the lens of a beneficiary.

This is why BCBSRI has stepped up efforts to improve provider data. Each month, we include an article in Provider Update to remind providers to notify us of any demographic changes and review their practice information. We also send out a monthly eblast as an additional level of notification. During the last several months, you may have received a phone call or an email from our partner, VIIAD Systems, which is working with us to validate provider data. Ultimately, we will roll out an online portal that will allow you to easily validate your practice information and submit any change requests electronically through our website.

We recognize there is a time commitment to make sure practice information is accurate, but in the end, the patient experience is vastly improved when patients can easily find the information they need.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

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BCBSRI Update

BCBSRI completes transition to Prime Therapeutics as new PBM

As of January 1, 2017, BCBSRI completed the transition of its pharmacy benefits manager (PBM) to Prime Therapeutics, LLC. Over the last several months, we've shared information in each issue of *Provider Update* to help our provider community become more familiar with Prime.

This month, we are recapping the new features we've highlighted in past *Provider Update* issues as well as sharing information about a quick reference guide.

Why Prime?

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.

How does this change affect my practice?

Starting on January 1, 2017, claims for patients who have BCBSRI prescription drug coverage will be processed through Prime, not OptumRx. BCBSRI worked closely with OptumRx and Prime to evaluate all current prior authorizations (PAs), which transferred to Prime prior to January 1, 2017. Please note that PAs set to expire between January 1, 2017 and February 28, 2017 will have a grace period through March 31, 2017, to allow offices to migrate patients to an alternate medication or renew the prior authorization for the existing medication.

Will patients be able to get the drugs I prescribe them?

You can check the formulary status of drugs you prescribe through the electronic medical record via ePrescribe or through your existing workflow. If the drug you prescribe has a UR program attached to it, you will need to initiate a new PA request. Forms are available online at myprime.com. You can also initiate PA requests electronically through CoverMyMeds®, Prime's electronic prior authorization (ePA) tool. Please note: The change in PBM does not affect the local pharmacy network. Patients may continue to fill their prescriptions at the local pharmacy of their choice.

What about specialty pharmacy?

Walgreens Specialty Pharmacy and Village Fertility Pharmacy will continue to be our partners for your Commercial patients' specialty pharmacy medications.

What is PrimeMail®?

PrimeMail is the mail order solution for our members using maintenance medications. 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 may save your patients money. Depending on their benefit plan, their out-of-pocket cost share is usually lower. Refillable mail order prescriptions at Catamaran Home Delivery (an OptumRx company) will automatically transfer to PrimeMail. To ease the transition from OptumRx to PrimeMail, Prime will manage personalized outreach to members who currently use mail-order pharmacy services.

What is CoverMyMeds?

CoverMyMeds is the ePA tool offered through BCBSRI and Prime. Through CoverMyMeds, you can submit PAs electronically for any drug. ePAs are seamlessly integrated with your EHR system to provide you with ePA functionality right in your office. Some of the benefits include:

- Reduction of administrative waste
  - Eliminates phone calls and faxes
  - Tracks the status of your PA
- Faster determinations
  - Streamlines process for a quicker response
  - Provides determination recommendations to reviewing staff
- Validated and accurate PA requests
  - Directs prescribers to complete required fields

Here's how you can create an account for CoverMyMeds:

- Go to www.covermymeds.com
- Click on "Create a Free Account"
- Log in using your email and password

To allow offices to migrate Medicare patients to an alternative medicine or renew the PA for the existing medicine, patients will be granted a 30-day transition supply for eligible Part D drugs (unless the prescription is written for fewer days) any time during their first 90 days of coverage.

For assistance with a new PA, you can contact Prime at:

- 1-855-457-0759 for Commercial members
- 1-800-693-6651 for Medicare members

For questions related to the status of an existing PA, please call the BCBSRI Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050.

BCBSRI Update

Quick reference support guide

BCBSRI has created a Quick Reference Support Guide to help you navigate through the transition to Prime. In it, you'll find information about prior authorizations (including ePA), PrimeMail, the formulary, and ways to access assistance.

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

CoverMyMeds is an independent company not affiliated with BCBSRI. It is your responsibility to review and decide whether to use CoverMyMeds' services. CoverMyMeds can be used for pharmacy prior authorization requests for Commercial BCBSRI patients who use Prime as their pharmacy benefits manager.

P Web-based referral management tool is now mandatory

Earlier this year, BCBSRI introduced a web-based referral management tool. All primary care providers (PCPs) and specialists are required to use this tool to launch a referral and check the status of referrals from PCPs to specialists. In September, we notified you that we were experiencing technical difficulties with the tool and had enacted a system override to prevent claims without a referral from denying while the problem was resolved. We're pleased to report that the referral management tool is now functioning properly. As a result, primary care providers are required to submit referrals through the web-based referral management tool for dates of service rendered by specialists on or after January 1, 2017.

The products that require web-based referrals include all BlueCHiP Commercial, BlueCHiP for Medicare Advance, and New England Health Plan (NEHP) products. These products have always required a referral, but the method has changed from a paper to a web-based process. Please note, NEHP cross-border referrals to providers in other New England states 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.

Primary care providers are responsible for generating referrals to specialists for members enrolled in these products. Specialists are 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 be denied.

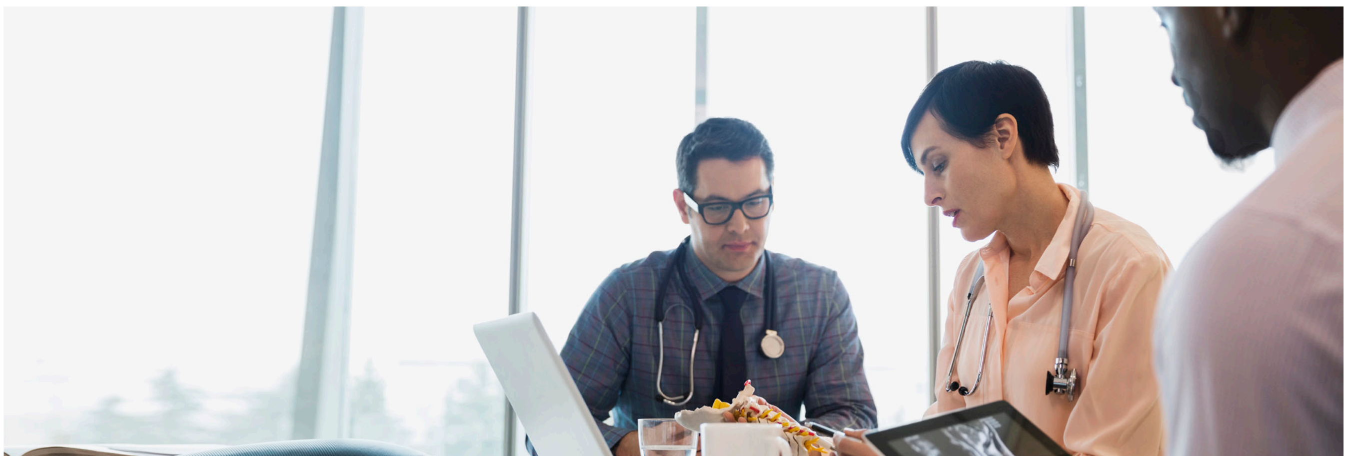
How to determine if your patient has a referral-based plan

1. Review our BCBSRI Product Overview, which outlines which plans require a referral for specialist visits and which do not.

2. Log on to the BCBSRI provider portal and go to the Patient Eligibility section to verify medical benefits. Click the Medical Benefits tab and select the applicable Service Category and Service Type to see if a referral is required.

Please note that some Systems of Care (SOCs) have developed an alternative process to submit an online referral to BCBSRI. If you are a PCP and are affiliated with a SOC, but are unsure if you need to follow an alternate process, please contact the SOC administrative staff for clarification.

If you have any questions about the referral management tool or the BCBSRI products that require web-based referrals, please call our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out of state only).



BCBSRI Update

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 by clicking here. If you have questions, please contact Susan Walker, provider relations manager, at (401) 459-5381 or susan.walker@bcbsri.org.

B CODAC Medication Assisted Treatment (MAT) Pilot Program

This outpatient buprenorphine/naloxone or buprenorphine program is offered by CODAC, a substance use disorder treatment facility. It is designed to provide comprehensive medication assisted treatment-related services to BCBSRI Commercial members to facilitate recovery from opioid use disorders. The goal of the program is to offer structured and intensive treatment, including medication assisted treatment such as Suboxone, nursing, counseling, and case management services that ultimately lead to recovery and the ability to maintain recovery in a less intensive treatment program. If you wish to refer someone to the program, please contact CODAC at (401) 871-6563.

PBF Important: Update your practice information!

When our members have up-to-date information about your practice, it helps ensure a positive experience for them and for you. Having accurate information is so important that it's a CMS requirement and a contractual obligation under your BCBSRI provider agreement. Providers must give BCBSRI a 60-day notification of any provider or practice changes.

Please take a moment to review your practice information in our Find a Doctor tool, focusing on the following areas:

- Your first and last name
- Practice name
- Practice location or locations
- NPI
- Specialty and sub-specialties
- Panel status
- BCBSRI product participation
- Practice phone number(s)
- Wheelchair accessibility

Panel status refers to whether or not you are accepting new patients, which applies to specialists as well as PCPs.

If updates are needed, please fill out and submit the BCBSRI Practitioner Change Form. If you have any questions, please email ProviderRelations@bcbsri.org or call your provider relations representative.

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 Courtney Reger, RN, BSN, Quality Management Analyst, at (401) 459-2763 or courtney.reger@bcbsri.org.

New onset, non-acute low back pain

Now that winter has arrived, low back pain diagnoses may appear more often as patients can potentially injure themselves shoveling or from slips and falls on ice and snow. Clinical evidence indicates that in the absence of red flags (see exclusions below), 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 Guidelines from the American College of Physicians and the American Pain Society*, which 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 aged 18-50 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:*** HIV, spinal infection, organ transplant other than kidney transplant, cancer, trauma, neurologic impairment, prolonged use of corticosteroids, or IV drug abuse *Denominator:* Members 18-50 years old with a principal diagnosis of low back pain at either an outpatient or an emergency room visit	• 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: 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.

Quality

Avoidance of antibiotic treatment in adults with acute bronchitis (AAB)

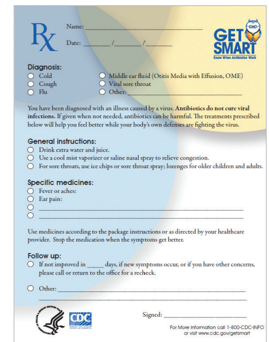
The AAB measure evaluates the inappropriate use of antibiotics in adults aged 18-64 with a diagnosis of acute bronchitis. The rationale is that the vast majority of cases of acute bronchitis are viral and do not require antibiotic therapy. This measure is aimed at improving antibiotic stewardship across the population. This helps stem the tide of antibiotic resistance in local communities and the nation and avoids potential side effects and complications of antibiotic therapy in an individual patient when the treatment is not clearly indicated.

Precise diagnostic coding is essential for accurate performance on this measure. The new ICD-10 codes are mostly specific to viral bronchitis. There are two unspecified ICD-10 codes: J20.8 and J20.9. Please pay careful attention to the diagnostic codes to reflect the condition you are treating and use bacterial ICD-10 codes when appropriate.

Certain comorbid conditions that could influence your decision to prescribe antibiotic therapy for bronchitis are critical to document as well, since they will result in removal of the patient from the denominator in this measure and more appropriately reflect your clinical thought process.

Here are some tips for clinical coding accuracy on this measure:

- Only use the code for acute bronchitis if the diagnosis is accurate/confirmed.
- If and when you do prescribe antibiotics for bronchitis, remember to code for relevant comorbidities, including:
    - HIV
    - Malignant neoplasm
    - Emphysema
    - COPD
    - Cystic fibrosis
    - HIV Type 2 **(new)**
    - Disorders of the immune system **(new)**


Rx

Name: ______________________

Date: _____ / _____ / _____

GET SMART
Know When Antibiotics Work

Diagnosis:
- ○ Cold
- ○ Cough
- ○ Flu
- ○ Middle ear fluid (Otitis Media with Effusion, OME)
- ○ Viral sore throat
- ○ Other: ______________________

You have been diagnosed with an illness caused by a virus. **Antibiotics do not cure viral infections.** If given when not needed, antibiotics can be harmful. The treatments prescribed below will help you feel better while your body's own defenses are fighting the virus.

General instructions:
- ○ Drink extra water and juice.
- ○ Use a cool mist vaporizer or saline nasal spray to relieve congestion.
- ○ For sore throats, use ice chips or sore throat spray; lozenges for older children and adults.

Specific medicines:
- ○ Fever or aches:
- ○ Ear pain:
- ○ ______________________
- ○ ______________________

Use medicines according to the package instructions or as directed by your healthcare provider. Stop the medication when the symptoms get better.

Follow up:
- ○ If not improved in _____ days, if new symptoms occur, or if you have other concerns, please call or return to the office for a recheck.
- ○ Other: ______________________

Signed: ______________________

For More Information call 1-800-CDC-INFO or visit www.cdc.gov/getsmart

We also realize that much pressure for antibiotic therapy comes from patients themselves. To assist you in educating your patients on the importance of antibiotic stewardship and the facts about viral versus bacterial processes, we would be happy to supply you with Rx pads from the Centers for Disease Control's Get Smart campaign about antibiotics **while supplies last**. If you would like to receive these Rx pads, please contact Courtney Reger, RN, Quality Management Analyst, at (401) 459-2763 or courtney.reger@bcbsri.org.

NEW this year

Effective with HEDIS 2017, NCQA added a new CPT Category 2 code, 3072F, to identify diabetic eye exams negative for retinopathy. While CPT category 2 codes are not reimbursed by BCBSRI, submission of this code will reduce the HEDIS medical record review burden on your practice. This code can be submitted effective immediately and can even be used for claims with older dates of service. If you have any questions, please contact Courtney Reger, RN, Quality Management Analyst, at (401) 459-2763 or courtney.reger@bcbsri.org with any questions.

Pharmacy

PBF Delay in Enforcement of the Medicare Part D Prescriber Enrollment Requirement

CMS is delaying the enforcement of the Part D Prescriber Enrollment Requirements until January 1, 2019. It was previously communicated in the April 2016 edition of Provider Update that the enforcement date was February 1, 2017.

Blue Cross Blue Shield of Rhode Island

provider update

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April 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.

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BCBSRI Update

P BCBSRI Launches New Health Analytics Platform to Support Rhode Island Primary Care Providers

Blue Insights for Rhode Island, a new data and analytics platform that offers a 360-view of patients' preventive, chronic, and complex health needs, is now available to support providers.

By making it easier for clinicians to assess individual patient information and offering the ability to analyze data for entire patient populations, Blue Insights will further raise the standard of care, leading to a better patient experience and improved health outcomes. Additionally, providers and health systems will now have accelerated access to information necessary to succeed in value-based payment arrangements.

"Today in healthcare, leading edge organizations are using advanced analytics to make data 'smarter' and actionable. Blue Cross is taking a major step forward with Blue Insights, which provides information to our clinical partners to improve the care experience and outcomes for our members," said Mark Waggoner, senior vice president for care integration and management at BCBSRI. "Blue Insights is a great example of our commitment to actively supporting our provider partners in their quest for continuously improved care."

Blue Insights offers Rhode Island primary care providers access to patient care registries, which include specific information necessary for effective care support and coordination for patients with complex and chronic care needs. Additionally, providers can proactively identify care gaps to keep patients healthy as well as identify emerging health concerns. As a result, BCBSRI members will be encouraged to address needed screenings or preventative care (such as colonoscopies or flu shots).

In addition, new electronic tools will allow providers to track the progress of patients with chronic conditions, send reminders or alerts to members for tests or follow-up appointments, and ensure patients are filling prescriptions. The Blue Insights health analytics platform will promote:

- Access to critical health information, allowing members and their physicians to make informed choices about specialty physicians, facilities, and treatments
- Timely patient care interventions through health monitoring systems
- Alignment of industry standard analytics and proactive patient intervention to improve the delivery of care and patient health
- Comprehensive analysis of payer and provider data to optimize care delivery and cost, based on the patient experience

(continued on next page)

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 (NCQA) has an established Healthcare Effectiveness Data and Information Set (HEDIS) measure, Follow Up After Hospitalization for Mental Illness, which will be the basis for our determination of timely transitions. BCBSRI is focusing on the component of this measure that assesses the percentage of members 6 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.

In an effort to improve the number and therefore the percentage of members who attend a follow-up behavioral health visit, and to 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, director of behavioral health, at (401) 459-1467 or rena.sheehan@bcbsri.org, or Sarah Fleury, behavioral health performance specialist, at (401) 459-1384 or sarah.fleury@bcbsri.org.

B Changes to the On Track Program

In an effort to continue to promote quality measurement and outcomes, BCBSRI will be changing the reimbursement structure for the On Track Outcomes Program. This client-informed feedback tool measures outcomes based on client-completed questionnaires.

In order for providers to improve outcomes and optimize client-informed feedback using On Track, they must log into the system on a regular basis to review their data. When reviewing the On Track log-in data for participating providers, BCBSRI discovered that a majority of providers submitting completed On Track outcomes questionnaires have never logged into the system to review their results. Without logging in, the provider is unable to use the data to determine which of their clients are most at risk of dropping out of treatment or are not progressing as expected. The clinician is also missing out on valuable, client-informed feedback, which is an evidence-based outcomes measurement.

Beginning February 1, 2017, all providers submitting forms for reimbursement will be required to log into the On Track system to monitor their data at a minimum of once a week. If a provider does not log into the system weekly, no reimbursement will be provided for that month. For those who do log in to review results, reimbursement will continue to be paid at the rate of $5 per form submitted for BCBSRI members.

If you have questions regarding this change, or need assistance with logging into the system or interpreting data, please contact Sarah Fleury, lead behavioral health clinical program specialist, at sarah.fleury@bcbsri.org.

B Federal Employee Program adds autism benefit

Beginning on January 1, 2017, BCBSRI members covered under the Federal Employee Program will have benefits for applied behavioral analysis (ABA), a service used to treat autism. Providers who currently offer this treatment will now be able to extend services to FEP members. Verification of benefits is strongly encouraged prior to providing services. Prior authorization of services is required. Please contact the Provider Service Call Center to verify benefits and coverage at (401) 274-4848 or 1-800-230-9050.

Products & Benefits

PBF Members' Rights and Responsibilities Statement

Upon enrollment, our members are granted certain rights and protection of these rights in all their encounters with BCBSRI's representatives, including physicians and other network providers, providers' employees, BCBSRI employees, and anyone else who has a role in the delivery of care and service. We expect all of our representatives to observe the principles we've established to preserve these rights.

In exchange for this careful observance of their rights, members guarantee to assume responsibility for their attitude, knowledge, and behavior related to the healthcare services they receive while enrolled.

Please see the Participating Provider Administrative Manual for a complete listing of members' rights and responsibilities.

Claims

P New claims filing requirements for diabetic supplies

Effective January 1, 2017, Medicare Advantage claims filed for diabetic test strips and glucometers will require the applicable national drug code (NDC) in addition to the appropriate Healthcare Common Procedure Coding System (HCPCS) code.

OneTouch is the exclusive brand of diabetic supplies for Medicare Advantage members and is covered at 100%. All other strips/meters will be denied unless reviewed and approved by BCBSRI's Utilization Management department for medical necessity.

The BCBSRI electronic data interchange (EDI) system has been updated to accept NDC numbers when filed with HCPCS codes. If your electronic claim submission cannot support the NDC number on the claim, you may file on paper by mailing claims to:

Blue Cross & Blue Shield of Rhode Island
ATTN: Basic Claims
500 Exchange Street
Providence, RI 02903

If a claim for diabetic test strips/meters is filed with a HCPCS code without an accompanying NDC number, the claim will be denied.

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).

Policies

PF Policies recently reviewed for annual update

The following policies were recently reviewed for annual update. The full text is available on the Policies page of the Provider section of bcbsri.com.

- Actigraphy
- Adoptive Immunotherapy
- Advance Notice of Noncoverage
- Autologous Platelet-Derived Growth Factors (i.e., Platelet-Rich Plasma)
- Axial Lumbosacral Interbody Fusion
- Balloon Ostial Dilation for Treatment of Chronic Sinusitis
- Behavioral Health Services Inpatient and Intermediate Levels of Care
- Bronchial Thermoplasty
- Carotid Angioplasty/Stenting Without Embolic Protection
- Chelation Therapy for Off-Label Uses
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure
- Corneal Topography/Computer-Assisted Corneal Topography/Photokeratoscopy
- CPT Category III codes
- Cranial Orthoses (Adjustable) for Positional Plagiocephaly and Craniosynostoses
- Cryoablation of Prostate Cancer
- Cryosurgical Ablation of Primary or Metastatic Liver Tumors
- Denosumab (Prolia and Xgeva)
- Dynamic Posturography
- Dental Services for Accidental Injury
- Electrical Bone Growth Stimulation of the Appendicular Skeleton – Implantable and Semi-Invasive
- Electrical Stimulation for Treatment of Arthritis
- Electrical Stimulation and Electromagnetic Therapy for Wound Treatment
- Electromagnetic Navigation Bronchoscopy
- Enteral/Parenteral Nutrition Therapy
- Esophageal pH Monitoring
- Extracorporeal Shockwave Therapy for Plantar Fasciitis and Other Musculoskeletal Conditions
- External Ocular Photography
- Gastric Electrical Stimulation – Insertion
- Hearing Aid Mandate
- Home Apnea Monitoring
- Home Uterine Activity Monitoring (HUAM)
- Homocysteine Testing in the Screening, Diagnosis, and Management of Cardiovascular Disease
- Immune Cell Function Assay
- Implantable Sinus Spacers for Postoperative Use Following Endoscopic Sinus Surgery and for Recurrent Sinus Disease
- Ingestible pH and Pressure Capsule
- Injectable Bulking Agent for Fecal Incontinence
- Injectable Clostridial Collagenase for Fibroproliferative Disorders
- Intravitreal Corticosteroid Implants
- Interferential Current Stimulation
- Islet Cell Transplant
- Lysis of Epidural Adhesions
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate
- Measurement of Small Low-Density Lipoprotein (LDL) Particles
- Mechanical Wound Suction
- Medical Necessity
- Meniscal Allograft Transplantation and Collagen Meniscus Implants

Policies

- Microvolt T-Wave Alternans Testing
- Midlevel Practioners
- Minimally Invasive Intradiscal and Annular Procedures for Back Pain
- Mobile Outpatient Cardiac Telemetry (MOCT)
- Molecular Markers in Fine Needle Aspirates of the Thyroid
- Ophthalmologic Techniques for Evaluating Glaucoma
- Optical Coherence Tomography of the Anterior Eye Segment
- Osteochondral Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions
- Oral Appliances for Sleep Apnea
- Prophylactic Mastectomy
- Proteomics-Based Testing Related to Ovarian Cancer
- Saturation Biopsy for Diagnosis and Staging of Prostate Cancer
- Semi-Implantable and Fully Implantable Middle Ear Hearing Aid – Insertion
- Serum Biomarker Human Epididymis Protein 4
- Signal-Averaged Electrocardiography (SAECG)
- Speech Therapy
- Transcranial Magnetic Stimulation
- Transesophageal Endoscopic Treatments for Gastroesophageal Reflux Disease
- Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization
- Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis Dynamic Posturography
- Urinary Tumor Markers for Bladder Cancer
- Vertebral Fracture Assessment

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 the Policies page of the Provider section. Once on that page, click the drop-down box to sort policies by draft.

PF Modifiers 59, X{EPSU}

During a recent claims review, it was noted that a high volume of claims were submitted with modifier 59, which defines a "Distinct Procedural Service." CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available, so the use of modifier 59 should be very limited.

Effective January 1, 2015, The Centers for Medicare and Medicaid Services (CMS) established four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of modifier 59, which are collectively referred to as X{EPSU} modifiers. CMS guidelines state that the X{EPSU} modifiers are more selective versions of modifier 59, so it would be incorrect to include both modifiers on the same line.

Here are the four modifiers:

- XE separate encounter, a service that is distinct because it occurred during a separate encounter
- XS separate structure, a service that is distinct because it was performed on a separate organ/structure
- XP separate practitioner, a service that is distinct because it was performed by a different practitioner
- XU unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

For additional information, please refer to the Coding and Payment Guidelines policy.

Policies

PF Artificial disc replacement, cervical

Effective February 1, 2017, insertion of an artificial cervical intervertebral disc will require prior authorization. The service and the corresponding CPT code will be found in the Preauthorization via Web-Based Tool for Procedures policy. Additionally, removal of an artificial cervical intervertebral disc will be a covered service and will no longer require prior authorization.

PF Clinical trials: BlueCHiP for Medicare

A new policy for Clinical Trials for BlueCHiP for Medicare has been created to provide important information concerning coverage and payment guidelines for BlueCHiP for Medicare members participating in approved clinical trials. The separate policy titled Clinical Trials Mandate is now applicable to Commercial products only.

BCBSRI follows The Centers for Medicare and Medicaid (CMS) National Coverage Determinations and coverage guidelines for clinical trials. For Medicare coverage and billing guidelines for clinical trials, please refer to the reference section of this new policy. Also, see the related BCBSRI policy for BlueCHiP for Medicare National and Local Coverage Determinations.

As a reminder, original Medicare (also referred to as Medicare "fee-for-service") covers most of the routine costs for BlueCHiP for Medicare members participating in qualified Medicare clinical trials. Qualified Medicare clinical trials are found at https://clinicaltrials.gov/. All claims for services as part of a clinical trial must be submitted to Original Medicare first. BCBSRI is responsible for the difference between the cost sharing in Original Medicare and the member's Medicare Advantage cost sharing. If the Medicare Advantage cost share is higher than Original Medicare, then BCBSRI will not make a payment.

BlueCHiP for Medicare claims are reviewed for correct coverage of clinical trial services. Please follow the procedures outlined in the newly updated "Physician/Provider Special Handling Claim Request Form" attached within this policy for correct claims submissions.

Submit original paper claims, a copy of the Medicare EOMB, and the Clinical Trial ID# with the Physician/Provider Special Handling Claim Request form to:

Blue Cross & Blue Shield of Rhode Island
Basic Claims Administration – Inquiry Unit – 00066
500 Exchange Street, Providence, RI 02903-3279

Paper claims will not be required once systems changes are completed. The Special Handling Claim Request form will be updated with this information when electronic claims may be submitted. Append the appropriate modifiers Q0 or Q1 and ICD-10 diagnosis code Z00.6 for clinical trial services. Please see the full text of this policy.

PF BlueCHiP for Medicare National and Local Coverage Determinations Policy

BCBSRI will undertake an effort to implement a number of updates to our claim editing rules and processes to help ensure that claims for members enrolled in our Medicare Advantage plans are processed according to standard Centers for Medicare & Medicaid Services (CMS) medical necessity guidelines.

The goal of these claim editing updates is to more closely align how we process Medicare Advantage claims with the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Noridian is our CMS LCD DME contractor and NGS is our CMS part B contractor. To ensure correct claims processing, we encourage our providers to review the CMS NCDs and LCDs that can be found on the CMS website. BCBSRI will continue to align with NCD and LCD updates and will make those updates on a quarterly basis.

A policy document was created to document the above information. Please see the full text of this policy.

Policies

PF Claim review reminders

As a reminder, when submitting claims, providers are to adhere to correct coding guidelines. During a recent claims review, it was noted that there was a high volume of claims that were submitted with the code pair 80061 and 83721 with Modifier 59. As documented in the NCCI Manual in Chapter 10:

> "CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) describes direct measurement of LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol in addition to total cholesterol (CPT code 82465) or lipid panel (CPT code 80061) may be reasonable and necessary if the triglyceride level is too high (greater than or equal to 400 mg/dl) to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier 59."

If BCBSRI continues to see use of this code combination with a bypass modifier, claims will be subject to audit and possible recoveries.

PF Prostatic urethral lift

Effective January 1, 2017, prostatic urethral lifts will be covered for BlueCHiP for Medicare and will not be medically necessary for Commercial products. Please see the full text of this policy.

PF Non-invasive prenatal testing

Effective January 1, 2017, CPT code 81507 will no longer require prior authorization and will be a covered service. Additionally, CPT code 81420 will be a covered service.

PF Minimally invasive surgery for snoring

Effective March 1, 2017, tongue base suspension will be not medically necessary for BlueCHiP for Medicare. There is no change to Commercial products coverage for this service, as it will remain not medically necessary. Please see the full text of this policy.

PF Out-of-network services

A policy was created to document the review process and criteria for when a member is requesting services from an out-of-network/non-contracted provider. This policy is applicable to Commercial products only. Please see the full text of this policy.

PF Interspinous distraction devices

Effective December 31, 2016, code 0171T was deleted and preauthorization of the service will no longer be required for BlueCHiP for Medicare. Preauthorization is not required on the new replacement CPT codes that are effective January 1, 2017, 22867 – 22870. Please see the full text of this policy.

PF Genetic testing services

Effective March 1, 2017, codes 81227 and 81355 will no longer require preauthorization. The codes will be covered for BlueCHiP for Medicare and will be not medically necessary for Commercial Products.

Policies

PF January 2017 CPT® and HCPCS Level II Code Changes

We have completed our review of the January 2017 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code changes, including CPT category II performance measurement tracking codes and CPT category III temporary codes for emerging technology. These updates will be added to our claims processing system and are effective January 1, 2017. This list includes codes that have special coverage or payment rules for standard products. (Some employers may customize their benefits.) We may include codes for services:

- "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.
- "Subject to the unlisted procedure process" – Submit a 1500 form, all procedural notes, and a completed unlisted procedure form with the request for review of the unlisted code.
- "Invalid" – Use alternate procedure code, CPT code, or HCPCS code.
- "Subject to diagnosis code editing" – Services will be covered when the appropriate diagnosis code is submitted with the corresponding procedure code.

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

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

CPT 2017

22853	Not medically necessary for BlueCHiP for Medicare and Commercial products
22854	Not medically necessary for BlueCHiP for Medicare and Commercial products
22859	Not medically necessary for BlueCHiP for Medicare and Commercial products
22867	Subject to diagnosis code editing for BlueCHiP for Medicare and not medically necessary for Commercial products
22868	Subject to diagnosis code editing for BlueCHiP for Medicare and not medically necessary for Commercial products
22869	Subject to diagnosis code editing for BlueCHiP for Medicare and not medically necessary for Commercial products
22870	Subject to diagnosis code editing for BlueCHiP for Medicare and not medically necessary for Commercial products
33340	Subject to medical review for BlueCHiP for Medicare and Commercial products
36473	Not medically necessary for BlueCHiP for Medicare and Commercial products
36474	Not medically necessary for BlueCHiP for Medicare and Commercial products
36907	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
36908	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
36909	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
37247	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
37249	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products

Policies

43284 Not medically necessary for BlueCHiP for Medicare and Commercial products
43285 Subject to medical review for BlueCHiP for Medicare and Commercial products
58674 Not medically necessary for BlueCHiP for Medicare and Commercial products
62320 Not medically necessary for BlueCHiP for Medicare and Commercial products
62321 Subject to medical review for BlueCHiP for Medicare and Commercial products
62322 Not medically necessary for BlueCHiP for Medicare and Commercial products
62323 Subject to medical review for BlueCHiP for Medicare and Commercial products
62324 Not medically necessary for BlueCHiP for Medicare and Commercial products
62325 Subject to medical review for BlueCHiP for Medicare and Commercial products
62326 Not medically necessary for BlueCHiP for Medicare and Commercial products
63237 Subject to medical review for BlueCHiP for Medicare and Commercial products
62380 Not medically necessary for BlueCHiP for Medicare and Commercial products
80305 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare and Commercial products
80306 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare and Commercial products
80307 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare and Commercial products
81327 Not medically necessary for BlueCHiP for Medicare and Commercial products
81413 Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
81414 Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
81422 Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
81439 Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
81539 Not medically necessary for BlueCHiP for Medicare and Commercial products
96160 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
96161 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
96377 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
97164 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
97168 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
97169 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare
97170 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare
97171 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare
97172 Invalid code for professional providers and institutional providers for BlueCHiP for Medicare
99151 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
99152 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
99153 Not separately reimbursed for institutional and professional providers for BlueCHiP for Medicare and Commercial products
99155 Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
99156 Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
99157 Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
0446T Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0447T Subject to medical review for BlueCHiP for Medicare and Commercial products
0448T Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products

Policies

0449T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0450T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0451T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0452T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0453T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0454T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0455T	Subject to medical review for BlueCHiP for Medicare and Commercial products
0456T	Subject to medical review for BlueCHiP for Medicare and Commercial products
0457T	Subject to medical review for BlueCHiP for Medicare and Commercial products
0458T	Subject to medical review for BlueCHiP for Medicare and Commercial products
0459T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0460T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0461T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0462T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0463T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0464T	Not medically necessary for BlueCHiP for Medicare and Commercial products
0465T	Not medically necessary for BlueCHIP for Medicare; not covered for Commercial products
0466T	Not medically necessary for BlueCHiP for Medicare and Commercial products
0467T	Not medically necessary for BlueCHiP for Medicare and Commercial products
0468T	Subject to medical review for BlueCHiP for Medicare and Commercial products

2017 HCPCS

A4224	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
A4225	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
A4467	Not covered for BlueCHiP for Medicare and Commercial products
A4553	Not covered for BlueCHiP for Medicare and Commercial products
A9285	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
A9286	Not covered for BlueCHiP for Medicare and Commercial products
A9515	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
A9587	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
A9588	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
A9597	Follow unlisted review process for BlueCHiP for Medicare and Commercial products
A9598	Follow unlisted review process for BlueCHiP for Medicare and Commercial products
C1889	Invalid code for professional providers; not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
C9140	Invalid code for professional providers; not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
G0493	Invalid code for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0494	Invalid code for professional and institutional providers for BlueCHiP for Medicare and Commercial products

Policies

G0495	Invalid code for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0496	Invalid code for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0499	Invalid code for professional and institutional providers for Commercial products
G0500	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0501	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0502	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0503	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0504	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0505	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0506	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0507	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0508	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
G0509	Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products
J2182	Subject to medical review for BlueCHiP for Medicare and Commercial products
J2786	Subject to medical review for BlueCHiP for Medicare and Commercial products
J7320	Subject to diagnosis code editing for BlueCHiP for Medicare and not medically necessary for Commercial products
J7322	Subject to diagnosis code editing for BlueCHiP for Medicare and not medically necessary for Commercial products
J8670	Not covered for Commercial products; pharmacy benefit only
L1851	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
L1852	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
T1040	Invalid code for professional and institutional providers for BlueCHiP for Medicare and Commercial products
T0141	Invalid code for professional and institutional providers for BlueCHiP for Medicare and Commercial products

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