Blue Cross Blue Shield of Rhode Island

provider update

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

October 2017

In previous Provider Update issues, we've consistently reached out to our provider community to remind you of your obligation, as a Blue Cross & Blue Shield of Rhode Island (BCBSRI)-contracted provider, to coordinate members' care with contracted, in-network providers and facilities.

This means we require BCBSRI-contracted providers to refer their patients to in-network healthcare providers and facilities. This means specialists, such as cardiologists and physical therapists, facilities, such as hospitals and ambulatory surgical centers. We hold the same in-network requirements for ancillary providers, such as radiology facilities, clinical and specialty labs, and durable medical equipment providers, as well.

Adhering to our requirement for network referrals creates a number of advantages for our overall healthcare system, but it's our members who benefit. When you refer to in-network providers, BCBSRI members generally receive more affordable healthcare services. This is achieved by coordinating care with participating providers to lower the administrative and financial burdens that many patients can experience, when referred for services out-of-network.

Here are some of the important advantages BCBSRI's network offers your patients:

- Avoidance of balance billing for healthcare services
- Ability for members and providers to search transparent pricing for procedures in BCBSRI's cost estimator tool.
- Lower overall costs as a result of negotiated rates for service, which means lower out-of-pocket costs for your patients

Additionally, all providers in our network are credentialed, which means they meet all state and federal requirements. Their contracts also ensure that they adhere to our medical and administrative policies designed to protect our members – your patients – and they contain provisions required by Rhode Island law and the Centers for Medicare and Medicaid Services (CMS).

All of these opportunities go a long way in creating a healthcare system that is simpler and more affordable for our members to use.

Before you establish a referral relationship, please confirm that the provider currently participates in BCBSRI's network. You can check the participation status of other providers through our Find a Doctor tool, found by clicking here.

If you would like more information, or need to access to our policy addressing in-network referral requirements, please reach out to Provider Relations at ProviderRelations@bcbsri.org.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

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BCBSRI Update

BCBSRI earns 'Excellent' rating from top national accrediting agency

Katherine Dallow, M.D.
Vice President, Clinical Affairs

In September, BCBSRI hit a significant milestone, regarding our commitment to providing high-quality healthcare in our state. BCBSRI's commercial PPO product line has been rated a score of "Excellent" by the National Committee for Quality Assurance (NCQA), a nationwide, not-for-profit accrediting organization devoted to measuring healthcare quality. This is BCBSRI's highest NCQA rating to date, and only insurers offering programs for service and clinical quality are eligible to earn it. This great news highlights the role that all BCBSRI employees and network providers play in helping us improve healthcare quality and patient satisfaction.

NCQA's survey renewal requirements for scoring are very rigorous. During a thorough review process, we complied with over 800 NCQA standards, ranging from providing reports and data and analytics to appeals, denials, credentialing and renewal records, and case management files. Given all that was involved in pursuing our NCQA renewal survey, it's especially worth mentioning how many associates and teams were involved in helping us attain this distinction. Most notably, our colleagues in Case management/Disease Management, Utilization Management, Behavioral Health, Clinical Affairs and Quality, Grievance & Appeals, Pharmacy, Delegation Oversight, Corporate Affairs, Credentialing, Administrative Quality Monitoring, and Provider Relations were linked up with NCQA from the start and were instrumental in driving our success on this effort.

We view our "Excellent" NCQA rating as cause for celebration, not only for all the dedicated BCBSRI employees who help us deliver high-quality, patient-focused healthcare on a regular basis, but for all providers working with us to make Rhode Island a healthier place.

Important: verify your practice information!

BCBSRI now conducts quarterly fax-based validation and attestation of provider practice information, displayed within our Find a Doctor tool. We are now contacting provider offices directly, via fax, to ensure this information is accurate and up-to-date.

The Centers for Medicare & Medicaid Services requires providers to note whether the location included is the same as where a patient is able to make an appointment. CMS also requires providers to note whether they are accepting new patients.

Once your office has verified your information, please check the "attestation" box and fax it back to BCBSRI, as soon as possible. Please note that even if your information is presently accurate and not in need of updates, your office is still expected to check the attestation box, verify your information, and fax the form back to BCBSRI.

If you have questions about these verification efforts, please email ProviderRelations@bcbsri.org.

BCBSRI Update

The Medicare Annual Enrollment Period is here!

October 15 marked the start of the 2018 Medicare Annual Enrollment Period (AEP). We're excited to once again offer many plan options to our Medicare members so they can choose the one that best meets their needs. Our 2018 plans have earned a rating of 4.0 stars from the Centers for Medicare and Medicaid Services (CMS) as part of their Five-Star Quality Rating System*.

Here are some of this year's highlights and benefit changes:

- A strong local presence, with three Your Blue Store retail locations—including our new flagship store in East Providence—where members can visit to ask questions.
- Our dedicated Medicare Concierge Team to support members and answer any questions they have.
- Savings on prescription drugs, including $0 mail order for a 90-day supply of many medications, as well as preferred local pharmacies where members can save money on certain drugs.
- A coordinated care approach that supports members and providers and promotes cohesive, quality, and cost-effective care.
- Programs to help members healthy and active, like our Living Fit $5 or $10/month gym membership (which includes YMCA locations) and the Virgin Pulse® wellness program
- The BlueCHiP for Medicare dental rider, with the same low monthly premium as in 2017.
- A 24/7 Nurse Care Line for all Medicare members, available at no cost.

You can find more detailed information at bcbsri.com/Medicare. Please note that all Individual Medicare plans will require a referral for 2018.

Thank you as always for your partnership—we can't do it without you! If you or your patients have any questions regarding our Medicare Advantage plans, please contact the BCBSRI Medicare sales representative for your area of the state, and they'll be happy to assist you or your patient.

* Medicare evaluates plans based on a 5-star rating system. Star ratings are calculated each year and may change from one year to the next.

PBF Hints for HEDIS® (and more)

As part of our ongoing efforts to provide the highest quality healthcare 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.

PBF October: Breast Cancer Awareness Month

According to 2014 data[1], the incidence of breast cancer in Rhode Island for females of all races was 133.2 per 100,000. This figure is comparable to national statistics for the same year, but opportunities remain for early detection and treatment of breast cancer.

BCBSRI's Well Adult clinical practice guidelines are derived from the U.S. Preventive Services Task Force guidelines and contain guidance on screening for breast cancer in women. The following table contains recommendations for women, who are not at an increased risk of breast cancer, due to a known genetic mutation or history of chest radiation:

Recommendation	Individualize decision to begin biennial screening, using mammography according to the patient's circumstances and values.	Screen every two years, using mammography.	None.

As of January 1, HEDIS excludes Medicare members age 65 and older within the measurement year, who are:

- Enrolled in an Institutional SNP (I-SNP) at any time during the measurement year.
- Living in an institution for a long-term period of time, at any point during the measurement year.

Organizations may use the LTI flag in the Medicare Part C monthly membership file.

Mammograms

Mammograms are a covered service for BlueCHiP for Medicare and Commercial members. Mammograms that are performed as preventive are covered at 100%, according to the Affordable Care Act. Benefit coverage for diagnostic mammograms varies, according to the member's coverage. Please encourage members to obtain their mammograms according to the clinical recommendations for their age, risk level, and circumstances.

[1] U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999-2014 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2017. Available at: www.cdc.gov/uscs.

Quality

If a member in your practice is coping with breast cancer or is newly diagnosed, they may seek recommendations for personal support community services, as a supplement to their medical care. The following is a list of local organizations that can provide information, advocacy, and support regarding breast cancer:

- American Cancer Society, Rhode Island Chapter: call (401) 243-2600
  – Cancer information specialists can also be reached 24 hours a day at 1-800-227-2345
- Breast Cancer Council of Rhode Island: call 1-800-216-1040 or email ribcc@aol.com
- Gloria Gemma Breast Cancer Resource Foundation: call (401) 861-HERO (4376), or email info@gloriagemma.org

You can also refer these members to our care coordination program, which assists members with coordinating screenings and meeting individual health goals.

Please refer members to (401) 459-CARE (2763), or email triage_group@bcbsri.org.

Comprehensive Diabetes Care

The HEDIS Comprehensive Diabetes Care measure set includes screening rates for retinal eye exams, HbA1c, blood pressure, nephropathy screening, as well as rates of A1C control in patients with type 1 and type 2 diabetes.

New HEDIS CPT category 2 code

Per developments in HEDIS 2017, NCQA added a new CPT Category 2 code to identify diabetic eye exams that are negative for retinopathy. The new code is 3072F.

There are time-saving benefits to using this new code. 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.

Please contact Courtney Reger, R.N., quality management analyst at (401) 459-2763 or courtney.reger@bcbsri.org with any questions.

Hemoglobin A1c Testing	An HbA1c test during the measurement year	• Pre-visit planning may be useful. • Medical assistants mail appointment reminder letters and lab slips to those due for HbA1c screening and other tests. • Reinforce the importance of routine A1c testing, as an indicator of diabetes control and guide to treatment planning.
HbA1c poor control (>9.0%)	• The most recent HbA1c test during the measurement year with a result greater than 9.0% • A missing result	• 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%)	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.

Quality

Comprehensive diabetes care measure	*Measure population: (Type 1 or 2 diabetes plus:)*	*Tips for success*
Eye exam (retinal) performed	• A retinal eye exam by an optometrist or ophthalmologist in the measurement year • A "negative for retinopathy" retinal exam by an above specialist, occurring in the year prior to the measurement year	• 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 • Evidence of nephropathy	• Dispensation of at least one ACE-I or ARB medication counts as evidence of treatment for nephropathy. • Remind patients that, like eye disease, diabetic kidney disease may be asymptomatic. Regular tests can detect issues early, when treatment may help delay disease progression. • Pre-visit planning may be useful, when screening tests are due. For members with upcoming appointments, have medical assistants note in the patient's schedules or records that a urine test for Microalbumin is needed.
BP Control (<140/90 mm Hg)	• The most recent blood pressure reading taken during an outpatient visit • A non-acute inpatient encounter	• Discuss the importance of BP control, especially given additional cardiovascular risks for people with diabetes. • Obtain two readings upon visit, if initial reading is elevated.

BCBSRI offers a disease management program for Commercial members with diabetes. Interventions are based on risk stratification. All identified low-risk members receive a mailing, which introduces the program and provides educational material. A call-in line is also available for members seeking additional information or answers to questions. Diabetic members with gaps in care, who are at moderate risk, receive notifications recommending they contact their physician to schedule necessary screening or testing.

For those members designated as high-risk, they are offered an opportunity to participate in telephone health coaching with a BCBSRI registered nurse or registered dietitian. High-risk members belonging to a patient centered medical home (PCMH) are notified with the recommendation that they contact their PCP's nurse case manager for assistance with diabetes management.

If you have Commercial members who are eligible to benefit from BCBSRI's diabetes disease management, please call the BCBSRI Triage Line at (401) 459-2273 or email triage_group@bcbsri.org.

Controlling blood pressure

Controlling Blood Pressure (CBP) is both a HEDIS and CMS Stars measure. The following table summarizes the 2018 HEDIS specifications for CBP:

Percentage of members ages 18–85 with a diagnosis of hypertension and whose BP was adequately controlled	• Members ages 18–59 whose BP was <140/90 mm Hg • Members ages 60–85 w/diagnosis of diabetes whose BP was <140/90 mm Hg	• HEDIS uses the most recent BP reading recorded in the measurement year, after a diagnosis of hypertension. Obtain two readings upon visit, if initial reading is elevated. If there are multiple readings in one visit, the lowest systolic and lowest diastolic can be used for HEDIS. • Document the actual number, as blood pressure values should not be rounded. • Use correct diagnosis codes. Notations of "rule out HTN," "consistent with HTN," "possible HTN" are not adequate confirmation of a hypertension diagnosis. • Perform annual check and calibration of sphygmomanometers. • Consider referral to a registered dietician for patients requiring nutritional guidance • Consider refresher training to help standardize BP measurement techniques among your staff.

When measuring blood pressure, technique matters.

The American Heart Association offers guidelines for measuring blood pressure, which include the following instructions for 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 measuring blood pressure 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. This is 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.
- Full guidelines are available on the NHLBI's website at www.nhlbi.nih.gov/guidelines/hypertension/index.htm. You can also view the BCBSRI clinical practice guideline for High Blood Pressure on our secure provider portal.

Tools for your patients

The Million Hearts® campaign is a national initiative working to prevent 1 million heart attacks and strokes. The Centers for Disease Control and Prevention and CMS co-lead this initiative on behalf of the U.S. Department of Health and Human Services. The website contains data, research, provider tools, and patient materials, designed to inform clinical practice and promote prevention and management of chronic cardiovascular diseases such as hypertension.

To visit the Million Hearts® website, please click here to find more information.

Antidepressant Medication Management

Antidepressant Medication Management is a HEDIS measure focusing on the percentage of members who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment. The measure captures two rates: the effective acute phase, along with the effective continuation phase.

Antidepressant Medication Management	Effective Acute Phase Treatment is the percentage of members who remained on antidepressant medication for at least 84 days (12 weeks)	A follow-up office visit to assess symptoms should be conducted at a maximum of six weeks. Visits should be sufficiently frequent to optimize adherence. Remind patients that symptom alleviation may take two-to-four weeks, and up to eight weeks for the medication to fully work. Remind patients to continue taking medications for at least six months, even if symptoms improve.
	Effective Continuation Phase Treatment is the percentage of members who remained on antidepressant medication for at least 180 days (six months)	

PF Clinical practice guidelines

The 2017 Clinical Practice Guidelines for Coordination of Care and Well Child with the Periodicity Schedule were reviewed and approved by the Professional Advisory & Credentials Committee on May 24, 2017. The next review will take place in May 2019.

The 2017 Clinical Practice Guidelines for Low Back Pain were reviewed and approved by the Professional Advisory & Credentials Committee on July 26, 2017. The next review will take place in July 2019. The 2017 Clinical Practice Guidelines for Chronic Heart Failure were reviewed and approved by the Professional Advisory & Credentials Committee on September 27, 2017. The next review will take place in September 2019.

B Behavioral Health

Our Behavioral Health partner, Beacon Health Options (Beacon), has updated their behavioral health medical necessity criteria. These updates will take effect November 1, 2017. To view Beacon's updated criteria, please click here. This new criteria is inclusive of ASAM, NCD/LCD for Medicare.

October 5th was National Depression Screening Day

BCBSRI supports and encourages use of the PHQ-9 for depression screening in primary care settings. As part of our commitment to helping our members live their healthiest lives, we are helping to spread the word on the importance of screening for depression. We encourage you to speak with BCBSRI members about the importance of screening for depression.

The month of October saw yet another National Depression Screening Day take place across the country, as well as here in Rhode Island. This important event serves as an effort to reach individuals across the nation with important mental health education and connect them with support services. Screening for Mental Health pioneered National Depression Screening Day as the first, voluntary mental health screening initiative in 1990.

Why screen for depression in primary care?

- The USPS Task Force has issued guidelines for universal depression screenings and stated that 100% of patients should be screened annually for depression.
- Depression is one of the most common chronic conditions across the population. NAMI estimates that 1 in 4 adults, at any point in time, are living with depression.
- Patients with mild or moderate depression often go undetected. By discussing and screening for depression, patients can experience relief and can work with their PCP to discuss treatment options. Discussing and screening for depression can also help patients create an action plan that may help them avoid more severe depression and the subsequent need for more intensive medical care.

What do I do if my patient screens positive for depression?

As a PCP, your established relationship with patients offers the opportunities to identify depression and facilitate treatment. Work together with your patient to create a comprehensive treatment plan, using shared decision making. Some examples of interventions may include providing the patient with resources on depression, as well as the relationship between depression and chronic disease. You can also intervene by providing patients with information on medication, when applicable. You may also consider offering Problem Solving Treatment, or even brief, supportive counseling services within your practice.

Provide member with referrals for specialty care as needed. Not everyone with depression needs a referral for therapy. Some patients could benefit from brief interventions that can be done by a nurse case manager or other clinical staff who are already working in your practice. Consider options for providing supportive counseling to patients as needed, particularly as a patient is starting on a new antidepressant. It is important to stay in contact with the patient as they are managing their depression and/or other chronic conditions. Frequent check-ins with patients to provide support and education as needed will help them stay on track with managing their depression. Behavioral Health Case Management, provided through our behavioral health partner, Beacon Health Options, is also available to you as a resource for your patients. Please see below for additional information on Beacon's program and other ways to connect your patients to behavioral health resources.

Behavioral Health

How do I connect a patient to Behavioral Health services?

The behavioral health system can be confusing and overwhelming for your patients to navigate. As BCBSRI continues to expand our continuum of services for Behavioral Health, we realize that providers may have questions regarding the types of services available for their patients. There are several ways to learn more about behavioral health benefits and services:

- The Physician and Provider Service Center can answer questions regarding a member's benefits, including member liability for services. They can also assist if you're simply looking for a participating behavioral health provider. You can contact the The Physician and Provider Service Center at (401) 274-4848. You may also search our website, bcbsri.com, if you are searching for a behavioral health provider.
- The Beacon Health Options Clinical Referral Line is available 24/7 and is answered by clinical behavioral health staff. The clinical referral line can assist you in identifying a behavioral health provider, as well as providing support and guidance. Please do not use the clinical referral line, if there is concern of imminent danger or self-harm. The referral line can be a first point of contact in non-emergency situations, however. The clinician, who may be a registered nurse, independently licensed social worker, or a mental health counselor, will ask questions to gain a better understanding of your patient's needs. The clinician will provide information on services are available, along with the names and contact information of providers offering these services. Contact Beacon's Clinical Referral Line by calling 1-800-274-2958. You may also share this number with your patients, if they prefer to contact Beacon themselves.
- Beacon Health Options Intensive Case Management Program can assist your patients in effectively managing their behavioral health conditions. Independently licensed behavioral health clinicians will work with your patient to:
  - Understand barriers that prevent them from maximizing their treatment or in obtaining recommended treatment.
  - Find and obtain services or resources needed to better manage their behavioral health condition(s).
  - Provide education and supports to help them better manage their condition(s).
  - Coordinate care with providers to they have the necessary information to pursue and receive the best care and support.
  - Understand what medications they're taking, along with their instructions.

To refer a patient to Beacon Health Options Case Management program, please call 1-800-274-2958, press option 3, followed by option 1.

You may also use our automated referral form at bcbsri.com, by following these easy steps:

1. Log on to the provider portal of BCBSRI.com
2. Click on Tools and Resources
3. Click on Forms
4. Click on Case Management Request
5. Complete the required fields and click Go!

If your office is seeking more information on depression screening and follow up care, please contact Sarah Fleury, LICSW, CPHQ, Lead Behavioral Health Clinical Program Specialist at (401) 459-1384 or email sarah.fleury@bcbsri.org.

Behavioral Health

New England Health Plan offering on substance use disorder

BCBSRI's New England Health Plan (NEHP) offers opportunities for members to use behaviorial health services for treatment of a substance use disorder (SUD). Because these are regional plans, BCBSRI's policies will follow mandates in the other participating New England states. If a state mandate for a service is stricter than our Rhode Island mandate, we will follow that state's mandate. Behavioral health services are impacted by this rule. Please consult the product policies to ensure your members receive the appropriate in-network coverage of services.

For New England Health Plan members only, BCBSRI will provide coverage for medically necessary substance use disorder (SUD) acute treatment services and medically necessary SUD clinical stabilization services for up to a total of 14 days with no prior authorization, provided that the facility shall notify the carrier of both admission and treatment plan within 48 hours of admission. Utilization review procedures may be initiated on day seven. This applies to inpatient services (ASAM levels 3.7 and 4) and residential treatment (ASAM level 3.5). Additionally, there is no prior authorization required for substance use disorder treatment for the following levels of care: partial hospital program (PHP); intensive outpatient program (IOP); and child and family intensive treatment (CFIT)/adult intensive treatment (AIS) services. Beacon Health Options will require a notification of admission and will authorize an initial length of stay as follows: PHP, five days; IOP, nine days; AIS/CFIT, 21 days.

Members in these plans can be identified by the three-letter prefixes on their ID card—RIN and RIS. If you have any questions regarding an authorization for behavioral health services, please contact our behavioral health vendor, Beacon Health Options, at 1-800-274-2958.

Pharmacy

As you know, BCBSRI updates our Commercial formularies in April and October. To review a summary of new formulary changes, please see the Pharmacy Information section in the provider portal at bcbsri.com.

PBF Drug formulary changes with Prime Therapeutics

BCBSRI's individual market segment (Direct Pay and Health Source Exchange) will be assigned to a new formulary of covered drugs, sponsored by Prime Therapeutics (Prime). BCBSRI Individual Market members may be impacted by changes in formulary coverage, drug copay tier and required pharmacy utilization management (UM) programs. Members who are negatively impacted by the formulary change will be notified by BCBSRI. Members with open authorizations on file for formulary-covered products will have those authorizations carried over as part of this transition. However, authorizations for non-formulary covered drugs will not be carried over as part of this transition.

To learn more about our new drug formulary with Prime, please click here to visit our website. For assistance with new prior authorizations, you can contact Prime at 1-855-457-0759 for Commercial members.

PBF New England Health Plan (NEHP): Network Blue New England and Blue Choice New England

BCBSRI has launched new NEHP product offerings, Network Blue New England and Blue Choice New England, which is aimed at streamlining affordability, improving in-network referrals, and supporting primary care as a touchstone of personal healthcare. NEHP products grant access to healthcare network options across five New England states, meaning that members using this product suite use a network provider, hospital, or select freestanding facility in Connecticut, Maine, Massachusetts, New Hampshire, or Rhode Island.

These Network Blue New England and Blue Choice New England products are effective on October 1, 2017, and members enrolled in these products are required to select a PCP to help coordinate their care with specialists.

We encourage you to work within NEHP to place primary care at the center of patient well-being. We want to make the relationship between our members and their PCPs a foundational component of healthcare that prioritizes affordability and simplicity for our members.

We invite you to learn more about our NEHP product offerings, along with the importance of primary care as an established function of healthcare, by contacting Provider Relations at ProviderRelations@bcbsri.org.

PBF Introducing BlueCHiP Direct Advance

Effective January 1, 2018, BCBSRI will offer a new product on the individual Commercial market, available through HealthSource RI. BlueCHiP Direct Advance will be available to members as a limited network, referral based product that supports our commitment to making healthcare simpler and more affordable.

The BlueCHiP Direct Advance provider network is designed around the Lifespan health system. This network includes select primary care, specialists, and ancillary providers, as well as all Lifespan hospitals and select freestanding facilities.

PCPs are responsible for generating referrals to specialists. While specialists are able to verify the status of a referral through our web-based referral tool they are not able to generate or enter referrals. If specialist services are rendered without a referral, the claim may be denied.

As always, we ask that you verify BCBSRI member benefits and eligibility by logging on to the secure provider portal of bcbsri.com to confirm member coverage prior to rendering services. You can verify BlueCHiP Direct Advance members by validating the prefix code ZBE on the member identification card.

If you have any questions regarding BlueCHiP Direct Advance or your participation status, please call Provider Relations at 1-844-707-5627 or speak with your practice manager/administrator.

PBF EDI update: HIPAA translator software

In October, Blue Cross & Blue Shield of Rhode Island (BCBSRI) will be updating its EDI HIPAA compliance validation requirements software. These updates will enforce stricter adherence to HIPAA X12 transactions, which are mainly Level 4 (situational) edits.

To ensure your files continue to be accepted for processing, please reach out to your electronic software vendor (837,834, 820, 27x) to inform them of this upgrade.

Using this new software, BCBSRI has analyzed production files and identified the following issues:

837s – Claims files

- HI Segment qualifiers for ICD-9 are no longer allowed. Must use ICD-10 ABK/ABJ, etc. (diagnosis codes)
- CTP segment (drug quantity) is required, when NDC codes are sent in LIN segment
- SBR segment: Payer name missing, Insurance type code missing
- SV1 segment: Service type code values must be valid
- SV2 segment: Conditional missing composite element
- DTP segment: Check date ranges to verify that the "from" date precedes the "to" date on claims
- N4 segment: Country code is not allowed, when the address is in the United States
- NM1 segment: Missing last name
- PAT segment: Unauthorized relationship code to insured member being sent
- HL segment: Missing and is required

834s – Group enrollment and changes files

- INS segment: INS07 is required, when INS06 is sent
- N4 segment: country code is not allowed when the address is in the United States
- PER segment: Must send data, when preceding field contains qualifier
- PAT segment: Unauthorized relationship code to insured member being sent

27x transactions (eligibility requests, claims status requests, pre-authorization requests)
INS segment

- If state/province code (N402) is non-alpha
- (ii) If subscriber TRN is present on a dependent inquiry
- (iii) If INS segment is provided, regardless of all mandatory search criteria being present

If any of these validation errors are found, a 997 is returned with appropriate Ak3 segment. If you wish to test your files, you may do so in the TEST region, using your T00 mailbox. If you do not make changes to your files for these issues, you will receive a 999 response back, detailing the specific issues your file is encountering, during HIPAA translation. If this occurs, you will need to make appropriate corrections and resubmit the file.

If you have any questions regarding this upgrade, please email hipaa.edi.support@bcbsri.org.

Correct coding

The American Academy of Orthopedic Surgeons (AAOS) and the Medicare National Correct Coding Initiative (NCCI) provide guidance on the coding of musculoskeletal-related services. BCBSRI follows NCCI guidelines

As we continue our review of correct coding, we noted that musculoskeletal-related services have a high volume of claims filed with modifier 59 "Distinct Procedural Service." Modifier 59 is commonly misused but, under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used specifically to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under certain circumstances and documentation must support one or more of the following:

- Different session
- A service that is different because it was performed by a different practitioner
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- An unusual Non-Overlapping Service, Separate lesion, or separate injury (area of injury with extensive injuries), not ordinarily encountered or performed on the same day by the same patient.

However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, then should modifier 59 be used.

Every surgical procedure includes an inherent Evaluation and management (E&M) component as part of the global surgical package. Performing a history and exam is a standard of care to assess for contraindications or reasons not to perform the procedure for procedures with a 0 or 10-day global period. If the decision is made to perform a major surgical procedure, the E&M is separately reportable with modifier 57.

An example of this would be an established patient with a history of carpal tunnel returns for the sole purpose of getting another therapeutic injection to relieve pain. An E&M is not warranted because, over time, the effects of an injection often fade and pain returns. This may require other injections in the series. If the patient returns for another injection as part of a series as a standard of care or treatment plan, it is not appropriate to report a separate (E/M) service.

Prior to reporting both an injection and E&M service with modifier 25 "significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or another service." E&M documentation must support one or more of the following:

- Is this a new injury/problem?
- Is this an exacerbation of a previous injury/problem?
- Is this an unanticipated change in the condition?
- Is there a change in the treatment plan?

Claims

If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates the procedure includes radiologic guidance, a provider should not separately report a HCPCS/CPT code for radiologic guidance. This is includes, but is not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the provider performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

Similarly, if the evaluation of an anatomic region and guidance for a needle placement procedure in the anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a provider should not report a diagnostic ultrasound CPT code and CPT code 76942 (Ultrasonic guidance for needle placement…) when performed in the same anatomic region on the same date of service. Providers should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service.

An example of this would be if a CPT code 20606 describes Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting and CPT 76882 describes an Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific. It is a misuse to report CPT 76882 with CPT 20606 when being performed in the same anatomic area, therefore; CPT 76882 is bundled into 20606.

CMS considers the ipsilateral shoulder to be a single anatomic structure. Only when procedures are performed on the contralateral shoulder or if extensive debridement is performed in a different area of the ipsilateral shoulder should they be bypassed with an NCCI-associated modifier. The knee is treated differently as CMS recognizes the knee as having three compartments and if the procedures performed do not overlap in the ipsilateral compartments they can be bypassed with an NCCI-associated modifier.

A final example of this would be a CPT Code 29827 describing Arthroscopy, shoulder, surgical; with rotator cuff repair and CPT Code 29820 describes Arthroscopy, shoulder, surgical; synovectomy, partial. When the procedures are performed on the same shoulder during the same operative encounter reporting CPT code 29827 with CPT code 29820 is not appropriate because the shoulder joint is a single anatomic structure. Also, 29827 is a more extensive procedure, therefore CPT Code 29820 is bundled into CPT Code 29827.

Contracting & Credentialing

PBF Requirement to refer members to in-network providers for all BCBSRI products

As a BCBSRI-contracted provider, there is an obligation to coordinate member care with contracted, in-network providers. This includes services, such as durable medical equipment, radiology, behavioral health providers, and clinical laboratory and pathology services.

To keep you up-to-date on all in-network developments. The following laboratories are not participating providers with BCBSRI:

- Lehigh Valley Toxicology
- Mercy Diagnostics
- Total Toxicology
- U.S. Lab & Radiology, Inc.
- Quest

Before you establish a referral relationship, please confirm that the provider you will be referring members to contracted within the BCBSRI network. You can confirm participation by checking the status of providers on BCBSRI's Find a Doctor tool.

Policies

PF Policies recently reviewed for annual update

The following policies were recently reviewed for annual update.

- Acute Inpatient Rehabilitation Level of Care
- Carotid Angioplasty/Stenting without Embolic Protection
- Cochlear Implants
- Diabetes Self-Management Education Mandate
- Functional Neuromuscular Electrical Stimulation
- Immune Cell Function Assay
- Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence (added Urinary)
- Intensity-Modulated Radiotherapy: Abdomen and Pelvis
- Intensity-Modulated Radiotherapy of the Breast and Lung
- Intensity-Modulated Radiotherapy: Cancer of the Head, Neck or Thyroid
- Intensity-Modulated Radiotherapy: Central Nervous System Tumors
- Intensity-Modulated Radiotherapy of the Prostate
- Manipulation under Anesthesia
- Oral Nutrition Mandate
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Proprietary Laboratory Analyses (PLA) Codes
- Serum Biomarker Human Epididymis Protein 4
- Therapeutic Shoes for Diabetics Mandate
- Venipuncture for State Mandated Lead Screening

To view the full text of these policies click here:

Policies

PBF New Policies

The following new policies are ready for review. Dates when these policies take effect vary, so please carefully review their full text. Policy information can be found in the Provider section of bcbsri.com, located under the Medical Policy heading. Please click on each below bullet point to review specific policy information:

- Molecular Testing in the Management of Pulmonary Nodules
- Proteogenomic Testing for Patients with Cancer (GPS Test)

PBF BlueCHiP for Medicare national and local coverage determinations policy

BCBSRI must follow CMS guidelines for national coverage determinations (NCD) or local coverage determinations (LCD). Therefore, policies for BlueCHiP for Medicare may differ from policies for Commercial products. In some instances, benefits for BlueCHiP for Medicare may be greater than what is allowed by CMS.

In the absence of an applicable NCD, LCD, or other CMS-published guidance, BCBSRI will apply policy determinations developed using peer-reviewed scientific evidence. BCBSRI will continually review NCD and LCD updates and implement appropriate policy changes.

Due to the ongoing effort to follow CMS NCDs and LCDs, many BCBSRI policies are now applicable to commercial products only. In these instances, please refer to the BlueCHiP for Medicare National and Local Coverage Determinations policy for further information on coverage for BlueCHiP for Medicare.

PF High-Tech Radiology Imaging

The High-Tech Radiology Imaging policy has been updated to reflect that the procedure codes listed below will require preauthorization effective January 1, 2018. Preauthorization will be required for BlueCHiP for Medicare and recommended for all commercial products for the High-Tech Radiology codes listed below. Please contact the Blue Cross Blue Shield of RI (BCBSRI) Radiology Management program vendor for BlueCHiP for Medicare and Commercial Products.

Tech Radiology codes are as follows:

78013	78102	78216	78266	78445	78605	78700	78800
78014	78103	78226	78278	78457	78606	78701	78802
78015	78140	78230	78290	78458	78607	78707	78803
78016	78185	78231	78291	78579	78610	78708	78804
78018	78195	78232	78300	78580	78630	78709	78805
78070	78201	78258	78305	78582	78635	78710	78806
78071	78202	78261	78306	78597	78645	78725	78807
78072	78205	78262	78315	78598	78647	78730	G0235
78075	78206	78264	78320	78600	78650	78740	
	78215	78265	78414	78601	78660	78761	

October 2017 CPT® CPT® and HCPCS Level II code changes

We have completed our review of the October 2017 current procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code changes, including category II performance measurement tracking codes and category III temporary codes for emerging technology. These updates will be added to our claims processing system and became effective October 1, 2017. 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 listed as:

- Invalid: use alternate procedure code, CPT code or HCPCS code
- Medicare Lab Network: codes that are reimbursed to a hospital laboratory outside of the laboratory network, physician or urgent care center providers for BlueCHiP for Medicare.
- Not Covered: includes services not covered in the main member certificate, such as services covered as a prescription drug.
- Not Medically Necessary: this indicates services where there is insufficient evidence to support medical necessity.
- Not Separately Reimbursed: services that are not separately reimbursed are generally included in payment for service another service, or they 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.

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 it is the responsibility participating BCBSRI network providers to notify members about non-covered services, prior to rendering them.

October 2017 CPT updates

0018U—subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products

0019U—not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products

0020U—not covered for institutional and professional providers for BlueCHiP for Medicare and Commercial products

0021U—subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products

0022U—not medically necessary for institutional and professional providers for BlueCHiP for Medicare

0023U—subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products

October 2017 HCPCS Updates

Code comments

C9491—invalid code for professional providers for BlueCHiP for Medicare and Commercial products

C94920—invalid code for professional providers for BlueCHiP for Medicare and Commercial products

C9493—subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products

C9494—subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products

PF Stereotactic Body Radiation Therapy

The medical coverage criteria for Stereotactic Body Radiation Therapy, formerly titled Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy, has been updated for BlueCHiP for Medicare and commercial products. Prior authorization continues to be required for stereotactic body radiation therapy for BlueCHiP for Medicare and is recommended for Commercial products. Prior authorization is obtained through BCBSRI's online tool for providers. Please click here to read the full text of this policy.

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