Blue Cross Blue Shield of Rhode Island

provider update

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

November & December 2017

Have a happy and healthy Holiday season, from all of us at Blue Cross & Blue Shield of Rhode Island!

Effective January 1, 2018, all BlueCHiP plans will require primary care providers (PCPs) to generate web-based referrals to specialists. This requirement applies to BlueCHiP Commercial and all individual BlueCHiP for Medicare products*. It reflects Blue Cross & Blue Shield of Rhode Island's (BCBSRI) ongoing efforts to place PCPs at the center of our members' healthcare.

Currently, only BlueCHiP for Medicare Advance members require a referral. Because all individual BlueCHiP for Medicare members will require a referral in 2018, PCPs can begin generating referrals in early December of 2017. Please communicate with your patients before making these referrals.

Here are a few things to keep in mind regarding web-based referrals:

- Web-based referrals are valid for up to 180 days
- PCPs can retroactively generate a web-based referral within 30 days of the specialist visit
- Claims filed for specialist services rendered without a web-based referral will be denied.

*Group BlueCHiP for Medicare members are not affected by this change and do not require a referral.

For more information on our web-based referral tool, as well as our suite of BlueCHiP products, please email ProviderRelations@bcbsri.org.

You can also learn more about the referral requirements for our Medicare Advantage plans in our Products & Benefits section on page 9.

I'd like to thank all of you for another year of working together to bring simpler and more affordable healthcare to Rhode Island. Enjoy your holidays, and have a happy new year.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

Contents

BCBSRI Update

Submit your story personal journey with heart disease or stroke through the Heart2Heart campaign

Heart disease and stroke remain leading causes of death in women. That's why BCBSRI and the American Heart Association (AHA) are teaming up to create the Heart2Heart campaign. We're inviting you to join us!

If you have patients who are heart disease or stroke survivors, we encourage you to speak to them about submitting their personal stories about the challenges faced and lessons learned when dealing with these issues. This helps inspire other women to make healthy, positive changes in their lives, while supporting the important work the AHA does to keep women healthy. If your patient is interested in sharing her journey in dealing with heart disease or stroke, she can submit her story by going to https://www.bcbsri.com/heart.

As part of the Heart2Heart campaign, BCBSRI will donate a total of $25,000 to the AHA's Go Red for Women Luncheon. Those whose stories are selected will have donations made in their name.

To learn more about the Go Red for Women Luncheon, visit SNEGoRedLuncheon.heart.org. You may also call Tami Iavarone at (401) 228-2322, or email her at tami.iavarone@heart.org.

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 (CMS) 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

BCBSRI offers LGBTQ Safe Zone certification!

Safe Zone
Committed to providing a supportive environment for LGBTQ individuals.
Blue Cross Blue Shield of Rhode Island
www.bcbsri.com

BCBSRI encourages healthcare providers in our participating network to collaborate with us in support of the lesbian, gay, bisexual, transgender, queer (LGBTQ) 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.

In 2017, 13 practices were certified, including:

- Four health centers
  - Planned Parenthood – Providence Health Center
  - Thundermist Health Center of South County
  - Thundermist Health Center of West Warwick
  - Thundermist Health Center of Woonsocket
- Three dental clinics
  - Thundermist Health Center of South County – Dental Services
  - Thundermist Health Center of West Warwick – Dental Services
  - Thundermist Health Center of Woonsocket – Dental Services
- Four behavioral health providers
  - Jayna Klatzker, LICSW
  - Jessica Peipock, LICSW
  - Laurie Thornton, MA, CAGS, LMHC
  - Wilder Therapy and Wellness
- Two specialty practices
  - Rhode Island Nutrition Therapy
  - R.I. Women's Health & Midwifery

If you would like to become a BCBSRI LGBTQ Safe Zone certified practice, please contact Susan Walker, provider relations manager, at (401) 459-5381 or susan.walker@bcbsri.org.

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.

Tips and tricks for HEDIS

The following tips will help you optimize your HEDIS performance, as the year comes to an end, ultimately increasing the quality of care your patients receive:

The National Committee on Quality Assuarance (NCQA) introduced a new measure for HEDIS 2018 called Transitions of Care. This measure seeks to improve coordination of care for Medicare patients transitioning from one care setting to another. Transitions of Care is a multiple part measure that addresses admission and discharge notification, patient engagement, and medication reconciliation.

Please note that hospital admission and discharge paperwork should be scanned into the patient's medical record on the day of admission and discharge, or on the following day. A follow-up visit should be booked within 30 days of discharge. Medication reconciliation may be completed during an outpatient visit occurring within 30 days of discharge. It can also be done via phone call with a prescribing practitioner, clinical pharmacist, or a registered nurse documented in the patient's chart. A provider with prescribing authority, a registered nurse, or a clinical pharmacist must perform medication reconciliation. Submit CPT Category 2 code 1111F when medication reconciliation is performed.

To be compliant with this measure, please:

- Notify of inpatient admission. Up to one day after discharge, provide documentation of inpatient admission.
- Provide documentation discharge information up to one day after discharge.
- Provide documentation of patient engagement within 30 days of discharge. Examples of patient engagement are office visits, home visits, or telehealth sessions.
- Provide documentation of medication reconciliation. You have a total of 31 days to provide this.

There are many other tips available for you to make the most use out of HEDIS. For providers, you can familiarize yourself with BCBSRI's Quality Incentive Program. You can report compliance, maximize coding through claims, and much more. Refer to BCBSRI's COT Category II Code guide, or see the PCP Quality Incentive Program booklet. Providers may also collaborate with BCBSRI on medical records requests. BCBSRI strives to minimize provider disruption, by coordinating HEDIS and risk adjustment medical record requests. No special request or patient authorization is needed.

Avoiding preventable admissions for patients with chronic conditions

Avoiding preventable admissions and readmissions of patients with chronic conditions is a combined effort by providers across all levels of care. Poor management of chronic health conditions have contributed to 22% of preventable 30-day readmissions and results in an estimated $17 billion in Medicare expenses every year. Aggressive management of patients with chronic conditions results in avoidance of unnecessary admissions and prevent readmissions. Proper care coordination, including reconciliation of medications, prevents waste by eliminating unnecessary medical care.

Quality

In response to these challenges, providers have transformed their practices to include care management and better coordination between healthcare providers. Providers are doing this by extending office hours to evenings and weekends. On the facility side, it remains imperative that coordination of care during discharge from a healthcare facility include medication management, individualized education on new diagnoses and explanation of the impact they will have on current chronic conditions. A discussion of post-discharge follow-up should also be completed. The amount of time between discharge from a hospital and contacting patients correlates with the likelihood of readmission. The more resources a patient receives, the greater chance they will be successful in managing their chronic conditions. Since 39% of patients indicate that they want their provider to play an active role in their healthcare and need assistance managing chronic conditions between appointments, engaging patients to have an increased understanding of their illness, treatment, and next steps is important.

HEDIS provides an indicator for measuring the management of chronic health conditions by providers in the BCBSRI network and currently indicates poor performance with hospital admissions > 2 times expected.

What can you do to best manage patients with chronic conditions?

- Identify high utilizers of healthcare services and create individualized care plans
- Use home care, phone contact by nurses, and pharmacy programs
- Monitor disease specific indicators
- Be proactive in helping patients manage chronic health conditions
- Address health literacy, knowledge deficits, and cultural barriers
- Tailor communications with personalized information
- Provide multiple resources to patients to increase the likelihood of success

We offer a Care Coordination program, which can help you coordinate BCBSRI members' care management and provide support needed to meet their health goals.

Please call (401) 459-CARE (2273) or TTY: 711. You can also email triage_group@bcbsri.org.

If you have any questions, comments, or ideas regarding any of our quality or clinical initiatives, please contact Monica Broughton, MPH and quality management analyst, at (401) 459-1146, or email her at monica.broughton@bcbsri.org.

Educating patients on important health screenings and exams

Colorectal cancer screenings

Regarding patient education around important health screenings, such as colorectal cancer, you can also document in a member's medical record any discussion you've had about screenings. You can follow up on referrals and educate members on any alternatives to a colonoscopy, if clinically appropriate. Cologuard®, and other stool tests, are generally covered at 100%. Moreover, they are HEDIS compliant.

High blood pressure

When working with patients to control high blood pressure, take two blood pressure readings during a visit, ensuring that patients with high readings are rechecked at the time of service. Ensure all documentation is legible.

Diabetes

When screening patients with comprehensive diabetes, all patients with diabetes should have a minimum of one HBA1C per calendar year and one nephropathy screening. Reach out to non-compliant patients or use acute visits to address the importance of these diabetic screening tests. Additionally, document any discussion in the medical record, including whether the member declined screening for reasons of inconvenience or cost.

Quality

Following up on referrals for diabetic eye exams is also important, when complying with HEDIS. Educate patients that receiving a dilated eye exam is not always necessary. Either a retinal dilated eye exam in 2017 or a negative retinal or dilated eye exam (with no evidence of retinopathy) in the year prior (2016) to the measurement year count toward HEDIS compliance for diabetic members. Both should be done by eye care professionals.

Please note: use of CPT® Category II code 3072F (Diabetic Retinal Screen Negative), when used, appropriately closes the gap in care for two years, as set forth by NCQA via the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures.

Adult BMI assessment

Create pportunities to capture Body Mass Index (BMI) even during acute visits. Results should be clearly recorded in the medical record. Reach out to patients, who have gone two years without being seen in two years. Remember, it's not too late to capture adult BMI information. If, during an outpatient visit in the past two years, a member has had their height and weight measurements taken, you can still calculate the BMI value and document it in a medical record as a late entry.

Going forward, it is important to use the ICD-10CM Codes to identify BMI (numerator) Adult BMI Value: Z68.1–Z68.45. This will close the gap in care without the burden of medical record review.

Cervical cancer screening

Please be sure to document a hysterectomy such as "total hysterectomy," "absence of cervix," or "PAP no longer needed" so members can be excluded from your population.

Prenatal and postpartum care

Schedule a postpartum visit within 21-56 days after delivery. This is important, even for women with C-sections. An incision check occurring between 7 and 10 days after delivery does not meet the intent of this measure.

BCBSRI thanks you for your ongoing cooperation during this HEDIS season and throughout the year!

Behavioral health measures: Attention Deficit Disorder (ADD) and follow-up after hospitalization for mental illness (FUH)

BCBSRI continues to expand collaborations between behavioral health provider and community stakeholders. Expect more initiatives on the way that will support members with behavioral health diagnoses, including initiatives that improve transitions of care, help the continuation of our HealthPath program, and more.

Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication

The HEDIS measure Follow-Up Care for Children Prescribed ADHD Medication (ADD) focused on the percentage of children, who have been newly prescribed ADHD medication. It also focused on children with at least three follow-up care visits within a 10-month period, one of which occurred within 30 days of first dispensing ADHD medication. The measure is concerned with both the initiation and continuation & maintenance phases. Details on each phase, as well as tips for success, are listed below:

<table>
<tr><th>Measure</th><th>Measure population</th><th>Tips for success</th></tr>
<tr><td rowspan="2">Follow-Up care for children prescribed ADHD medication (ADD)</td><td>Initiation Phase: the percentage of children 6-12 years of age as of the index prescription date (IPSD). Should have ambulatory prescription dispensed for ADHD medication and one follow-up visit with a practitioner with prescribing authority. Follow-up visit should occur in the first 30 days of the Rx dispensation.</td><td rowspan="2">• When prescribing new ADHD medication, schedule a follow-up visit within 30 days to assess how the medication's is working. Schedule this visit, while your patient is still in your office.
• Schedule two additional visits in the nine months after the first 30 days to continue monitoring your patient's progress.
• Telephone codes can help satisfy the requirements for the Continuation & Maintenance phase part of the measure. Coes 98966, 98967, 98968, 99441, 99442, and 99443 are covered but not separately reimbursed by BCBSRI. These codes satisfy the numerator for the continuation measure, if the patient is not seen face-to-face, but instead complete a follow–up call.
• Controlled substances should not be reordered without at least two visits per year to evaluate a child's progress and growth.</td></tr>
<tr><td>Continuation & Maintenance Phase: the percentage of children who are 6-12 years old as of the index prescription date (IPSD). Should have an ambulatory prescription dispensed for ADHD medication and should remain on medication for at least 210 days. In addition visiting during the Initiation Phase, should have had at least two follow-up visits with a practitioner, occurring within 270 days (9 months) after the Initiation Phase has ended.</td></tr>
</table>

FUH HEDIS measure

The HEDIS measure FUH is the percentage of discharges of members who are six years of age and older who were hospitalized for treatment of selected mental illness diagnoses. The measure also focuses on members who've had an outpatient visit, partial hospitalization, or intensive outpatient encounter with a mental health practitioner. Please see below for how the FUH measure focuses on the following two rates:

Measure	*Measure population*	*Tips for success*
FUH	**30 day follow-up:** an outpatient visit, partial hospitalization with a mental health practitioner, or intensive outpatient visit within 30 days of being discharged. These include visits and partial hospitalization that occur on the date of discharge.	Collaboration between the inpatient facility and outpatient provider is critical. Therefore, if a provider is aware of an inpatient admission, efforts should be made to work with hospital discharge planners to set up appointments prior to patient leaving the hospital.
	Seven day follow-up: an outpatient visit, partial hospitalization, partial hospitalization with a mental health practitioner, or intensive outpatient visit within seven days of being discharged. These include visits and partial hospitalization that occur on the date of discharge.	

Behavioral Health

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.

B Access standards

BCBSRI recently updated its administrative policies for participating providers, including behavioral health providers. These policies address access standards for BCBSRI members, including a minimum average practice requirement of 20 hours per week. Minimum practice requirements are in place to ensure effective coordination of care for our members. All providers shall make necessary arrangements to assure the availability of care to members on a 24/7 basis, including coverage by another physician or provider.

Additionally, please adhere to the following standards:

- Return phone calls on the same day, if triaged by office staff. Off-hours calls must be returned within one hour. Calls from an emergency room must be returned in 30 minutes.
- Emergent care must be provided immediately or referred as medically appropriate.
- Urgent care must triaged or provided within 24 hours.
- Routine care appointments for behavioral health must be provided within 10 business days.
- These standards are in place to ensure that the network is able to support our members, when they need care.

Products & Benefits

PBF Referral requirement for all individual Medicare Advantage plans in 2018

In 2018, all seven of BCBSRI's individual Medicare Advantage plans will require a member's PCP to generate a web-based referral for specialist office visits*.

Prior to the 2017 calendar year, our only Medicare Advantage plan requiring a referral was BlueCHiP for Medicare Advance.

PCPs are responsible for generating referrals to specialists for members in a referral-based plan. Specialists are responsible for ensuring a referral from a PCP is made, prior to rendering services. Any specialist services rendered without a PCP first making a web-based referral will result in a denied claim and the specialist will be held liable. Additionally, specialists should note that Medicare Advantage members cannot be balance-billed, when there is no referral on file.

As a reminder, only PCPs can generate referrals — specialist-to-specialist referrals are not allowed.

To determine if your patient is enrolled in a referral-based plan, you can:

- Click here to review which of BCBSRI's products require a web-based referral for specialist visits.
- Verify medical benefits by logging on to BCBSRI's Provider Portal and going to the Patient Eligibility section. From there, click the Medical Benefits tab, and then select the appropriate Service Category and Service Type.

We encourage you to share our referral tip sheet with BCBSRI members enrolled in BlueCHiP and Medicare Advantage plans.

If you have any questions regarding our web-based referral management tool or BCBSRI plans and products needing referrals, please call our Physician & Provider Service Center at (401) 27 4-4848 or 1-800-230-9050 (out of state only).

* Group BlueCHiP for Medicare members are not affected by this change and do not require a referral.

Individual market formulary

Effective January 1, 2018, the below formulary changes will take effect. These changes apply only to the Individual market segment, including Direct Pay and Direct Pay through HealthSource RI. This formulary is developed and maintained with a comprehensive review of relevant clinical information by the Prime Therapeutics National Pharmacy and Therapeutics Committee. It includes local review by the BCBSRI Pharmacy and Therapeutics Committee.

Excluded from coverage

As part of the transition to the new formulary, the following drug products will be excluded from the prescription drug list, effective January 1, 2018:

ACTEMRA
ADAPALENE
ADDERALL
ADZENYS XR-ODT
AEROCHAMBER PLUS FLOW-VU
ALPHAGAN P
AMLODIPINE/OLMESARTAN MEDOXOMIL
AMPHETAMINE/DEXTRO-AMPHETAMINE
APRISO
AZELASTINE HCL
BASAGLAR KWIKPEN
BELBUCA
BENZONATATE
BETIMOL
BICILLIN L-A
BOTOX
BROMSITE
BYETTA
CALCIPOTRIENE/BETAMETH DIPRO
CARAFATE
CAVERJECT IMPULSE
CHERATUSSIN AC
CHORIONIC GONADOTROPIN
CIMETIDINE
CITRANATAL HARMONY
CLINDAMYCIN PHOSPHATE
CLINDAMYCIN PHOSPHATE/TRETINOIN
CLOBETASOL PROPIONATE
CODEINE/GUAIFENESIN
COMPLETE NATAL DHA
CORDRAN
COREG CR
COSOPT PF
CYTOMEL
DEPAKOTE
DEPAKOTE ER
DESONATE
DESOXIMETASONE
DESVENLAFAXINE ER
DEXEDRINE
DIHYDROERGOTAMINE MESYLATE
DIPHENHYDRAMINE HCL
DOXYCYCLINE
DOXYCYCLINE HYCLATE DR
DULOXETINE HCL
DUPIXENT
DYANAVEL XR
DYMISTA
EDARBYCLOR
EMVERM
ENDOMETRIN
ENTYVIO
EPINEPHRINE
ETHACRYNIC ACID
EXTAVIA
EYLEA
EZETIMIBE/SIMVASTATIN
FAMOTIDINE
FENOFIBRATE
FENORTHO
FLECTOR
METHYLPHENIDATE HCL ER
METHYLPHENIDATE HCL ER (LA)
MINOCYCLINE HCL ER
MOMETASONE FUROATE
MORPHINE SULFATE ER
NAMENDA XR
NEOMYCIN/POLYMYXIN/HYDROCORTISONE
NOVAREL
NUCALA
NUEDEXTA
NUTROPIN AQ NUSPIN 20
OLOPATADINE HYDROCHLORIDE
OMEGA-3-ACID ETHYL ESTERS
OMNIPOD 5 PACK
ONETOUCH ULTRA 2
ONETOUCH ULTRA BLUE
ONETOUCH ULTRA CONTROL
ONETOUCH ULTRA MINI
ONETOUCH VERIO
ONETOUCH VERIO TEST STRIPS
OPANA ER (CRUSH RESISTANT)
OPTICHAMBER DIAMOND
OPTICHAMBER DIAMOND/LARGEFACE MASK
OPTICHAMBER DIAMOND/MEDIUM FACE MASK
OPTICHAMBER DIAMOND/SMALLFACE MASK
ORENCIA
OSENI
OSPHENA
OXTELLAR XR
TEKTURNA
TOBRADEX ST
TOPAMAX
TOPICORT
TRELSTAR MIXJECT
TRETINOIN MICROSPHERE
TRIANEX
TRILEPTAL
TUDORZA PRESSAIR
TYSABRI
UCERIS
VALVED HOLDING CHAMBER
VANCOMYCIN HCL
VANIQA
VENLAFAXINE HCL ER
VERAMYST
V-GO 40

Bolded products will be available through medical coverage only

VIRTUSSIN A/C
VITAFOL ULTRA
VITAFOL-OB
VIVITROL
XGEVA
XOLAIR
XOPENEX HFA
ZEMAIRA
ZOMIG
ZUBSOLV
ZYCLARA PUMP
ZYLET

If applicable, prescription legend products have medical exception criteria available. OTC products are designated as benefit plan exclusions from coverage.

Prior authorization now required

Effective, January 1, 2018, the following products will require prior authorization for coverage:

ADAPALENE
AUBAGIO
AVONEX
BETASERON
CICLOPIROX NAIL LACQUER
COPAXONE
DANAZOL
DOXEPIN HYDROCHLORIDE
GILENYA
GLATOPA
HUMALOG
HUMALOG KWIKPEN
HUMALOG MIX 50/50 KWIKPEN
HUMALOG MIX 75/25
HUMALOG MIX 75/25 KWIKPEN
HUMULIN 70/30
HUMULIN N
HUMULIN N KWIKPEN
HUMULIN R
INGREZZA
KUVAN
LIDOCAINE
PICATO
PLEGRIDY
REBIF
TECFIDERA
TERBINAFINE HCL
TRAMADOL HCL ER
TRETINOIN

Step therapy now required

Effective January 1, 2018, the following products will require a trial of preferred products for coverage:

BEPREVE
DICLOFENAC SODIUM
ELIDEL
LASTACAFT
MECLOFENAMATE SODIUM
RASUVO
ROZEREM
TACROLIMUS

Non FDA approved/certificate of coverage exclusions

The following products do not carry an FDA approved use or are designated as coverage exclusions and will be excluded from formulary coverage, effective January 1, 2018:

BEPREVE
BENZEPRO
BENZEPRO CREAMY WASH
BENZEPRO FOAMING CLOTHS
BENZEPRO SHORT CONTACT
BP WASH
ESTERIFIED ESTROGENS/METHYLTEST
HYDROCORTISONE ACETATE
HYDROCORTISONE ACETATE/PRAMOXINE
HYDROCORTISONE/IODOQUINOL
HYDROQUINONE
HYOSCYAMINE SULFATE
HYOSCYAMINE SULFATE ER
LIDOCAINE
PHENAZOPYRIDINE HCL
SELENIUM SULFIDE
SODIUM CHLORIDE SOL

Bolded products will be available through medical coverage only

Pharmacy

Cost share changes

Effective January 1, 2018, the following products will require a higher out-of-pocket cost share:

ALINIA
ALORA
AMOXICILLIN
ANGELIQ
ATROPINE SULFATE
ATROVENT HFA
AURYXIA, HUMALOG
AZITHROMYCIN
BUPRENORPHINE
CARBIDOPA/LEVODOPA/ENTACAPONE
CIPRODEX
CIPROFLOXACIN
COLCHICINE
COLCRYS
COLY-MYCIN S
COMBIPATCH
COMBIVENT RESPIMAT
CONDYLOX
DEXAMETHASONE
DEXAMETHASONE SODIUM PHOSPHATE
DIAZEPAM
DILANTIN
DOXEPIN HYDROCHLORIDE
EDURANT
ELIDEL
ELMIRON
EMTRIVA
EPROSARTAN MESYLATE
EQUETRO
ERYTHROMYCIN BASE
ESTRING
FLURAZEPAM HCL
HALOG
HUMALOG
HUMALOG KWIKPEN
HUMALOG MIX 50/50 KWIKPEN
HUMALOG MIX 75/25
HUMALOG MIX 75/25 KWIKPEN
HUMALOG, HUMALOG KWIKPEN
HUMALOG, HUMALOG MIX 75/25
HUMULIN 70/30
HUMULIN N
HUMULIN N KWIKPEN
HUMULIN R
HYDROXYZINE PAMOATE
JENTADUETO
LOTEMAX
MECLOFENAMATE SODIUM
MESALAMINE DR
METHYCLOTHIAZIDE
METOPROLOL TARTRATE
MONUROL
MOVIPREP
NALOXONE HCL
NEFAZODONE HCL
NORTRIPTYLINE HCL
NP THYROID 15
OFLOXACIN
OSMOPREP
POTASSIUM CHLORIDE ER
PREDNISONE
PREMARIN
PREMPRO
PROCTOFOAM HC
RENAGEL
SANTYL
SCOPOLAMINE
SELZENTRY
TANZEUM
THEO-24
TOBRADEX
TOBREX
TRADJENTA

Quantity limit per fill restrictions

Effective January 1, 2018, the below prescriptions have quantity limits per prescription fill, based on daily use. Members will only be impacted, if daily use exceeds the quantity limit.

ACETAMINOPHEN/CODEINE
ASCOMP/CODEINE
BUPRENORPHINE HCL
BUPRENORPHINE HCL/NALOXONE HCL
BUPROPION HCL
BUPROPION HCL ER
BUPROPION HCL SR
BUPROPION HCL XL
BUTALBITAL/ACETAMINOPHEN
BUTALBITAL/ACETAMINOPHEN/CAFFEINE
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/COD
BUTALBITAL/ASPIRIN/CAFFEINE
BUTORPHANOL TARTRATE
CICLOPIROX NAIL LACQUER
CITALOPRAM HYDROBROMIDE
DESVENLAFAXINE ER
DOXEPIN HYDROCHLORIDE
ENTRESTO
ESCITALOPRAM OXALATE
FETZIMA
FLUOROURACIL
FLUOXETINE HCL
FLUVOXAMINE MALEATE
FORTEO
HYDROCODONE BITAR/ACETA
HYDROMORPHONE HCL
IMIQUIMOD
INGREZZA
LIDOCAINE
MIRTAZAPINE
MIRTAZAPINE ODTMORPHINE SULFATE
NUCYNTA
OSELTAMIVIR PHOSPHATE
OXYCODONE HCL
OXYCODONE/ACETAMINOPHEN
OXYMORPHONE
HYDROCHLORIDE
PAROXETINE HCL
PROMACTA
SERTRALINE HCL
SUBOXONE
TERBINAFINE HCL
TRINTELLIX
VENLAFAXINE HCL
VENLAFAXINE HCL ER
VIIBRYD

Bolded products will be available through medical coverage only

PBF The Medicare National Correct Coding Initiative (NCCI) tools

BCBSRI is informing our provider network of the Medicare National Correct Coding Initiative (NCCI) edits. NCCI nationally promotes correct coding methodologies and controlling improper coding, which can lead to inappropriate payments. To be transparent with our provider community, BCBSRI utilizes this editing, as it is the national industry standard for correct coding.

The National Correct Coding Initiative Policy Manual for Medicare Services is available to you as a reference tool for correct coding. It explains the rationale for NCCI's edits. Each chapter corresponds to a separate section of the CPT Manual, with the exception of Chapter 1, which contains general correct coding policies. Each chapter is subdivided by subject, allowing easier access to a particular code or group of codes. Accurate coding and reporting of services are critical aspects of proper billing. Services denied based on NCCI code pair edits may not be billed to BCBSRI members, as they are based on incorrect coding.

How to locate the NCCI tables

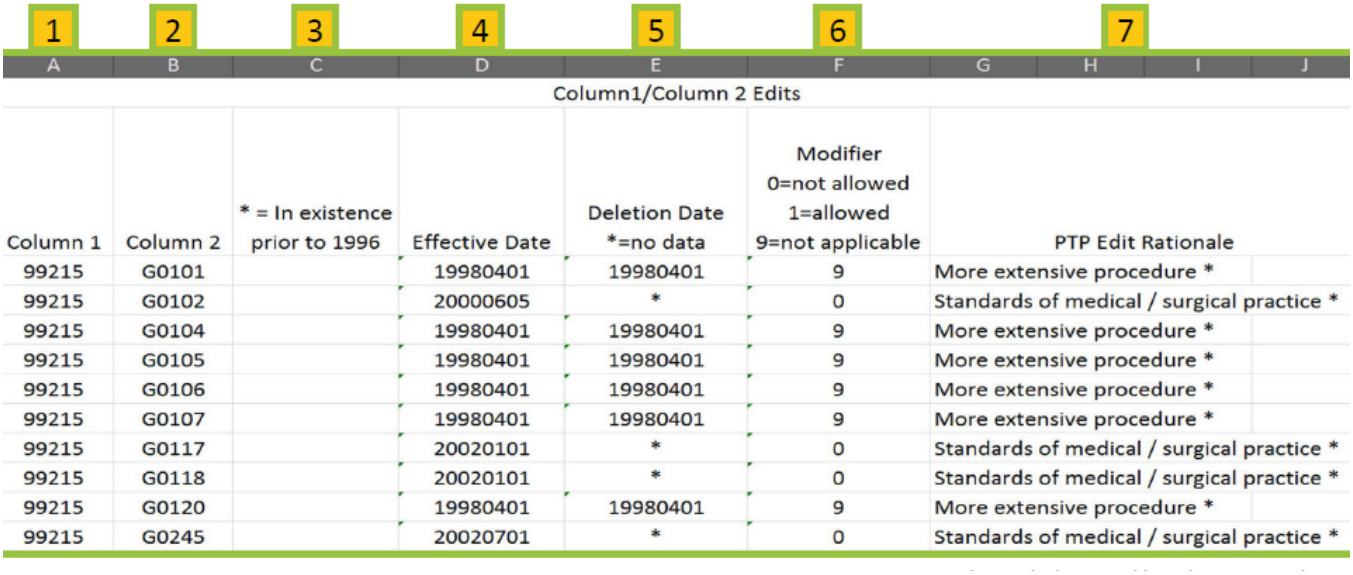
1. Clicking here, which will bring you cms.gov, where you can log on.
2. Links to different edit tables are located in the top left menu, found on NCCI's web page.
3. Click on desired edit type, and then scroll to the related links section at the bottom of the page to find the appropriate file.
4. Click on the Edits table you wish to view or save. A license agreement will appear. To continue to the table selected, please accept the AMA copyright terms and conditions. Click 'accept' to indicate you have read and agree to the AMA terms and conditions.

Procedure to procedure (PTP) edits

PTP code pairs are comprised of two provider-type choices of PTP code pair edits.

Provider type	***Measure population***	***PTP edits-hospital***
These PTP code pair edits are applied to claims submitted.	• Physicians • Non-physician practitioners • Ambulatory surgery center	The following types of bills are subject to the Outpatient Code Editor: • Hospitals (TOB 12X and 13X), • SNFs (TOB 22X and 23X) • Home health agencies • (HHAs) Part B (TOB 34X) • Outpatient physical therapy and speech-language • Pathology providers (OPTs) (74X) • Comprehensive outpatient • Rehabilitation facilities (CORFs) (TOB 75X)

Understanding the PTP table



1	2	3	4	5	6	7			
A	B	C	D	E	F	G	H	I	J
Column1/Column 2 Edits									
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale			
99215	G0101		19980401	19980401	9	More extensive procedure *			
99215	G0102		20000605	*	0	Standards of medical / surgical practice *			
99215	G0104		19980401	19980401	9	More extensive procedure *			
99215	G0105		19980401	19980401	9	More extensive procedure *			
99215	G0106		19980401	19980401	9	More extensive procedure *			
99215	G0107		19980401	19980401	9	More extensive procedure *			
99215	G0117		20020101	*	0	Standards of medical / surgical practice *			
99215	G0118		20020101	*	0	Standards of medical / surgical practice *			
99215	G0120		19980401	19980401	9	More extensive procedure *			
99215	G0245		20020701	*	0	Standards of medical / surgical practice *			

Place column number here	***Place column header name here***	***Place column contents here***
1	Column 1	Contains the reimbursable code of the code pair.
2	Column 2	Contains the non-reimbursable code of the code pair, unless a modifier is allowed and submitted.
3	* = In existence prior to 1996	Indicates whether the edit was in existence prior to 1996
4	Effective date	Contains the effective date of edit
5	Deletion date *=no data	Contains the deletion date, if applicable
6	Modifier 0=not allowed 1=allowed 9=not applicable	Override modifier use indicator
7	PTP edit rationale	PTP edit policy rationale

Hospital PTP code pair tables operate the same way the practitioner PTP code pair tables does; however, modifiers and coding pairs may differ from the practitioner PTP code pair tables because of differences between facility and professional services.

Looking up PTP code pair edits

PTP code pairs comprise The Column 1 and Column 2 tables. If a provider submits the two codes of an edit pair for payment for the same member on the same date of service, the Column 1 code is eligible for payment. The Column 2 code will be denied, unless there are certain circumstances, in which a clinically appropriate and an appropriate NCCI-associated modifier is added to the Column 2 code of a code pair with a 1 indicator. Supporting documentation should be in the member's medical chart. A modifier should not be appended to an HCPCS/CPT code solely to bypass an NCCI PTP edit, if the clinical circumstances do not justify its use.

PTP modifier indicators

Modifier indicator	Definition
0	There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair. There are no circumstances in which both procedures of the PTP code pair should be paid for the a member on the same day of service by the same provider.
1	Modifiers associated with NCCI are allowed with this PTP code pair, when clinically appropriate and added to the column 2 code.
9	NCCI edit does not apply to this PTP code pair or the edit for this PTP or the code pair was deleted retroactively.

PTP modifier indicators

1. Click here to go to cms.gov, and log on.
2. Links to different edits are provided in the top left menu of the page.
3. Click the Quarterly PTP Version Update Changes, and then scroll to the related links section at the bottom of the National Correct Coding Initiative Edits web page. You can then find the appropriate file for the quarter you are searching for.
4. Click on the additions, deletions, and revisions file you wish to view or save. A license agreement will appear. To continue to the table selected, the AMA copyright terms and conditions must be accepted. Click Accept to indicate that you have read and agree to the AMA terms and conditions.

Medically Unlikely Edits (MUEs)

BCBSRI follows the CMS Medically Unlikely Edits (MUE) program. MUEs were implemented to reduce the error rate in Medicare Part B paid claims. MUEs are the maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System and Current Procedural Terminology (HCPCS/CPT) code that is billed by a provider on a single date of service (DOS). BCBSRI may decide to apply its own maximum frequency per day values, which differ from the CMS MUE limit. In this instance, there would be a supporting policy documenting the MUE value. Providers should not inconvenience members, or increase risks to members, by performing services on different dates of service to avoid MUE edits.

MUEs are updated quarterly. The most recent MUE Tables for practitioner services, facility outpatient services, and DME supplier services, along with additional information regarding the rationale for MUEs, are on the CMS website. MUE files include MUE adjudication indicators (MAI) to inform a provider of what edit is applicable. These indicators are '1' to indicate that the edit is a claim line MUE and '2' or '3' to indicate that the edit is a DOS MUE.

MAI	Edit type	Definition
1	Claim line	This is based on line level. The reporting of medically necessary UOS in excess of MUE with the appropriate use of CPT modifiers, such as 59, 76, 77, 91, and anatomic, to report the same HCPCS/CPT code on separate lines of a claim is allowed.
2	DOS	Modifiers associated with NCCI are allowed with this PTP code pair, when clinically appropriate and added to the column 2 code.

PTP modifier indicators

Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

- Anatomic considerations that may limit UOS based on anatomic structures.
- CPT code descriptors/CPT coding instructions in the CPT Manual may limit UOS.
- Established CMS policies may limit UOS
- The nature of an analyte may limit UOS and is in general determined by one of three considerations:
  - The nature of the specimen may limit the UOS as for a test requiring a 24-hour urine specimen.
  - The nature of the test may limit the UOS as for a test that requires 24 hours to perform.
  - The physiology, pathophysiology or clinical application of the analyte is such that a maximum UOS for a single date of service can be determined.
- The nature of a procedure/service may limit UOS and is in general determined by the amount of time required to perform a procedure/service or clinical application of a procedure/service.
- The nature of equipment may limit UOS and in general determined by the number of items of equipment that would be utilized.
- Clinical judgment considerations and determinations are based on input from numerous physicians and certified coders.
- Prescribing information is based on FDA labeling as well as off-label information published in CMS approved drug compendia.
- Submitted claims data (100%) from a six-month period is utilized to ascertain the distribution pattern of UOS typically billed for a given HCPCS/CPT code.

Understanding the MUE table

A	B	C	D
Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2015 American Medical Association. All rights reserved. *CPT® is a registered trademark of the American Medical Association.* *Applicable FARS\DFARS Restrictions Apply to Government Use.* *Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.*			
1 **HCPCS/ CPT Code**	2 **Practitioner Services MUE Values**	3 **MUE Adjudication Indicator**	4 **MUE Rationale**
0001M	1	1 Line Edit	Nature of Analyte
0002M	1	1 Line Edit	Nature of Analyte
0003M	1	1 Line Edit	Nature of Analyte
0006M	1	2 Date of Service Edit: Policy	Nature of Analyte
0007M	1	2 Date of Service Edit: Policy	Nature of Analyte
0008M	1	3 Date of Service Edit: Clinical	Nature of Analyte
0019T	1	1 Line Edit	Nature of Service/Procedure
0042T	1	1 Line Edit	Nature of Service/Procedure
0051T	1	2 Date of Service Edit: Policy	Anatomic Consideration
0052T	1	2 Date of Service Edit: Policy	Anatomic Consideration

Claims

Place column number here	*Place column header name here*	*Place column contents here*
1	HCPCS/CPT Code	Contains the HCPCS/CPT Code.
2	Services MUE Value	Contains Maximum units of service a practitioner would report under most circumstances for a member on a single date of service.
3	* = In existence prior to 1996	MUE adjudication indicator
4	MUE Rationale	Contains edit rationale

CMS' goal with implementing MUEs was to reduce claims payment errors that were due to clerical entry mistakes or incorrect coding. There is concern that providers will incorrectly interpret MUE values as utilization guidelines. It's recommended that providers should only report services that are medically reasonable and necessary. If a provider encounters a code with frequent denials, due to the MUE or frequent use of a CPT modifier to bypass the MUE, the provider or supplier should consider the denial to be an indication of incorrect reporting, due to things as clerical errors or errors in the interpretation or application of coding instructions. It is also possible some reporting errors could be associated with a lack of medical necessity for the excess units, although the MUE itself does not address medical necessity, but only the medically unlikely nature of the reported value.

Contracting & Credentialing

PBF Skilled nursing facility network changes effective January 1, 2018

BCBSRI is committed to ensuring our members have access to the best care possible. To do this, we regularly evaluate the participation of skilled nursing facilities (SNFs) within our provider network.

Effective January 1, 2018, the following SNFs will no longer be participating in BCBSRI's network:

- **Bannister House**, 135 Dodge Street, Providence, RI 02907
- **Oak Hill Health and Rehabilitation Center,** 544 Pleasant Street, Pawtucket, RI 02860
- **Summit Commons Rehabilitation & Healthcare Center,** 99 Hillside Avenue, Providence, RI 02906
- **Wingate at Blackstone,** 353 Blackstone Boulevard, Providence, RI 02906

BCBSRI uses nationally recognized, publicly available data for quality and efficiency to carefully assess which SNFs participate in our provider network.

Those BCBSRI members who received skilled nursing services within the last 90 days from one of these listed facilities will receive written notification of this change approximately 30 days in advance.

If a BCBSRI member is residing at one of these facilities and receiving long-term, custodial levels of care, they will receive a phone call from a BCBSRI utilization management nurse informing them of this change.

Members receiving long-term care from one of the above-listed facilities, who leave their residence for treatment in an emergency room or acute setting, may go back to their place of residence for skilled nursing care, regardless of whether a SNF participates in BCBSRI's network. Pending prior authorization, these members will have the same level of coverage and cost sharing, if skilled nursing services are appropriate.

Contracting & Credentialing

For members who **do not** reside at one of the above-listed facilities, please ensure they are only admitted to facilities participating in BCBSRI's network, after being discharged from a hospital.

To obtain a list of SNFs participating in BCBSRI's network, please click here to use our Find a Doctor tool, located on bcbsri.com.

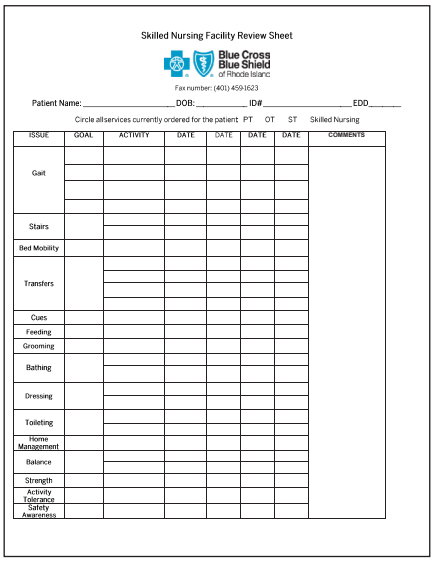
PF Skilled nursing facility review sheet

BCBSRI is committed to working collaboratively with our partners in SNFs to ensure that our members are receiving quality care in the most appropriate setting. As part of our continuing effort to provide SNFs with the resources needed to effectively partner with BCBSRI, we have developed a SNF Review Sheet to help streamline the concurrent review of the pertinent clinical information required to support a skilled level of care. This new SNF Review Sheet will also help us to focus on a goal-oriented discharge plan. The initial clinical review should include the BIM score and current medication list.

The SNF Review Sheet is a tool that will enable you to communicate important information on the services you provide, such as dates of service, patient goals, types of skilled nursing services provided, and specific member health issues.

We ask that SNFs begin using this review sheet immediately, and make it a standard part of your documentation and review process for appropriate services rendered to BSBRI members.

See below for a sample of our new review sheet for SNFs:



Skilled Nursing Facility Review Sheet

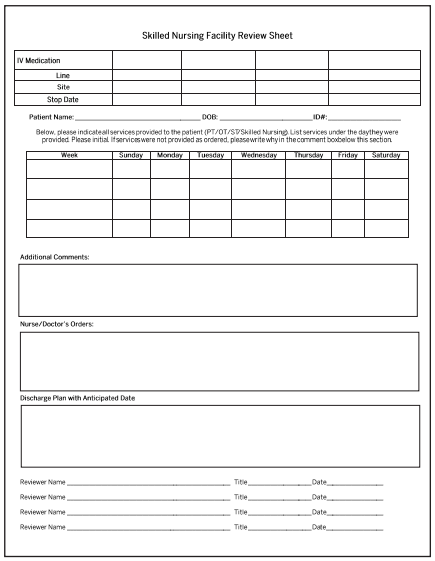
Blue Cross Blue Shield of Rhode Island

Fax number: (401) 459-1623

Patient Name:_____DOB:_____ ID#_____EDD_____

Circle all services currently ordered for the patient PT OT ST Skilled Nursing

ISSUE	GOAL	ACTIVITY	DATE	DATE	DATE	DATE	COMMENTS
Gait							
Stairs							
Bed Mobility							
Transfers							
Cues							
Feeding							
Grooming							
Bathing							
Dressing							
Toileting							
Home Management							
Balance							
Strength							
Activity Tolerance							
Safety Awareness							



Skilled Nursing Facility Review Sheet

IV Medication							
Line							
Site							
Stop Date							

Patient Name:_____DOB:_____ID#:_____

Below, please indicate all services provided to the patient (PT/OT/ST/Skilled Nursing). List services under the day they were provided. Please initial. If services were not provided as ordered, please write why in the comment box below this section.

Week	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Additional Comments:

Nurse/Doctor's Orders:

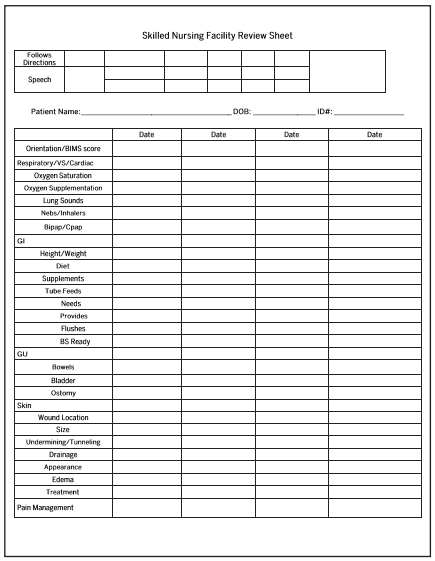
Discharge Plan with Anticipated Date

Reviewer Name _____ Title_____Date_____

Reviewer Name _____ Title_____Date_____

Reviewer Name _____ Title_____Date_____

Reviewer Name _____ Title_____Date_____



Skilled Nursing Facility Review Sheet

Follows Directions							
Speech							

Patient Name:_____DOB:_____ID#:_____

	Date	Date	Date	Date
Orientation/BIMS score				
Respiratory/VS/Cardiac				
Oxygen Saturation				
Oxygen Supplementation				
Lung Sounds				
Nebs/Inhalers				
Bipap/Cpap				
GI				
Height/Weight				
Diet				
Supplements				
Tube Feeds				
Needs				
Provides				
Flushes				
BS Ready				
GU				
Bowels				
Bladder				
Ostomy				
Skin				
Wound Location				
Size				
Undermining/Tunneling				
Drainage				
Appearance				
Edema				
Treatment				
Pain Management				

Contracting & Credentialing

PBF Network changes for genetic testing laboratories effective January 1, 2018

Please be advised that effective January 1, 2018, Sequenom Laboratories will no longer be a participating provider within BCBSRI's network. Sequenom provides genetic testing, specifically non-invasive parental testing (NIPT).

Please click on the following links, if you need to refer a member to genetic testing facility for NIPT. Your other laboratory choices are Natera, Ariosa and Counsyl.

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

As a BCBSRI-contracted provider, it is your 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.

We want to keep you up-to-date on all in-network developments. The following laboratories do **not** participate within the BCBSRI network:

- 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

- Allergy Testing
- Aqueous Shunts and Stents for Glaucoma
- Artificial Pancreas Device System
- Automated Point-of-Care Nerve Conduction Tests
- Biofeedback
- Bone Mineral Density Studies
- Breast Pumps- Hospital Grade - Title change only
- CA 125
- Dental Services Rendered in the Outpatient Setting
- Dopamine Transporter Imaging with Single-Photon Emission Computed Tomography (DAT-SPECT)
- Dynamic Posturography
- Gene Expression Profiling and Protein Biomarkers for Prostate Cancer Management
- Genetic Testing for Mental Health Conditions
- Glucose Monitoring – Home
- Home Uterine Activity Monitoring
- Intraocular Lens (IOL) Implants
- Islet Cell Transplant
- Measurement of Small Low-Density Lipoprotein (LDL) Particles
- Radioembolization for Primary and Metastatic Tumors of the Liver
- Serum Tumor Markers for Breast and Gastrointestinal Malignancies
- Urinary Tumor Markers for Bladder Cancer
- Viscocanalostomy and Canaloplasty
- Medical Necessity – added language for BlueCHiP for Medicare
- Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy
- Out of Network Services
- PathFinderTG® Molecular Testing
- Preventive Services - BlueCHiP for Medicare 2018
- Radioembolization for Primary and Metastatic Tumors of the Liver
- Serum Tumor Markers for Breast and Gastrointestinal Malignancies
- Urinary Tumor Markers for Bladder Cancer
- Viscocanalostomy and Canaloplasty

To view the full text of these policies, please click here:

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 on bcbsri.com. Once on that page, click the drop-down box to sort policies by draft.

New policies

The following new policies have been created and are ready for review. Effective dates vary so please review the full text of these policies, located in the provider section of bcbsri.com under the Medical Policy heading.

- Tisagenlecleucel (KYMRIAH™)
- Treatment of Hyperhidrosis
- Telemedicine Service

PF Additional policies recently reviewed for annual update

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

- Actigraphy
- Adoptive Immunotherapy
- Advance Notice of Noncoverage
- Ambulance - Ground
- Autologous Platelet-Derived Growth Factors (i.e. Platelet-Rich Plasma)
- Balloon Ostial Dilation for Treatment of Chronic Rhinosinusitis
- Behavioral Health Services Inpatient and Intermediate Levels of Care
- Bioimpedance Devices for Detection and Management of Lymphedema
- Buprenorphine Implant for Treatment of Opioid Dependence
- Botulinum Toxin Injections
- Cardiac Hemodynamic Monitoring
- Cellular Immunotherapy for Prostate Cancer
- Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy)
- Cranial Orthoses (Adjustable) for Positional Plagiocephaly and Craniosynostoses
- Cryosurgical Ablation of Primary or Metastatic Liver Tumors
- Electrical Bone Growth Stimulation of the Appendicular Skeleton- Implantable and Semi Invasive
- Electrical Stimulation and Electromagnetic Therapy for Wound Treatment
- Electronic Brachytherapy for Nonmelanoma Skin Cancer
- Esophageal pH Monitoring
- Hearing Aid Mandate
- High-Tech Radiology Imaging
- Implantation of Intrastromal Corneal Ring Segments
- Lysis of Epidural Adhesions
- Oral Appliances for Sleep Apnea
- Oral Surgeons Filing Anesthesia Services in the Office Setting
- Outpatient Pulmonary Rehabilitation
- Post Payment Audits
- Prostatic Urethral Lift
- Provider Guidelines for Requesting Point of Service Payment and Maintaining Patient Credit Card Information (former title: Provider Guidelines for Credit Card on File Requests)
- Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
- Respiratory Syncytial Virus Immunogolbulin
- Salivary Estriol as Risk Predictor for Preterm Labor and Management of Menopause and/or Aging
- Treatment of Hyperhidrosis
- Whole Gland Cryoablation of Prostate Cancer (formally Cryoablation of Prostate Cance

PFB 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. Please refer to the BlueCHiP for Medicare National and Local Coverage Determinations Policy for more information.

For your review, we also post monthly drafts of created or reassessed medical policies. As a reminder, you can provide comments on draft policies for up to 30 days. Draft policies are located on the Provider section of bcbsri.com. Simply click on the Medical and Payment Policy icon to view the list of final and draft policies. Once on that page, click the drop-down box to sort policies by draft.

PF Osteopathic Manipulative Treatment (OMT)

The Physical and Occupational Therapy policy is updated and reflects the following OMT code range 98925-98929 being covered as part of Physical and Occupational Therapy benefit. Please click here to read the full text of this policy.

PF Important reminder regarding coverage for knee walkers

We have been made aware that some DME providers in our network are incorrectly advising members that DME is not a covered service. As was published in our April edition of Provider Update, claims with dates of service for May 1, 2017 and after, E0118RR, Crutch substitute, lower leg platform, with or without wheels, (e.g., Roll-A-Bout Walker, Rolleraid, Turning Leg Caddy) or a kneeling crutch (e.g., iWALKFree), is medically necessary for short term as a rental only for use following a below-the-knee injury/condition when the member is non-weight bearing on one extremity and unable to safely use a standard walker or crutch. As this is for short-term rehabilitation, the rental period is limited to 4-month Please click here to read the full text of this policy.

PF EKG as part of preventive visit

A recent claims audit identified that providers were routinely performing EKG's as part of their members' preventive exams, even though the claim showed no other diagnosis that would justify this testing. Recent guidelines from the U.S. Preventive Services Task Force (USPSTF) in 2011, the American Academy of Family Physicians (AAFP) in 2011, the American College of Cardiology (ACC) Foundation in 2010, and the American Heart Association (AHA) in 2010 all advised against electrography in asymptomatic, low-risk individuals.

Please be advised that:

- There is little evidence that detection of coronary artery stenosis in asymptomatic patients, who are at low-risk for coronary heart disease, improves health outcomes.
- False-positive tests likely to lead to harm, through unnecessary invasive procedures, over-treatment, and misdiagnosis.
- Potential harms of this routine annual screening exceed the potential benefit.
- The AHA compiled data, including information from the Framingham Heart Study, to determine appropriate use of cardiac screening tests, by looking at prognostic considerations. Those risk factors include gender and age (males over the age of 45 years) with one or more risk factors. The greater the number of risk factors a patient has, the more likely it is that the patient will benefit from screening. If a patient's risk is less than 10% screening is not recommended.
- The USPSTF reviewed new evidence regarding the reduction of risk for coronary heart disease (CHD) events in asymptomatic adults, by screening with electrocardiography (EKG) compared to not screening. After doing so, the USPSTF recommends against screening with resting or exercise ECG for the prediction of CHD events in asymptomatic adults at low risk for CHD events (D recommendation). Additionally, the USPSTF concludes that current evidence is insufficient to assess the balance of benefits and harms of screening with resting or exercise ECG for the prediction of CHD events in asymptomatic adults at intermediate or high risk for CHD events.

PF Advanced care planning

Effective January 1, 2018, providers will now be able to bill for advance care planning services using one of the following CPT codes 99497 or 99498. Claims submitted with S0257 will deny as use alternate code. CPT 99497 and 99498 will be reimbursed based on the following guidelines:

CPT 99497

- Will be covered but NOT separately reimbursed when filed with an Annual Well (G0438, G0439) or Preventive Medicine (99385-99387) Visit.
- Will be covered and separately reimbursed when filed as the only service or when filed with 99210-99215
- Reimbursement will be limited to once per year
- Limited to the following specialties: PCP or internal Medicine
- Copays and deductibles apply when only services appear on claim
- Deductible only applies when filed with 99210-99215

CPT 99498, which is an add on code, will continue to be covered but not separately reimbursed.

Documentation in the medical record must reflect the following information:

- Total time in minutes spent on discussion
- Patient/surrogate/family given opportunity to decline
- Details of discussion, such as:
  - Who was involved? What was discussed? What is the understanding of the illness? What are spiritual and other factors at play? Why are the decisions made being made? Was/is there any advance directive offered or filled out?

Please note that this policy relates to BlueCHiP for Medicare and Commercial products. Please click here to read the full text of this policy.

PBF Autism spectrum disorders mandate effective January 1, 2018

Effective January1, 2018, our claims processing system will be updated, and providers should now file for Autism services using the applicable Category III CPT code. Prior authorization is recommended. The provider must contact Beacon Health Management at 1-800-274-2958. Please click here to read the full text of this policy

PF Surgery for gynecomastia – benefit change for 2018

As groups renew benefits in 2018, surgery for gynecomastia will be a medically necessary, when the medical criteria are met. Prior authorization is required for BlueChip for Medicare and recommended for Commercial products, via the online tool for participating providers.

Please click here to read the full text of the Preauthorization via Web-Based Tool for Procedures policy.

Blue Cross
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of Rhode Island

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11/17 PRR-17940