Blue Cross Blue Shield of Rhode Island

provider update

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

May 2017

Spring is here again, which means we are in the midst of the annual Centers for Medicare and Medicaid Services (CMS) Medicare Health Outcomes (HOS) Survey. This survey is a great way for us to gauge our members' perception of their overall health status and to help ensure that members are receiving quality care and feel good about their health.

Each year, a sample of Medicare members is randomly surveyed, and then sent a follow-up survey two years later. This year's survey was sent to 1,200 of our Medicare members in April and will remain open until July.

Given the respect patients have for their providers, your encouragement to complete the survey can make sure that the most accurate information is captured. The results will offer a full view of your patients' health, including how it has improved under your care.

Since Rhode Island ranks first in the country for the percentage of its population aged 85 or older, surveys like the HOS are critically important. The HOS focuses on measures related to improving members' physical and mental health, improving bladder control, and reducing fall risks. We ask that you talk with your patients about these health issues, which are an important way to measure health and wellness. Together we can have a positive impact on our HOS results, and most importantly, on your patients' overall health.

You can find more detailed information about the 2017 HOS Survey on page 4 of this issue and at www.hosonline.org. As always, please contact us with any comments or questions you have, either at ProviderRelations@bcbsri.org or by talking with your provider relations representative. On behalf of all of us at BCBSRI, we are grateful for your continued partnership and collaboration.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

Contents

BCBSRI Update

PBF Provider Relations Seminars: June 2017

Please join us in June to learn about new and ongoing BCBSRI programs available to your patients. This seminar will provide an overview of the following programs and benefits:

- Behavioral health
- Case management
- HEDIS and quality management
- Your Blue Store offerings

Complimentary coffee and refreshments will be served.

Below is a list of dates so you can choose the seminar that works best for you. Please click here to RSVP no later than June 10.

Monday, June 12
8:00 – 9:00 a.m.
Doctors' Auditorium, Kent Hospital
455 Toll Gate Rd., Warwick

Tuesday, June 20
8:00 – 9:00 a.m.
Your Blue Store
71 Highland Ave., East Providence

Friday, June 23
8:00 – 9:00 a.m.
Sopkin Auditorium, Miriam Hospital
164 Summit Ave., Providence

Thursday, June 15
8:00 – 9:00 a.m.
Kay Auditorium, Roger Williams Medical Center
825 Chalkstone Ave., Providence

Thursday, June 22
8:00 – 9:00 a.m.
George Auditorium, Rhode Island Hospital
593 Eddy St., Providence

Monday, June 26
8:00 – 9:00 a.m.
South Pavilion Auditorium 1
Women and Infants Hospital
101 Dudley St., Providence

See you in June!

PBF New! Your Blue Store in East Providence

In May, we opened our newest and largest Your Blue Store℠ retail location, located in East Providence at 71 Highland Avenue, right near the Seekonk line. We've outgrown our Bristol location, which closed on April 21, and this state-of-the-art store will allow us to provide an enhanced level of service to our East Bay members.

The East Providence store will offer these features:

- Customer service in English, Portuguese, and Spanish for all members
- Knowledgable reps who can help members select the right medical, dental, vision, and travel health insurance coverage
- On-site nurses for members who have ongoing health conditions
- Free fitness classes, educational seminars, and events such as bingo
- Later hours (until 7:00 p.m.) at least one night per week to accommodate members' busy schedules

BCBSRI customers can get great service at this and our other stores in Lincoln and Warwick. For store hours, locations, and class schedules, visit bcbsri.com/yourbluestore or call (401) 459-2200.

BCBSRI Update

P Web-based management referral tool requirements

As previously communicated, the products that require web-based referrals include all BlueCHiP Commercial, BlueCHiP for Medicare Advance, and New England Health Plan (NEHP) products. Please note, NEHP cross-border referrals to providers in other New England states will continue to follow the traditional fax-based process. However, services rendered in RI, within the BCBSRI network, will need to be submitted through the web-based tool.

It is important to note that BCBSRI will not accept a fax referral for any referral that should be entered through the web-based referral tool. If you are experiencing any issues that are preventing you from entering a referral in the web-based referral tool, please call our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out of state only). Our call center team will work with you to address the issue, or will put you in touch with your provider relations representative for follow-up.

PBF Important: Update your practice information!

We are committed to ensuring that the information included in our Find a Doctor tool is accurate and up-to-date. That's why we are now conducting quarterly validation by contacting provider offices directly.

In March, we began to reach out to provider offices via fax requesting validation and attestation of the practice and the provider information we currently have listed in our directory. The next quarterly validation will take place in June 2017. When you receive this fax, please review and make any needed updates. It's important to note if the location included is where a patient can make an appointment to see the provider (this is a CMS requirement) and whether the provider is accepting new patients (also a CMS requirement).

Once you've reviewed, please make the appropriate changes, check the "attestation" box, and fax it back to us as soon as possible. Even if the information is accurate, you are expected to check the attestation box and return the form. If you have questions about our verification efforts, please email ProviderRelations@bcbsri.org. Thank you for your assistance.

PBF BCBSRI offers LGBTQ Safe Zone certification!

BCBSRI encourages healthcare providers in our participating network to collaborate with us in support of the LGBTQ (lesbian, gay, bisexual, transgender, queer) community. Our goal is to identify environments in which LGBTQ members feel welcome and safe when seeking healthcare services locally. Healthcare settings that meet specific criteria will be referred to as LGBTQ Safe Zones and receive BCBSRI identification, such as an award, window cling, and designation in the Find a Doctor tool. More information about our program and the requirements can be found by clicking here.

2016 was a great year for the program. Twelve practices were certified, including:

- Three health centers
  - Thundermist Health Center of South County
  - Thundermist Health Center of West Warwick
  - Thundermist Health Center of West Woonsocket
- Three dental clinics
  - Thundermist Health Center of South County – Dental Services
  - Thundermist Health Center of West Warwick – Dental Services
  - Thundermist Health Center of West Woonsocket – Dental Services
- Four behavioral health providers
  - Jayna Klatzker, LICSW
  - Jessica Peipock, LICSW
  - Laurie Thornton, MA, CAGS, LMHC
  - Wilder Therapy and Wellness
- One partial hospitalization program
  - Rhode Island Hospital Partial Hospitalization Program
- One specialty practice
  - R.I. Women's Health & Midwifery

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

PBF The Medicare Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is currently being administered by CMS to a random sample of BCBSRI's Medicare Advantage members. The HOS is administered each year between April and July, with 1,200 BCBSRI Medicare members being surveyed about how they perceive their overall health status. These members will receive a follow-up survey in two years.

HOS is the first patient-reported outcomes measure used in Medicare managed care. The goal of the HOS is to gather valid, reliable, and clinically meaningful data to help health plans and providers develop quality improvement activities to improve Medicare members' health. Survey results also help BCBSRI monitor its quality performance against other health plans.

HOS and the Medicare Star Ratings

CMS uses the HOS as a component of the Medicare Star ratings as a way to monitor plan performance and reward top-performing health plans. Managed care plans with Medicare Advantage (MA) contracts must participate. Five HOS measures (two functional health measures and three HEDIS Effectiveness of Care measures) are included in the annual Medicare Part C Star Ratings:

- Improving or Maintaining Physical Health – 3 weight
- Improving or Maintaining Mental Health – 3 weight
- Monitoring Physical Activity – 1 weight
- Reducing the Risk of Falling – 1 weight

The measure for Improving or Maintaining Physical Health is the combined Physical Health Percent Better+Same result, and the Improving or Maintaining Mental Health measure is the combined Mental Health Percent Better+Same result. These outcome measures are heavily weighted, and our goal is to work closely with our providers to ensure that our members perceive their health to stay the same, or, ideally, improve as a result of the care they have received from you.

**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.*

PF Hints for HEDIS (and more)

As part of our ongoing efforts to provide the highest quality care to our members, BCBSRI reviews data from the Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Stars, Consumer Assessment of Healthcare Providers and Systems (CAHPS), 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, BCBSRI clinical quality management analyst, at (401) 459-2763 or courtney.reger@bcbsri.org.

NEW this year

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

Controlling blood pressure

Controlling Blood Pressure (CBP) is both a HEDIS and CMS Stars Measure. The following table summarizes the 2017 HEDIS specifications:

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

Measuring blood pressure: Technique matters

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

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

BCBSRI adopts the recommendations of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), published and developed by the National High Blood Pressure Education Program (NHBPEP) in coordination with the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH).

The full guideline is available on the National Heart, Lung, and Blood Institute (NHLBI) 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 site.

Tools for your patients

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

PF 80% by 2018: National Colorectal Cancer Roundtable

BCBSRI has pledged "80% by 2018" as part of a National Colorectal Cancer Roundtable (NCCRT) initiative in which more than 1,000 organizations have committed to substantially reducing colorectal cancer as a major public health problem. We are all working toward the shared goal of ensuring that 80% of adults aged 50 and older are being regularly screened for colorectal cancer by December 31, 2018. For reference, the current screening rate in Rhode Island is approximately 75.4%.

The initiative—which is led by the American Cancer Society (ACS), the Centers for Disease Control and Prevention (CDC) and the NCCRT (an organization co-founded by ACS and CDC)—was created to get the word out that screening can save lives . . . **but only if people get tested**.

To put the importance and urgency of screenings into perspective, consider this: If participating organizations can achieve the nationwide goal of 80% by 2018, approximately 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

Here's how you can help:

- Educate patients who are receiving routine, preventive colorectal cancer screenings that they will **pay no cost-share** when the screening is coded as preventive, including polyp removal, facility fees, etc. The following tests are included: colonoscopy, flexible sigmoidoscopy, CT colonography, guaiac-based fecal occult blood test/fecal immunochemical test, and stool DNA tests.
- To ensure correct application of the preventive benefit, services must be filed as indicated in the payment policies for Preventive Services for BlueCHiP for Medicare and Preventive Services for Commercial members.
- Consider signing the "80% by 2018" pledge.
- Encourage colorectal cancer screening by giving these free materials to your patients.

If you have any questions, please contact Courtney Reger, RN, BSN, BCBSRI clinical quality management analyst, by calling (401) 459-2763 or emailing courtney.reger@bcbsri.org. Thank you for your support.

Routine colonoscopies

Routine colonoscopy remains the gold standard because of the ability to detect colon cancer and precancerous changes that might otherwise develop unnoticed. However, for members who refuse to have a colonoscopy, there are alternatives.

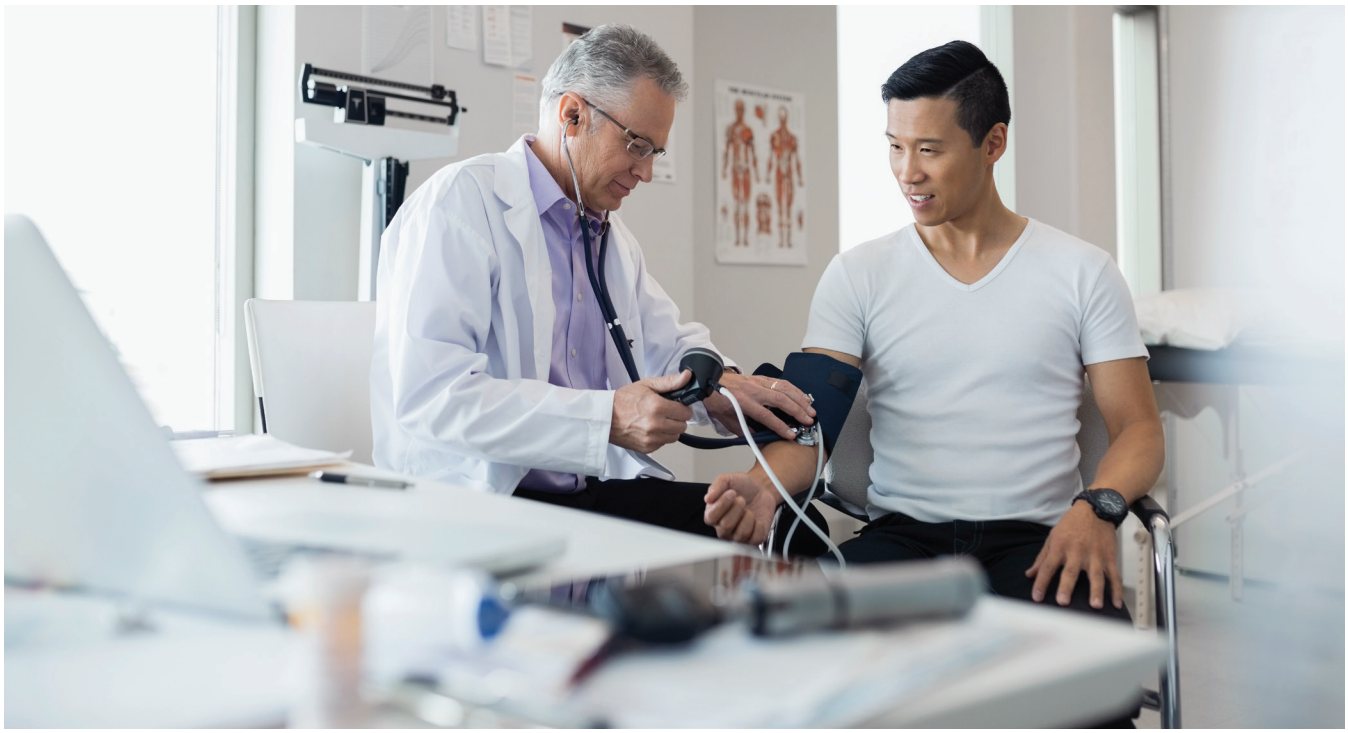
As of June 2016, the U.S. Preventive Services Task Force (USPTF) has updated its screening guidelines. It is recommended that adults aged 50-75 undergo regular screening; methods and screening intervals vary and may depend upon patient risk profile, health status, and other factors.

The HEDIS measure for Colorectal Cancer Screening (CCS) evaluates the percentage of eligible members who have had FOBT, flexible sigmoidoscopy, CT colonograpy, DNA-FIT test, or colonoscopy during certain time frames. The measure is summarized on the next page, along with tips for success.

Quality

Test/exam	Measure population	Exclusions	Tips for success
Colorectal cancer screening	Adults aged 50 to 75 who have had one of these types of screenings: • Fecal occult blood test (FOBT) during the measurement year • Flexible sigmoidoscopy in the measurement year (or the 4 years prior to the measurement year) • Colonoscopy during the measurement year (or the 9 years prior to the measurement year) • CT colonography during the measurement year or the 4 years prior to the measurement year • FIT-DNA during the measurement year or the 2 years prior to the measurement year	• Colorectal cancer • Total colectomy	• A digital rectal exam is not counted as evidence of a colorectal screening. • Talk with patients about what to expect from the recommended screening (e.g., procedure preparation, anesthesia, etc.). This may allay fears about the test and help patients schedule tests more readily. • Preventive tests are covered with no copay/cost-share.*

**When suspicious tissue is encountered during routine screening and removed or sampled for biopsy, a test typically considered preventive may be coded as diagnostic. In this case, the member may be subject to copays or cost-sharing based on their respective benefit plan.*



PBF May is Mental Health Month

Mental Health Month was started in 1949 by the national organization Mental Health America to raise awareness about mental health conditions and the importance of good mental health for everyone. The 2017 Mental Health Month campaign is titled "Risky Business," and will provide insight on habits and behaviors that increase the risk of developing or exacerbating mental illnesses, or are signs of mental health problems themselves. The goal is to raise awareness of the risks that these behaviors present, particularly to young people, to help detect early warning signs, and to provide resources for prevention and intervention. To learn more about Mental Health Month, please visit www.mentalhealthamerica.net/may.

BCBSRI has many resources available to our members with mental health issues. Please read on to learn more.

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 **Provider Call Center** (401-274-3103) 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 also search our website at bcbsri.com if you are simply looking for a behavioral health provider.
- **The Beacon Health Options (Beacon) Clinical Referral Line** (1-800-274-2958) 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. The clinical referral line should not be used if there is concern of imminent danger, but can be a first point of contact in non-emergency situations. The clinician, who may be a registered nurse, independently licensed social worker, or mental health counselor, will ask questions to get a better understanding of your patient's needs. The clinician will provide you with information about services that are available and will offer the names and contact information for providers who offer these services. 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:
    - Help them understand barriers that prevent them from getting the most from their treatment or in obtaining recommended treatment.
    - Help them find and obtain services or resources needed to better manage their behavioral health condition.
    - Provide education and support to help them better manage their condition.
    - Coordinate care with providers to ensure you and your patient have the necessary information to provide them with the best care and support.
    - Work with them to ensure they know the medications they should be taking and understand the instructions you've provided to them.

To refer a patient to Beacon Health Options Case Management Program, please call 1-800-274-2958, option 3, then option 1. You may also use our automated referral form at bcbsri.com by following these easy steps:

1. Log in to the secure Provider site 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!"

PBF Claims adjustments: helpful tips

Here are some helpful tips when submitting a claims adjustment.

Please use one form per claim to make adjustments to a claim that was previously submitted.

Common reasons to request a claim adjustment

- Corrected claim (original submission error)
- Referral/authorization obtained (documentation attached with supporting referral or authorization information)
- Retraction request (filed in error, duplicate payment)
- Review with additional documentation
- Waive timely filing when you have another carrier's EOB

Please do not highlight line items on settlements. Use asterisks to identify relevant line items on your settlements. To comply with HIPAA, all other non-pertinent PHI on attached settlements must be blacked out.

Reasons to submit a corrected claim/claim adjustment

- If another carrier retracts payment from you and you file your claim within 180 days of that retraction along with a copy of the settlement showing the retraction
- If your claim date of service is greater than 180 days aged but within 180 days of the date of disposition unless your provider contract states otherwise
- If you file your clean claim within timely filing guidelines and your claim says you have 18 months in accordance with the post payment mandate to request an adjustment unless your provider contract states otherwise

Please send claims adjustments to:
Attn: Basic Claims Administration – Inquiry Unit 00066
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903

BCBSRI's Grievances & Appeals Unit (GAU) has strict time frames to review and determine the outcome of a true grievance and/or appeal request. If a claim adjustment request is sent to GAU when it should be sent through the claims adjustment process, it will be sent back to you and will not be processed.

Common reasons to submit an appeal on a denied claim

- Timely filing when it does not meet the criteria outlined above
- Administrative claim denial
- Provider not authorized for the service
- Service not in the provider's contract
- Preauthorization was denied during initial review
- Investigational/experimental/not medically necessary denial

As a reminder, please only use the Claims Adjustment Request Form when submitting a corrected or adjusted claim. For true appeals, please use the Provider Appeal Request Form.

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

PF Modifier 59 reminder

A 2005 report from the Office of Inspector General found that 40% of code pairs billed with modifier 59 in FY 2003 did not meet program requirements, resulting in $59 million in improper payments. In its 2013 Cert Report data, CMS estimated that the projected error rate for lines billed with modifier 59 was $320 million. Modifier 59 is both commonly used and abused.

BCBSRI follows The Medicare National Correct Coding Initiative (NCCI), also known as CCI. The purpose of NCCI is to control improper coding that leads to inappropriate payment. The Medicare NCCI edits consist of Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and add-on code edits.

PTP edits

NCCI Procedure-to-Procedure (PTP) edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported. When appropriate, modifier 59 is **correctly reported when added to the Column two code of a code pair.**

MUEs

A MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

Add-on code edits

Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment.

As a reminder, when submitting claims, providers are to adhere to correct coding guidelines. It is important to understand that the NCCI edits do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent the use of an inappropriate code combination.

It is recommended that providers verify the existence of a NCCI edit prior to claim submission. When appropriate and supported by medical record documentation, modifier 59 should be appended to the Column two code in the code pair.

Claims can be subject to pre-pay/post-pay audit and possible recoveries. The NCCI policy manual can be found on the CMS website.

Contracting & Credentialing

PBF Contract restatement for the entire provider network

Recently, all current credentialed providers received a first class, certified notification, which accompanied the updated contract in its entirety. These restated contracts do not require a signature, but they require acknowledgement through electronic signature that the provider or a delegate of the provider has received the certified notification.

Additionally, any newly credentialed provider will receive the newly updated Participating Physician/Provider Agreement, which will include updated contract language and modifications to our administrative and fair hearing policies.

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

As a BCBSRI-contracted provider, you have an obligation to coordinate members' care with contracted, in-network providers. This includes all ancillary services such as clinical laboratory and pathology services, durable medical equipment, radiology, and behavioral health providers.

Before you establish a referral relationship, please confirm that the provider currently participates in the BCBSRI network. One way to do that is by checking the participation status of providers on our Find a Doctor tool.

Policies

PF Policies recently reviewed for annual update

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

- Advance Directives Planning
- Asthma Management Services
- Autonomic Nervous System Testing Using Portable Automated Devices
- BCBSRI Use of Provider Performance Data for Healthcare Operations
- Cardiointegram
- Constraint Induced Movement Therapy
- Coordination of Benefits
- Date of Service (DOS) for Laboratory Specimens
- Digital Breast Tomosynthesis
- Dry Needling
- Electronic Funds Transfer/Direct Deposit for Participating Providers
- Evaluation of Hearing Impairment/Loss
- Gender Reassignment Surgery
- Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
- High Risk Pregnancy Services and Maternity Global Reimbursement
- Home Cardiorespiratory Monitoring (former title: Home Apnea Monitoring)
- Home Spirometry
- Hospital Readmission
- Infertility Treatment Mandate
- Inpatient admissions
- Interim Billing
- Intravenous Anesthetics for the Treatment of Chronic Pain
- Long Term Acute Care Hospital (LTACH) Admission and Transition of Care Criteria
- Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD)
- Multimarker Serum Testing Related to Ovarian Cancer (former title: Proteomics Based Testing Related to Ovarian Cancer)
- Orally Administered Anticancer Medication Mandate
- Physician Concierge Services
- Private Duty Nursing
- Specimen Provenance Error Testing
- Sympathetic Therapy for the Treatment of Pain
- Thoracic Lumbo Sacral Orthosis with Pneumatics
- Topographic Brain Mapping
- Transtympanic Micropressure Applications as a Treatment of Menier's Disease
- Vacation Pharmacy Supply
- Wireless Pressure Sensors in Endovascular Aneurysm Repair
- Wig Mandate

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

PBF BlueCHiP for Medicare products

BCBSRI must follow the Centers for Medicare and Medicaid Services (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 applicable 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.

Policies

PBF Reminder: Clean Claim Criteria Policy

As a reminder, BCBSRI requires providers to report the name and National Provider Identifier (NPI) of the ordering provider for all diagnostic laboratory, imaging, diagnostic tests, durable medical equipment, and home infusion claims. On the CMS-1500 form or the electronic submission, the ordering provider's name should be reported in box 17, and the NPI should be reported in box 17b.

When the ordering provider is also the performing provider, the provider should enter his or her name and NPI in boxes 17 and 17b respectively.

Effective September 1, 2017, the claim will be rejected if box 17 and 17b of the CMS-1500 form or the electronic submission does not contain this information.

Please see the full text of this policy.

P Advance Primary Care Program policies – 2017 update

BCBSRI recently released updated Program Policies for all providers who participate in a contracted patient-centered medical home (PCMH) or systems of care (SOC) practice site. The updated program policies, which provide valuable information related to performance and reporting expectations, as well as incentive payments, became effective May 1, 2017, and will be updated as needed.

Participating PCMHs received the updated policies via email or through SOC leadership. BCBSRI practice facilitators are available to meet with practices to review policy changes and share resources as it relates to PCMH transformation activities. If you did not receive these policies from BCBSRI directly or through your SOC, please contact your BCBSRI practice facilitator or PCMH@bcbsri.org.

PF Claim filing requirements for drugs

Please review the full text of this policy for when it is appropriate to file unlisted drug codes with the 11-digit NDC number for the drug. If a valid HCPCS code has not yet been assigned to a drug, the appropriate not otherwise classified (unlisted) drug code (J3490, J3530, J3535, J3590, J7199, J7599, J7699, J7799, J8498, J8499, J8999, J9999, Q0181, Q4082) must be submitted with the 11-digit NDC number for the drug. Unlisted codes should ONLY be used when there is not a valid HCPCS code for the drug. NDC codes will not be considered for payment except when submitted with an unlisted HCPCS code when a valid HCPCS code is not yet available. Please see the full text of this policy.

PF Molecular markers in fine needle aspirates of the thyroid

Effective for claims with dates of services of July 1, 2017 and after, code 81545 will require prior authorization for Commercial products. The service already requires prior authorization for BlueCHiP for Medicare and there will be no change. Please see the full text of this policy.

PF Genetic testing services

Effective for claims with dates of services of July 1, 2017 and after, code 81287 will no longer require prior authorization for BlueCHiP for Medicare and Commercial products. The service will be covered for BlueCHiP for Medicare and will be not medically necessary for Commercial products. Please see the full text of this policy.

PF Mechanical wound suction

Effective for claims with dates of services of July 1, 2017 and after, the Mechanical Wound Suction policy will be updated to correctly reflect that CPT codes 97607 and 97608 are not medically necessary for Commercial products. Please see the full text of this policy.

Policies

PF Surgical ventricular restoration

Effective May 1, 2017, surgical ventricular restoration for the treatment of ischemic dilated cardiomyopathy is considered not medically necessary for BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

PF Chronic intermittent intravenous insulin therapy

Effective May 1, 2017, chronic intermittent intravenous insulin therapy as a technique for delivering variable-dose insulin to diabetic patients with the goal of improved long-term glycemic control is considered not medically necessary for BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

PF Nusinersen for spinal muscular atrophy

A new medical policy has been created regarding coverage for Nusinersen, which is a new drug for the treatment of spinal muscular atrophy. Nusinersen may be considered medically necessary for patients with infantile-onset or type I spinal muscular atrophy with a documented genetic diagnosis of spinal muscular atrophy. It is considered not medically necessary for patients with type 0, II, III, and IV spinal muscular atrophy as the evidence is insufficient to determine the effects of the technology on health outcomes. Preauthorization is recommended for Commerical products and required for Blue CHiP for Medicare.

To request preauthorization, contact the Health Services Management Department at (401) 272-5670, extension 3012, or fax your request to (401) 272-8885. Please see the full text of this policy.

PF Cranial electrotherapy stimulation and auricular electrostimulation

A new medical policy has been created for BlueCHiP for Medicare and Commercial products indicating that cranial electrotherapy stimulation (also known as cranial electrostimulation therapy) and auricular electrostimulation are considered not medically necessary as the evidence is insufficient to determine the effects of the technology on health outcomes. Please see the full text of this policy.

PF Lactation consultations – update to policy

The Lactation Consultation Policy has been updated to reflect that lactation consultations are covered for one of the diagnosis codes listed in the policy when the services are provided by a licensed lactation consultant (LLC) or physician. Lactation consultants must be licensed in the state in which they provide services. Please see the full text of this policy.

In addition, effective April 10, 2017, BCBSRI will begin credentialing licensed lactation consultants for participation in the provider network.

To request to become participating, the LLC should visit bcbsri.com and go to the Provider page, and then follow the link to "Become a Participating Provider." They will then be directed to a short form that must be completed and submitted.

The credentialing process takes approximately 30 to 60 days. BCBSRI utilizes CAQH as its application for credentialing so LLCs must ensure that their CAQH application is updated. In addition to the CAQH application, applicants must complete and return all necessary documents requested for their application to be processed.

BCBSRI has partnered with Aperture, a national NCQA credentialing verification organization, to perform verification of credentials. LLCs should respond directly to Aperture if contacted by one of their representatives during the credentialing process.

PF Correction to CPT 22853, 22854, and 22859

CPT 22853, 22854, and 22859, for interspinous fusion devices, are being updated to reflect that the services will be covered. The system changes will be made in May 2017. Claims will be adjusted to pay for any claims filed from January 1, 2017. This update is effective for both BlueCHiP forMedicare and Commercial products.