Blue Cross Blue Shield of Rhode Island

provider update

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

June 2017

In the April 2017 issue of Provider Update, I wrote about the high cost of healthcare in Rhode Island (Rhode Island ranks in the top 10 in the country) and our commitment to improving affordability, which is one of the tenets of the triple aim—better health for our state, a simpler patient experience, and lower costs.

We've already taken numerous steps to move toward the triple aim by investing in primary care, integrating medication therapy management into primary care provider offices, and continuing to move toward a reimbursement model that embraces quality, value, and efficiency. While most of our efforts have targeted the primary care space, we recognize that our view needs to be broader to include that of specialists. This is especially important as we transition to value-based care or alternative payment methodologies.

To support this effort and to better understand specialist performance, we've partnered with a healthcare data analytics vendor, RowdMap. Their platform will help us to analyze data—both publicly available data from the Centers for Medicare and Medicaid Services and our own claims data—to identify high-performing providers delivering high-value care.

In the coming months, we'll be sharing more information about what constitutes high-value care as well as the impact of low-value care in Rhode Island. We encourage providers to become more involved in cost efficiency and making healthcare affordable by becoming more familiar with our strategy around specialist utilization and provider readiness for alternative payment models.

You can learn about our efforts at one of two informational webinars. The first will be held on **Tuesday, July 18, from 7:30 a.m. to 8:30 a.m.**, and the second is on **Monday, July 24, from 5:00 p.m. to 6:00 p.m.** Registration is required. To register, please email bcbsriwebinar@bcbsri.org or call Provider Relations at (844) 707-5627.

We look forward to working with you and our entire provider community to make healthcare more affordable for Rhode Islanders.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

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BCBSRI Update

P Referral tool inquiries

Effective July 1, 2017, the Physician & Provider Service Center will be the first point of contact regarding any referral tool inquiries or to report any technical issues. The Secure Messaging feature, which is accessible by logging on to our secure Provider site, can also be used to report any issues.

Physician & Provider Service Center
(401) 274-4848 or 1-800-230-9050 (out of state only)
Monday – Friday, 8:00 a.m. to 4:30 p.m.

PBF Tips for keeping emails secure

Each year we become more and more reliant on email for communication. It is quick and easy, and many times it is an efficient form of information exchange. However, if not used with caution, email can cause a great deal of harm to your patients. Below are some reminders about email security.

1. Email sent outside of your practice may not be encrypted automatically. Typical business email systems require a trigger to invoke the encryption security for outgoing email.
2. Many email systems have an automated address matching capability enabled. This feature is convenient but can create errors when not careful. Always verify the recipient names and addresses prior to sending an email.
3. Opening a suspicious email is unlikely to cause the computer or network to be infected with a virus. However, clicking on a link embedded within the suspicious email may activate a malicious virus. Be sure to follow internal procedure for appropriate reporting of suspicious emails.
4. Some email systems will automatically add addressee contacts to an address book based on emails you send and receive. This is another convenience feature that can cause errors if not used carefully.
5. Be sure to review and understand how your employer email encryption tool works.
6. When replying to an email, review the recipients and content to ensure that all of it continues to be necessary. Any nonessential information should be removed from the email prior to sending.

Please see additional email security tips.

P 2017 PCMH Program Policies

BCBSRI released the 2017 PCMH Program Policies on May 1, and they will go into effect July 1. The key changes to these policies reflect the feedback received from patient-centered medical home (PCMH) practices. The changes include:

- Refinement of the Johns Hopkins algorithm current identification of High Risk "orange" and pediatric definition
- A move to quarterly reporting for nurse care manager high-risk engagement
- A requirement for practice sites to submit a plan for National Committee on Quality Assurance (NCQA) accreditation renewal six months prior to current NCQA accreditation expiration

Please refer to the policies that were mailed to PCMH practices for the exact details.

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.

BCBSRI now conducts quarterly fax-based validation and attestation of provider practice information for the information we currently have displayed in our Find a Doctor tool. The next quarterly validation takes 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 Hints for HEDIS (and more)

As part of our ongoing efforts to provide the highest quality care to our members, BCBSRI reviews data from the Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Stars, Consumer Assessment of Healthcare Providers and Systems, Medicare Health Outcomes Survey, and internal resources. This helps us identify opportunities to enhance clinical care for your patients, our members. "Hints for HEDIS (and More)" provides guidance and resources to help address these opportunities. If you have any questions, comments, or ideas regarding any of our quality or clinical initiatives, please contact Courtney Reger, RN, BSN, quality management analyst at (401) 459-2763 or courtney.reger@bcbsri.org.

CPT® Category II Codes

Did you know that the use of CPT Category II Codes can close gaps in care as set forth by the National Committee for Quality Assurance? While CPT Category II Codes are not reimbursed by BCBSRI, submission of these codes will greatly **reduce the HEDIS medical record review burden on your practice** by closing gaps in care through claims data. Here is a list of relevant CPT Category II Codes. These codes can be submitted effective immediately and can even be used for claims with older dates of service. If you have any questions, please contact your Provider Relations representative or email ProviderRelations@bcbsri.org.

Caring for members with asthma and allergies

For members with asthma, allergies, and both conditions, the summer months often bring an increase in triggers such as humidity, mold, spores, and certain animals/insects. Members with asthma may benefit from conversations about condition management, including the following:

- Review triggers and plan for mitigating impact for any newly identified triggers.
- Review (or create) a personal asthma action plan.
- Remind members to refill seasonal control and rescue medications.
- Encourage members to contact customer service at the number on their BCBSRI card to learn more about coverage for spirometers.
- Let Commercial members with asthma know they are eligible for our Asthma Disease Management Program (see below).
- Ask if families of pediatric patients with asthma (regardless of insurance coverage) are interested in Hasbro Children's Hospital's Draw a Breath Program (see below).

Resources

- **BCBSRI Asthma Disease Management Program** – BCBSRI offers this disease management program to Commercial and FEP adults and children with asthma. Interventions are based on risk stratification.
    - All identified members (low risk) receive a mailing to introduce the program and provide educational material. A call-in line is also made available for additional information or questions.
    - Members stratified as high risk are offered the opportunity to participate in telephonic health coaching. Health coaches are RNs who may be certified asthma educators and/or have clinical/educational experience in asthma management. The notification to high-risk members who belong to a patient-centered medical home (PCMH) includes a recommendation that they contact the nurse case manager at their primary care provider's office for assistance with their diabetes management.
    - If you have members who could benefit from the Diabetes Disease Management Program, please call the BCBSRI Triage Line at (401) 459-2273.
- **Draw a Breath Program** – This asthma education program for children and their parents, based at Hasbro Children's Hospital, is designed to provide families with the knowledge, skills, and tools to effectively manage asthma and to reduce emergency room and overnight hospital stays for asthma. The CVS/pharmacy Draw A Breath Program is the largest asthma education program in Rhode Island and includes educational programming for children with asthma and their families, including Asthma Camp and parent support groups. The program is offered in English and Spanish. For more information, call (401) 444-8340.

Practice tips for HEDIS

This chart offers tips for the HEDIS measure Medication Management for People with Asthma.

Measure	Population: Numerator and Denominator	Tips for Success
Medication Management for People with Asthma	*Denominator:* Patients 5-85 years of age with persistent asthma. Two rates are reported: *Numerator:* The number of patients who remained on an asthma controller medication for: • At least 75% of the treatment period • At least 50% of the treatment period ***Exclusions:*** Diagnosis of COPD, emphysema, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis, or acute respiratory failure any time during the patient's history through the end of the measurement year	• Help members identify common allergies that could trigger asthma symptoms and recommend ways to avoid exposure to triggers. • Educate members about medications that can cause or worsen asthma symptoms. • Help members develop an action plan to identify when they are doing well and when they need help. • Encourage members to keep a journal of their medications and asthma symptoms to review during appointments to determine if medication adjustments should be made.

Asthma Medications

Antiasthmatic combinations	• Dyphylline-guaifenesin • Guaifenesin-theophylline
Antibody inhibitor	• Omalizumab
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol • Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide • Flunisolide • Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast • Zafirlukast • Zileuton
Methylxanthines	• Aminophylline • Dyphylline • Theophylline
Short-acting, inhaled beta-2 agonists[1]	• Albuterol • Levalbuterol • Pirbuterol

[1]These drugs help to identify patients in the denominator but are not considered controller medications.

Caring for members with chronic obstructive pulmonary disease

COPD, or chronic obstructive pulmonary disease, is a lung disease that causes coughing, wheezing, shortness of breath, and other symptoms. COPD is a major cause of disability and a leading cause of death in the United States. Spirometry is an inexpensive, simple test that can diagnose COPD and help distinguish asthma from COPD and determine an appropriate treatment regimen.

Below are practice tips for the use of spirometry testing as a HEDIS measure

Measure	Population: Numerator and Denominator	Tips for Success
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	*Denominator:* Members ages 40 and older with a new diagnosis of COPD or newly active COPD *Numerator:* At least one claim/encounter for spirometry in the two years before the diagnosis date through six months after the diagnosis date ***Exclusions:*** Members in hospice	• Encourage members to wear loose clothing that won't interfere with their ability to take a deep breath. • Instruct member before arrival to avoid eating a large meal before their test, so it will be easier to breathe. • The following CPT codes® for spirometry make a member compliant for HEDIS. Please make sure to use the most clinically appropriate code: • 94010 • 94014 • 94015 • 94016 • 94060 • 94070 • 94375 • 94620

PBF Clinical practice guidelines

The 2017 Clinical Practice Guidelines for Hyperlipidemia, Perinatal Care and Depression in Primary Care were reviewed and approved by the Professional Advisory & Credentials Committee on March 15, 2017. The next review will take place in May 2019.

B Follow-Up After Hospitalization Quality Pilot Program

BCBSRI is committed to promoting better health outcomes and quality care for members with behavioral health needs. As part of this commitment, BCBSRI implemented a quality program for our behavioral health participating providers aimed at improving timely transitions from inpatient behavioral healthcare to outpatient behavioral health specialist services for members who experience an inpatient mental health admission.

This pilot program is based on the National Committee on Quality Assurance (NCQA)-established Healthcare Effectiveness Data and Information Set (HEDIS) measure, Follow Up After Hospitalization for Mental Illness. It incentivizes providers to have appointments with members six years of age and older for a follow-up behavioral health visit within seven calendar days of discharge from an inpatient admission for a primary mental health diagnosis. BCBSRI provides a $40 incentive payment to participating providers who complete a visit with a member within the seven-day timeframe. This pilot program is an effort to improve the number and therefore the percentage of members who attend a follow-up behavioral health visit as well as to improve transitions of care.

This pilot program will be coming to a close on June 30, 2017. We are currently analyzing results of the program and welcome feedback from providers about this measure. If you've received an incentive as part of our program, please contact us at BehavioralHealth@bcbsri.org and let us know the successes and challenges you've experienced in trying to see your patients within 7 days of discharge.

Antidepressant Medication Management (AMM)

The HEDIS measure Antidepressant Medication Management is the percentage of members 18 years of age and older who were treated with antipressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. The measure looks at two rates—the effective acute phase and the effective continuation phase. Details about each phase, as well as tips for success, are listed below.

Measure	Measure Population	Tips for Success
Antidepressant Medication Management (AMM)	*Effective Acute Phase Treatment:* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)	A follow-up office visit to assess symptoms should be conducted at a maximum of 6 weeks. Visits should be sufficiently frequent to optimize adherence. Roughly half of all patients treated for depression stop taking their medication within the first month. Patients should be reminded that symptom alleviation may take 2 to 4 weeks and that it can sometimes take up to 8 weeks for the medication to fully work. Patients should also be reminded to continue to take medications for at least six months even if symptoms improve.
	Effective Continuation Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)	

PBF Professional drug reimbursement fee schedule changes

On a regular basis, BCBSRI analyzes how our payment methodologies align with standards in the industry. Where variation is determined, BCBSRI will, from time to time, bring its practices in line with such standards. We have recently concluded a review of professional drug reimbursement and the methodology used to reimburse providers for drugs they procure and administer to BCBSRI Commercial and Medicare Advantage members.

Effective August 1, 2017, BCBSRI will modify its professional drug reimbursement fee schedule to better align with industry standards, specifically those set by the Centers for Medicare and Medicaid Services (CMS). BCBSRI will move from the Average Wholesale Price (AWP) model, which does not reflect actual drug acquisition prices for purchased drugs, to the Average Sales Price (ASP) model. The ASP model was adopted by CMS as its standard for Medicare Fee-for-Service reimbursement in 2005 and more accurately reflects the drug acquisition cost by providers. CMS reimburses at 106% of ASP.

BCBSRI has planned a multi-year phase in for drugs rendered to BCBSRI Commercial members. This phase in will be as follows:

- 115% of ASP on August 1, 2017
- 110% of ASP on April 1, 2018
- 106% of ASP on April 1, 2019

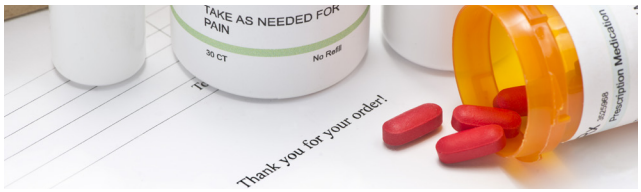
Reimbursement will move to 106% of ASP on August 1, 2017 for drugs rendered to BCBSRI Medicare Advantage members. (BCBSRI will update rates quarterly based on the most current ASP values available.)

There are two exceptions for both Commercial and Medicare reimbursement:

- Provider-purchased vaccines will remain at 95% of AWP, also consistent with current CMS reimbursement.
- In instances where CMS doesn't have a published ASP for a drug, BCBSRI will continue to pay at 90% of AWP.

We recognize this change will impact revenue for some providers; however, BCBSRI has a responsibility to make healthcare affordable and simple for our members and the broader community.

If you have any questions about these changes, please call Provider Relations at (844) 707-5627 or email ProviderRelations@bcbsri.org.



P Medical drug review

BCBSRI continues to assess ways to achieve the triple aim in healthcare—improving population health, patient experience, and cost of care. As previously communicated, BCBSRI, with our pharmacy benefits manager, Prime Therapeutics LLC (Prime), has committed to improving the prior authorization process, emphasizing efficiency and ease of use through the CoverMyMeds portal.

After careful consideration, BCBSRI has decided to expand the electronic prior authorization (ePA) platform to accommodate additional medications for the commercially insured patient population, including medications that are new to the PA process. More information about the expansion of the ePA process will be made available through the Pharmacy page of bcbsri.com, and through direct provider outreach, as the date approaches.

P Opioid prescription state mandate – July 2017

In partnership with the Rhode Island Department of Health, BCBSRI is informing the provider community about recent regulatory changes regarding opioid use and the management of acute pain and chronic pain. As it is recommended that patients receive the lowest effective dose of opioids for the shortest possible duration, these regulations limit maximum dosing for patients who have not had an opioid prescription filled in the previous 30 days. Updated regulations are effective **July 6, 2017** and apply to patients new to the prescription of opioids. The following provides further detail on the regulations and how BCBSRI is supporting this effort: Section 4.4C of Rules and Regulations for Pain Management, Opioid Use, and the Registration of Distributors of Controlled Substances in Rhode Island [216-RICR-20-20-4].

Claims

PBF Reminder: Claim filing across states

As a reminder, when a BCBSRI participating provider renders services to a BCBSRI member in a city or town outside of Rhode Island that is within the contiguous county (e.g, Attleboro, Fall River, Swansea, etc.), claims should be filed directly to BCBSRI.

If a BCBSRI participating provider renders services to a non-BCBSRI Blues plan member in a city or town outside of Rhode Island that is within the contiguous county (e.g, Attleboro, Fall River, Swansea, etc.), claims should be filed directly to the Blues plan state where services are rendered .

P New England Health Plan Cross-Border Referral Form

To improve the referral process for New England Health Plan members, we have updated the NEHP Cross-Border Referral Form. The form is also available in the Provider section of bcbsri.com.

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).

PBF The Medicare National Correct Coding Initiative

BCBSRI follows the Medicare National Correct Coding Initiative (NCCI). NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The Medicare NCCI edits consist of:

- Procedure-to-Procedure (PTP) Edit
- Medically Unlikely Edits (MUEs)
- Add-on code edits

NCCI PTP code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. MUEs are the maximum number of units of service 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 member. MUE and NCCI PTP edits are based on services provided by the same physician to the same members on the same date of service. Add-on code edits prevent the payment of an add-on code without an appropriate primary procedure performed by the same provider on a date of service for a single member. **Providers should not inconvenience members nor increase risks to members by performing services on different dates of service to avoid MUE or NCCI PTP edits**.

As a reminder, 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. However, 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 an NCCI edit prior to claim submission. Claims can be subject to pre-pay/post-pay audit and possible recoveries. The NCCI policy manual can be found on the Centers for Medicare & Medicaid Services (CMS) website.

When submitting claims, providers are to adhere to correct coding guidelines. We would like to remind you of important correct coding guidelines to keep in mind when submitting claims.

NCCI PTP code pair edits

Procedures should be reported with the most comprehensive CPT code that describes the services performed. It's improper to unbundle the services described by a HCPCS/CPT code. Additionally, a procedure should not be fragmented into component parts specifically when a single comprehensive HCPCS/CPT code describes these services.

Example

The code descriptor for CPT code 21045 is "Excision of malignant tumor of the mandible; radical resection" and the code descriptor for CPT code 21044 is "Excision of malignant tumor of the mandible." Based upon the code descriptors, the procedure described by CPT code 21044 is a component of the procedure described by CPT code 21045, and CPT code 21044 is bundled into CPT code 21045.

Services that are integral to a more comprehensive procedure should not be unbundled. When integral component services have their own HCPCS/CPT codes, NCCI PTP edits place the comprehensive service in column one and the component service in column two. Examples of services integral to a large number of procedures include but are not limited to:

- Cleansing, shaving, and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration
- Insertion of urinary catheter
- Sedative administration by the provider performing a procedure (**Medicare rules allow providers performing a surgical or diagnostic procedure to separately report medically reasonable and necessary moderate conscious sedation with a procedure.*)
- Local, topical, or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles, including stimulation for identification or monitoring
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into the same site
- Surgical closure and dressings (**Lesion removal may require closure—simple, intermediate, or complex—adjacent tissue transfer, or grafts. If the lesion removal requires dressings, strip closure, or simple closure, these services are not separately reportable. Thus, CPT codes 12001-12021—simple repairs—are integral to the lesion removal codes*.)

- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS unit
- Institution of patient controlled anesthesia
- Preoperative, intraoperative, and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where CMS policy permits separate payment

Examples

The CPT Manual instruction under "Excision – Benign Lesions" states that the excision includes simple closure. Therefore the procedure described by the column one CPT code 11400—"Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms, or legs; excised diameter 0.5 cm or less"—includes the procedure described by the column two CPT code 12001—"Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet; 2.5cm or less)". CPT code 12001 is bundled into CPT code 11400.

CPT code 11055 describes paring or cutting of benign hyperkeratotic lesion and CPT code 11720 describes debridement of the nail(s) by any method; 1 to 5. Treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Therefore, CPT code 11720 cannot be reported separately and is bundled into CPT code 110555 when both services are performed on the same digit.

CPT code 11770 describes excisions of pilonidal cysts and/or sinuses. A CPT code 10080 describes incision and drainage of pilonidal cyst. When the incision and drainage of the pilonidal cyst(s) are performed on at the same anatomic site and the same patient encounter, CPT code 10080 is bundled into 11770.

Fluoroscopy is inherent in many radiological supervision and interpretation procedures. Unless specifically noted, fluoroscopy necessary to complete a radiologic procedure and obtain the necessary permanent radiographic record is included in the radiologic procedure and should not be reported separately. Additionally, fluoroscopy reported as CPT codes 76000 or 76001 is integral to many procedures including, but not limited to, most spinal, endoscopic, and injection procedures and should not be reported separately.

Example

Colorectal cancer screening using a barium enema radiologic study as an alternative to screening by colonoscopy (HCPCS code G0120) includes as a standard of medical/surgical practice all fluoroscopy (CPT code 76000) necessary to perform the procedure. Therefore, CPT code 76000 is bundled into HCPCS code G0120.

If a CPT code descriptor includes the term "separate procedure," the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region, often through the same skin incision, orifice, or surgical approach. A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area, often through a separate skin incision, orifice, or surgical approach.

Example

The code descriptor for CPT code 29870—"Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)"—includes the "separate procedure" designation. When a surgical arthroscopy of the knee with major synovectomy in two or more compartments (CPT code 29876) is performed, the procedure described by CPT code 29870 on the same knee does not meet the definition of a "separate procedure." Therefore, CPT code 29870 cannot be reported separately and is bundled into CPT code 29876 when both services are performed on the same knee.

The definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites. CMS considers the ipsilateral knee or shoulder to be a single anatomic structure. The contralateral knee or shoulder is considered a different anatomic site.

Example

CPT code 29827 describes arthroscopy, shoulder, surgical; with rotator cuff repair and CPT code 29820 describes arthroscopy, shoulder, surgical; synovectomy, partial. Since both procedures are performed on the same shoulder during the same operative session, CPT code descriptors often define correct coding relationships where two codes may not be reported separately with one another at the same anatomic site and/or same patient encounter.

CPT code descriptor examples

a) A "partial" procedure is not separately reportable with a "complete" procedure.

b) A "partial" procedure is not separately reportable with a "total" procedure.

c) A "unilateral" procedure is not separately reportable with a "bilateral" procedure.*

d) A "single" procedure is not separately reportable with a "multiple" procedure.

e) A "with" procedure is not separately reportable with a "without" procedure.

f) An "initial" procedure is not separately reportable with a "subsequent" procedure.

Example

CPT Code 77066 describes diagnostic mammography... bilateral. CPT code 77065 describes diagnostic mammography... unilateral. CPT 77065 should not be reported with two units or with RT and LT modifiers when a single comprehensive code exists when performed bilaterally.

Some surgical procedures may be performed by different surgical approaches. If an initial surgical approach to a procedure fails and a second surgical approach is utilized at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. If there are different HCPCS/CPT codes for the two different surgical approaches, the two procedures are considered "sequential," and only the HCPCS/CPT code corresponding to the second surgical approach may be reported.

Example

If a needle or punch biopsy of the prostate by any approach (CPT code 55700) is unsuccessful and is followed by the same patient encounter by an incisional biopsy of the prostate (CPT code 55705), only CPT code 55705 may be reported. Therefore, CPT code 55700 is bundled into CPT code 55705.

The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require a return to the operating room.

Example

Control of bleeding is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable unless the patient must be returned to the operating room for treatment. The control of bleeding may be separately reportable with the use of modifier 78 (Unplanned Return to the Operating/ Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period).

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit **if the clinical circumstances do not justify its use**. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicare restrictions are fulfilled. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers: 24, 25, 57, 58, 78, 79
- Other modifiers: 27, 59, 91, XE, XS, XP, XU

It is very important that NCCI-associated modifiers only be used when appropriate. In general, these circumstances relate to separate patient encounters, separate anatomic sites, or separate specimens. Modifiers 76 ("repeat procedure or service by the same physician") and 77 ("repeat procedure by another physician") are not NCCI-associated modifiers. Use of either of these modifiers does not bypass an NCCI PTP edit. However, modifiers 76 and 77 may be used on MUEs with an MAI on 1 when appropriate.

Medically Unlikely Edits (MUEs)

MUEs are adjudicated either as claim line edits or DOS edits. The MUE files on the CMS NCCI website display an "MUE Adjudication Indicator" (MAI) for each HCPCS/CPT code. Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

- Anatomic considerations may limit units of service based on anatomic structures.
- CPT code descriptors/CPT coding instructions in the CPT Manual may limit units of service.
- Edits based on established CMS policies may limit units of service.

- The nature of an analyte may limit units of service and is in general determined by one of three considerations:
    a) The nature of the specimen may limit the units of service, as for a test requiring a 24-hour urine specimen.
    b) The nature of the test may limit the units of service as for a test that requires 24 hours to perform.
    c) The physiology, pathophysiology, or clinical application of the analyte is such that a maximum unit of service for a single date of service can be determined.
- The nature of a procedure/service may limit units of service and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).
- The nature of equipment may limit units of service and is in general determined by the number of items of equipment that would be utilized (e.g., cochlear implant or wheelchair).
- 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 units of service typically billed for a given HCPCS/CPT code.

An MAI of "1" indicates that the edit is a claim line MUE. An MAI of "2" or "3" indicates that the edit is a date of service MUE. If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, appropriate use of CPT modifiers (e.g., 59, 76, 77, and 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting the use of these modifiers with some HCPCS/CPT codes.

MUEs for HCPCS codes with an MAI of "2" are absolute date of service edits. These are "per day edits based on policy. "HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service in excess of the MUE value would be considered impossible because it was contrary to the statute, regulation, or sub-regulatory guidance. This sub-regulatory guidance includes a clear correct coding policy that is binding on both providers and CMS claims to process contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the HIPAA-mandated coding descriptors and CMS-approved coding guidance as well as specific guidance in CMS and NCCI manuals. As a result, claims processing contractors are instructed that an MAI of "2" denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy.

MUEs for HCPCS codes with an MAI of "3" are "per day edits based on clinical benchmarks." MUEs assigned an MAI of "3" are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If providers have evidence (e.g., medical review) that units of service in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the providers may bypass the MUE for a HCPCS code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

Most MUE values are set so that a provider or supplier would only very occasionally have a claim line denied. 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 following:

1. Is the HCPCS/CPT code being used correctly?
2. Is the unit of service being counted correctly?
3. Are all reported services medically reasonable and necessary?
4. Why does the provider's or supplier's practice differ from national patterns?

Examples

CPT code 27440 (arthroplasty, knee, tibial plateau) may only be performed on a knee once on a single date of service. If performed on a single knee, this procedure would be reported with one unit of service. If this procedure is performed bilaterally, it should be reported with modifier 50 and one unit of service. If units of service in excess of one are reported, the MUE prevents payment.

CPT code 33470 (valvotomy, pulmonary valve, closed heart; transventricular) may be reported with a maximum of one unit of service on a single date of service since the heart has one pulmonary valve. If units of service in excess of one are reported, the MUE prevents payment.

CPT code 94002 describes all ventilation assist and management for the initial day of observation or inpatient hospital care. Therefore, CPT code 94002 may be reported with a maximum of one unit of service for a single date of service. If units of service in excess of one are reported, the MUE prevents payment.

Add-on code edits

In general, NCCI PTP edits do not include edits with most add-on codes because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure (i.e., if an edit prevents payment of the primary procedure code, the add-on code should not be paid).

Example

CPT code 49568 is an add-on code describing implantation of mesh or another prosthesis for incisional or ventral hernia repair. This code may be reported with incisional or ventral hernia repair CPT codes 49560-49566. If CPT code 49568 is billed alone, it is not eligible for payment because the primary code is not present.

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, 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. (For more information, see "The Medicare National Correct Coding Initiative" article, which starts on page 9.")

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 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 Centers for Medicare & Medicaid Services (CMS) website.

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 services such as clinical laboratory and pathology services, durable medical equipment, radiology, and behavioral health providers.

The following laboratories are not a participating provider with BCBSRI:

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

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 of these policies is available in the Provider section of bcbsri.com.

- Alemtuzumab (Lemtrada)
- Anastomosis of Extracranial-Intracranial Arteries
- Auditory Brain Stem Implant
- Automatic External Defibrillators (AED)
- Benign Skin Lesion and Viral Infectious Lesion Removal
- Beta Amyloid Imaging with Positron Emission Tomography (PET) for Alzheimer's Disease
- BCBSRI Provider Transparency
- Clinical Trial Mandate Commercial
- Cooling Devices Used in the Home and Outpatient Setting
- Digital Electroencephalography (DEEG)
- Drugs and Biologicals
- Fecal Calprotectin Testing
- Focal Treatments for Prostate Cancer
- Hospital Utilization Review
- Human Leukocyte Antigen (HLA) Testing
- Intensive Behavioral Therapy (IBT) for Obesity
- Interferential Current Stimulation
- In Vitro Chemoresistance and Chemosensitivity Assays
- Laser Removal of Port Wine Stains
- Microwave Tumor Ablation
- Neural Therapy
- Ocriplasmin for Symptomatic Vitreomacular Adhesion
- Oral Anti-emetic Drugs
- Orthotic and Prosthetic Services Mandate
- Outpatient Observation Services
- Prostate Specific Antigen (PSA) Screening Testing Mandate
- Scintimammography and Gamma Imaging of the Breast and Axilla
- Sensory Integration Therapy and Auditory Integration Therapy
- Thermal Capsulorrhaphy as a Treatment of Joint Instability
- Transitional, Chronic and Complex Chronic Care Management

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

PF Percutaneous electrical nerve stimulation and percutaneous neuromodulation therapy

Effective June 1, 2017, percutaneous electrical nerve stimulation and percutaneous neuromodulation therapy for the treatment of chronic pain conditions is considered not medically necessary for BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

P Eteplirsen for Duchenne muscular dystrophy

A new policy has been created for Eteplirsen for Duchenne muscular dystrophy. The use of eteplirsen is considered not medically necessary for all indications, including treatment of Duchenne muscular dystrophy, 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 Policy update

As of April 1, 2017, lactation consultations are covered for one of the diagnosis codes in the policy when the services are provided by a licensed lactation consultant who has been credentialed by BCBSRI. Please see the full text of this policy.

PF New policy for laboratory and genetic testing for use of 5-fluorouracil in patients with cancer

A new policy has been created to document that My5-FU™ testing or other types of assays is not medically necessary for:

- Determining 5-fluorouracil area under the curve to adjust 5-fluorouracil (5-FU) dose for colorectal cancer patients or other cancer patients
- Testing for genetic variants in dipyrimidine dehydrogenase (DPYD) or thymidylate synthase (TYMS) genes to guide 5-FU dosing and/or treatment choice in patients with cancer

The evidence is insufficient to determine the effects of the technology on health outcomes. This policy is applicable to BlueCHiP for Medicare and Commercial Products. Please see the full text of this policy.

PF Vestibular function testing

A new medical policy has been written to reflect that vestibular function testing is not medically necessary for the following indications:

- Assessment of typical benign paroxysmal positional vertigo that can be diagnosed clinically
- Repeat vestibular function testing when treatment resolves symptoms
- Vestibular evoked myogenic potential tests

Evidence shows that the technology is unlikely to improve the net health outcome. This policy is applicable to BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

PF Cerebrospinal fluid and urinary biomarkers of Alzheimer's disease

A new medical policy has been written to reflect that measurement of cerebrospinal fluid biomarkers of Alzheimer's disease is not medically necessary, including but not limited to:

- Tau protein
- Amyloid-peptides
- Neural thread proteins
- Measurement of urinary biomarkers of Alzheimer's disease

This policy is applicable to BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

Policies

PF Glucose Monitor – Continous

Effective January 1, 2017, the Dexcom G5® Mobile CGM System is the only continuous glucose monitoring (CGM) that is covered, and it replaces the finger stick blood glucose monitor (BGM) testing for diabetes. All other CGM devices are not covered.

In addition to the DME receiver included in the Dexcom G5 Mobile CGM System, members can display the received data using the Dexcom G5 app on a smartphone or tablet. Smartphones or tablets are not covered. Please see the full text of this policy.

PF Dynamic spinal visualization

A new policy has been created to document that the use of dynamic spinal visualization is 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 Ustekinumab (Stelara®) intravenous use for Crohn's disease

A new policy has been written that documents the coverage criteria for intravenous use of Ustekinumab (Stelara) for the initial loading dose for Crohn's disease. Prior authorization is required for BlueCHiP for Medicare and recommended for Commercial products. The maintenance dosage of ustekinumab (Stelara) is given as a self-administered injection and it is covered as a pharmacy benefit. Please see the full text of this policy.

PF Hospital-based clinics

Hospital-based clinics are reimbursed a global fee that includes all professional services, drugs, administration of drugs, and supplies. Claims should file using the clinic revenue code and the appropriate CPT code for services that are rendered. BCBSRI will not separately pay a physician for a hospital-based clinic visit, as the reimbursement will be paid only to the facility as part of the global rate for the clinic. Laboratory or radiology services obtained during the clinic visit are not included in the clinic global rate and are reimbursed according to the applicable benefit. Please see the full text of this policy.

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 for Medicare and Commercial products.