of Tennessee

January 2016

Bluealert℠

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Feb. 14, 2016

- Ecallantide **(New)**
- Filgrastim/Pegfilgrastim **(Revised)**
- Magnetic Resonance Imaging (MRI) of the Breast **(Revised)**

Effective Feb. 20, 2016

- Carfilzomib **(Revised)**
- Elosulfase Alfa **(Revised)**
- Golimumab for Intravenous Infusion **(Revised)**
- Ramucirumab **(Revised)**

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

Utilization Management Guideline Updates/Changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming changes to select Utilization Management Guidelines. These upcoming changes to the UM Guidelines can be viewed on the Utilization Management Web page.

Effective Feb. 20, 2016

BlueCross BlueShield of Tennessee will begin using MCG Care Guidelines® 19th edition for the following guidelines.

The following Utilization Management Guidelines related to Rehabilitative Care will be archived:

- Inpatient Rehabilitation Admissions UM Guidelines
- Skilled Nursing (SNF) Admission UM Guidelines

The following Utilization Management Guideline related to Inpatient Surgical Care will be archived:

- Sacral Colpopexy, Abdominal Approach

Note: These effective dates also apply to BlueCare/TennCare*Select* pending State approval.

New Drugs Added to Commercial Specialty Pharmacy Listing

Effective Jan. 1, 2016, the following drugs have been added to our Specialty Pharmacy drug list. Drugs requiring prior authorization are identified by (PA).

Provider-administered via pharmacy benefits:

- Empliciti (PA)
- Onivyde (PA)
- Imlygic (PA)
- Mircera (PA)
- Nucala (PA)
- Portrazza (PA)
- Yondelis (PA)

Self-administered via pharmacy benefit:

- Daklinza (PA)
- Daraprim (PA)
- Keveyis (PA)
- Lonsurf (PA)
- Mircera (PA)
- Ninlaro (PA)
- Odomzo (PA)
- Praulent (PA)
- Repatha (PA)
- Tagrisso (PA)
- Xenazine(PA)

Providers can obtain prior authorization for:

- **Provider-administered drugs** that have a valid HCPCS code by logging onto BlueAccess℠, the secure area of www.bcbst.com, selecting Service Center from the Main menu, followed by Authorization/Advance Determination Submission. If you are not registered with BlueAccess or need assistance, call eBusiness Technical Support†.
- **Provider-administered specialty drugs** that do not have a valid HCPCS code by calling 1-800-924-7141.

- **Self-administered specialty drugs** by calling Express Scripts at 1-877-916-2271.

NOTE: BlueCross updates web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

CMS Changes for Toxicology Testing

All BlueCross lines of business will follow the Centers for Medicare & Medicaid Services (CMS) 2016 coding changes for drug presumptive and definitive testing, which include appropriate coding for the four tiers of definitive testing. Code G0478 has also replaced code G0434 on the Quest BlueCare Exclusion List.

New Regulations to Improve Provider Directory Data Quality

Beginning Jan. 1, 2016, a new regulation from the Centers for Medicare & Medicaid Services (CMS) will require Medicare Advantage and Medicare-Medicaid health plans to maintain more current, accurate provider directories. Health plans are required to contact participating health care providers on a quarterly basis to review, update and confirm their information in provider directories.

The Council for Affordable Quality Healthcare (CAQH) is helping health plans and providers meet these requirements by using CAQH ProView™, which dramatically streamlines the credentialing process.

BlueCross is working with CAQH to use that same self-reported professional information to also simplify the process of updating provider directories. CAQH will email reminders, on at least a quarterly basis, to select providers to review their directory information. Providers who do not respond will be contacted by phone. We ask that all providers in our networks respond promptly to CAQH email requests to update the information required for provider directories.

With BlueCross' participation in this initiative, we hope to reduce the administrative burden on health care providers, increase the accuracy of our directories and enable patients to make more informed choices about their care.

Gender Reassignment Surgery

Effective Jan. 1, 2016, gender reassignment surgery is now a covered benefit for certain commercial, fully-insured groups and requires prior authorization.

Provider Service Hours Extended

Beginning in January, Provider Service Phone Lines for our Commercial lines of business, as well as eBusiness Technical Support and BlueCard, will be available to you until 6 p.m. (ET), Monday through Friday. This change has been made to provide better service and availability to our provider community.

Update: BlueCross Behavioral Health Network

The BlueCross BlueShield of Tennessee Behavioral Health network is effective Jan. 1, 2016.

BlueCross Medicare Advantage and Commercial members are impacted by this change with the exception of two accounts, Nissan and State of Tennessee, which will still use the Magellan behavioral health network. Providers who elected not to participate in the BlueCross network have been notified about the 120-day member transition period.

More information on the BlueCross Behavioral Health network, including a recorded webinar, is available at http://www.bcbst.com/providers/Behavioral-Health-Network.page. If you have any questions about this transition, please contact your behavioral health network manager.

Reminder: ICD-10 Compliance

The transition from ICD-9 to ICD-10 diagnostic codes is now complete. In order to help ensure prior authorization requests and claims are processed correctly, please keep these key points in mind:

- ICD-9 and ICD-10 codes **cannot** be submitted on the same claim.
- Claims for individuals who were inpatient as of the Oct. 1, 2015, effective date for ICD-10 must be processed according to CMS transmittal 950 terms.
- Providers are required to submit ICD-10 codes for dates of service Oct. 1, 2015, and beyond.

- Retrospective prior authorization requests for dates of service before Oct. 1, 2015, should be submitted with applicable ICD-9 codes.
- Prior authorization requests that have already been approved that span the Oct. 1 compliance date will not need to be resubmitted.

Additional information about ICD-10 codes can be found at http://www.bcbst.com/providers/icd-10.page.

Reminder: New Prior Authorization Needed for CPT® Codes 64581 and 64590

As of Jan. 1, 2016, prior authorization is required for codes 64581 and 64590 that are related to neurostimulator implantation for occipital nerve stimulation, as well as fecal and urinary incontinence, for Commercial lines of business. Previously, medical records were reviewed by a nurse after claims were submitted. If the claims did not meet the appropriate guidelines, they were denied and the provider was financially liable. This new prior authorization requirement will reduce claims issues related to these codes. If you have questions, please contact the Provider Service Line†.

CPT® is a registered trademark of the American Medical Association.

Reminder: Dental Coding Changes

Per the current guidelines set by the American Dental Association (ADA), the following CDT® codes will be deleted as of Jan. 1, 2016: D0260, D0421, D2970, D9220, D9221, D9241, D9242 and D9931.

The following CDT® codes will be added as of Jan. 1, 2016, and will be covered under the standard DentalBlue contract: D4283, D4285, D5221, D5222, D5223, D5224, D9223** and D9243**.

** D9223 will replace D9220 and D9221 and D9243 will replace D9241and D9242. Anesthesia for dental will now be filed in 15 minute increments so it will be important to file with the correct code and time beginning Jan. 1, 2016.

If a deleted code is filed beginning with date of services Jan. 1, 2016 or after, that line item will not be processed and you will be advised to refile with the most current ADA code. For questions contact Dental Customer Service.

CDT® is a registered trademark of the American Medical Association

Electronic Claims Submission

During the past few months, BlueCross has shared our efforts with you to achieve 100 percent electronic claims submission. Beginning April 1, 2016, network providers (including oral surgeons) will be required to submit all claims to BlueCross electronically.

We have worked to make it easier for you to achieve 100 percent electronic claims submission, which should help eliminate any disruption to your current processes as a result of this transition.

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support at (423) 535-5717† to discuss your office's transition and any barriers that may prevent you from filing electronic claims.

Reminder: Refer members to network providers

Our members get the most from their health benefits when they visit participating network providers. As one of our network providers, please remember you are contractually obligated to refer our members to other contracted network providers. This is especially important when referring members to hospitals, for lab work, DME and any other ancillary services. Our "Find a Doctor" tool on bcbst.com can be used to easily locate other participating network providers. Genetic testing not performed by a network provider requires prior authorization, and other out-of-network services may require a review.

BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

Laws Prohibit Billing BlueCare Tennessee Members for Authorized and Covered Services

Federal and Tennessee laws prohibit BlueCare Tennessee providers from billing or attempting to collect payment from BlueCare Tennessee members for authorized and/or covered services (excluding applicable copayments or patient liability amounts). This applies to all TennCare providers, including those who are considered out-of-network. You may only seek payment from a BlueCare Tennessee member in certain situations.

For complete guidelines and information, please see the BlueCare Tennessee Provider Administration Manual or TennCare Rules.

Emergency Room Services During Inpatient Psychiatric Admission

Historically, inpatient psychiatric facilities have been responsible for reimbursement of emergency room services rendered to TennCare members that occurred during the inpatient psychiatric admission.

However, starting Jan. 1, 2016, BlueCare Tennessee and other managed care organizations will process and pay for acute care emergency room services that are rendered to TennCare members during an inpatient psychiatric admission. As of Jan. 1, 2016, acute care facilities should bill emergency room services while a member is inpatient at a psychiatric facility to the respective MCO.

Treat Medical Record Requests as High Priority

BlueCare Tennessee and CoverKids sometimes needs to access the medical records of our members while conducting audits or medical necessity reviews. When your office receives a request to review the medical records of our members, please make them a high priority and submit all requested information as soon as possible.

Codes for Hospice and Home Health Nursing Care Change in January

Direct skilled nursing care provided to patients in a home or hospice setting is currently included comprehensively under one code (G0154), but that code will not be valid after 2015. Starting Jan. 1, 2016, direct skilled nursing for BlueCare Tennessee and CoverKids members will be coded based on the designation of the nurse who provides the care. Care from registered nurses (RN) will code as G0299 and care from licensed practical nurses (LPN) will code as G0300.

Please use the proper codes to help ensure timely and accurate payment for your claims.

*Select*Community Claims Should be Submitted through BlueAccess℠

Historically, in accordance with the member's individualized plan of care and to facilitate immediate action to resolve any service gaps, an Electronic Visit Verification (EVV) system was used to monitor the initiation and daily provision of home health/private duty services for *Select*Community members who need such services.

Effective Jan. 1, 2016, providers no longer need to log in and out using the EVV system for services they provide to *Select*Community members. All claims for care provided to *Select*Community members must be submitted through BlueAccess, BlueCare Tennessee's secure web portal on http://bluecare.bcbst.com/.

If you are already registered, look for the "BlueAccess" login box located in the top right-hand corner of the Web page to submit claims electronically, or view information just as it appears **right now** in our computer system. Simply enter your user ID and password. First time users can click on the "Register Now" button, and follow the easy registration instructions.

Note: This process does not apply to CHOICES members, only to *Select*Community members.

CoverKids Application for Pregnant Women *

Beginning Jan 1, 2016, a new application is available for pregnant women applying for CoverKids benefits. The revised application and required cover page are available on the CoverKids website at http://tn.gov/coverkids/topic/coverkids-application or a paper application can be requested by calling (866) 620-8864.

The application and signed cover page can be submitted via:

- Mail to CoverKids at P.O. Box 305230 Nashville, TN 37230-5230,
- Fax to (866) 913-1046; or
- Online at www.healthcare.gov or by calling 1-800-318-2596.

For more information visit http://tn.gov/coverkids/section/cover-kids#sthash.gy4wdeab.dpuf.

Note: Providers should discontinue use of the previous version of the CoverKids application.

Medicare Advantage

This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.

Submit 2015 Claims by Feb. 15

To ensure the accuracy of your final Stars score for 2015, be sure to submit all attestations to the Provider Performance Module and claims for 2015 by Feb. 15, 2016. In April, these scores will be used to set fee-schedule reimbursement levels for all BlueAdvantage and BlueChoice℠ network providers.

Reminder: Oxygen Authorizations Now Limited to a Calendar Year

Beginning Jan. 1, 2016, BlueAdvantage members no longer receive lifetime or multi-year approval for oxygen equipment rentals. Because plan benefits can change at the beginning of each calendar year, a new authorization will be required at the beginning of the new year and be valid for a maximum of 12 months. If an authorization is approved during the year, it will remain in effect through the end of the calendar year and will need to be recertified for continued approval in the new year.

The annual request will need a certification of medical necessity completed by the requesting physician and dated within two months of the request. Please remember, oxygen equipment rental is only covered for 36 months according to CMS regulations.

Reminder: Guidelines for Submitting a Provider Assessment Form

In 2016, physicians will again be eligible to receive payments for completing and submitting a Provider Assessment Form for their attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service as E/M Code 99420 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2016
- $200 for dates of service between April 1 and June 30, 2016
- $175 for dates of service between July 1 and Sept. 31, 2016
- $150 for dates of service between Oct. 1 and Dec. 31, 2016

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the writable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be included in your patients' chart as part of their permanent records.

For additional information about the Provider Assessment Form, please visit: http://www.bcbst.com/providers/quality-initiatives.page

Reminder: BlueCross Offers BlueAdvantage and BlueChoice Members In-Home Health Assessments

To comply with CMS risk adjustment and HEDIS requirements, BlueCross BlueShield of Tennessee, in partnership with CenseoHealth, arranges voluntary, in-home health assessments for a portion of our Medicare Advantage membership. The health assessment program is intended to collect data, not provide treatment, and should not interfere with care administered by the member's physician. A key aspect of the program is encouraging routine appointments with the member's primary care practitioner (PCP) for wellness and maintenance check-ups. Once the assessment is complete, a summary of findings is sent to the PCP of record.

Any questions regarding this program may be directed to your provider relations consultant or BlueCross' Provider Service Line, 1-800-841-7434.

Reminder: A Healthy New Year Starts with an Annual Wellness Exam

BlueAdvantage and BlueChoice are rolling out a new member reward campaign that encourages members to take more active roles in managing their health. In 2016, these members will need to take two steps to be eligible for rewards:

1. Opt in to the rewards program with Novu, our new rewards partner. Each member has received a welcome kit from Novu with opt-in instructions.

2. Receive an annual wellness exam. Members will receive an incentive for wellness exams as long as the claim is filed with either a G0438 or G0439 code. Members must receive a wellness exam to receive additional rewards in 2016, including any needed screenings for colorectal cancer, breast cancer, osteoporosis, HbA1c, retinal eye and urine nephropathy.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Cervical Cancer Screening

You play an essential role in developing and helping to ensure patient trust by offering high quality health care. Help your patients maintain a high level of quality care by making sure they receive recommended screenings.

Cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up says the Centers for Disease Control

and Prevention (CDC). Beginning at age 21 your female patients should begin receiving a pap smear and HPV testing at least every three years. At age 30 women can continue with these cytology screenings every three years or opt to receive the tests every five years if cytology and HPV testing are done together. However the CDC recommends cervical cancer screenings every three years for all women ages 21 to 65. You are in the best position to help your patients make the best health care decision related to the frequency of these screenings. An *annual* pap test is a covered benefit if you feel it is necessary.

Note:

- Improve your quality scores with correct coding.
- All billed procedures, screenings and exams require documentation in your patient's medical record.

Be sure your CAQH ProView™ profile is kept up to date at all times.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian)* ; کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** Any changes will be included in the appropriate 1Q 2016 provider administration manual update.

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

AccessTN/CoverKids 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus℠ 1-800-299-1407
BlueChoice℠ 1-866-781-3489
SelectCommunity 1-800-292-8196
Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 5 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

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February 2016

Bluealert SM

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Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Feb. 20, 2016

- Rituximab (Revised)
- Varicose Vein Treatments for the Lower Extremities (Revised)

Effective March 11, 2016

- Autologous Chondrocyte Implantation (Revised)
- Mechanical Embolectomy for Treatment of Acute Stroke (Revised)
- Percutaneous Tibial Nerve Stimulation (PTNS) (Revised)
- Prostatic Urethral Lift (New)

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

Reminder: Electronic Claims Submission

As previously communicated, beginning April 1, 2016, network providers (including oral surgeons) will be required to submit all claims to BlueCross electronically.

We have worked to make it easier for you to achieve 100 percent electronic claims submission, which should help eliminate any disruption to your current processes as a result of this transition.

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support at (423) 535-5717† (Option 2) to discuss your office's transition and any barriers that may prevent you from filing electronic claims.

2016 HEDIS® Medical Record Review Project to Begin

Each year BlueCross BlueShield of Tennessee and BlueCare Tennessee are required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. Data is collected for Medicaid, Medicare Advantage, Commercial and CHIP/CoverKids products.

We are seeking medical records related to prevention and screening, diabetes care, cardiovascular conditions, access and availability, medication management and utilization measures and will be contacting you soon.

Your cooperation is greatly appreciated and important to the success of the outcome. We will work with you to arrange the most appropriate method for obtaining medical record information, which may include scheduling an onsite review in your office or arranging delivery of records. Oversight audits of our medical record abstraction methodology require that we scan pertinent elements of member charts. If you use a copy service, please ask them to respond promptly to record requests.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows Covered Entities (such as practitioners and their practices) to disclose protected health information (PHI) to another Covered Entity (such as BlueCross and BlueCare Tennessee) without patient authorization as long as both parties have a relationship with the patient and the PHI pertains to that relationship for the purposes of treatment, payment, and health care operations. Additionally, all nurses reviewing charts on behalf of BlueCross and BlueCare Tennessee have signed a HIPAA-compliant confidentiality agreement.

ArroHealth Medical Records Acquisition

The Centers for Medicare & Medicaid Services (CMS) requires Affordable Care Act (ACA) individual and small group health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross BlueShield of Tennessee has partnered with ArroHealth, formerly MedSave USA, to obtain medical records on our behalf to meet this requirement.

ArroHealth will begin formal medical records requests over the next two months. We ask that you please follow the return instructions provided with the list of requested records.

Medical records can be returned to ArroHealth by either:

- Faxing to: 1-866-465-0110 or
- Mailing to:
  ArroHealth
  Attn: MRR3 Unit – BCBST
  49 Wireless Blvd, Ste. 140
  Hauppauge, NY 11788

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Effective immediately, the following prior authorization codes have been updated for Commercial plans.

New codes that require prior authorization for pain management:
Codes: 64461, 64462, 64463, C1822

Deleted codes that are no longer used for pain management:
Codes: S2360, S2361

Revised code for Generator, neurostimulator (implantable), non high-frequency w/rechargeable battery and charging system: Code: C1820

Prior to submitting prior authorization to the Musculoskeletal Program (administered by Orthonet), please verify member benefits and eligibility through BlueAccess℠ or by contacting the BlueCross Provider Service Line†.

Prior authorization requests can be submitted via fax to 1-800-747-0587 or through BlueAccess, our secure area on www.bcbst.com. When submitted via the web, musculoskeletal must be the primary code.

BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

Tennessee Health Care Innovation Initiative

New Tennessee Health Care Innovation Initiative (THCII) Provider Reports for episodes of care are available the first week of February. To review your February THCII Provider Reports, please log into BlueAccess at www.bcbst.com by clicking the Log In/Register link found at the top-right corner of the page. If you are not registered for BlueAccess, the site will guide you through registration.

For more information about the Tennessee Health Care Innovation Initiative episodes of care, visit the State of Tennessee website at https://tn.gov/hcfa/section/strategic-planning-and-innovation-group.

Make Sure Medical Records Follow TennCare Guidelines

Maintaining a carefully organized and detailed system of medical records is not only practical for patient care, it's consistent with best practices. Proper records maintenance also makes the process of external reviews and medical audits much easier and effective.

Medical record reviews of primary care physicians (PCPs) who care for BlueCare Tennessee members under age 21 include evaluation of compliance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, sharing additional educational resources, and helping ensure proper immunization schedules are followed. These reviews take place every two years, but can be requested at any time.

These reviews follow guidelines from TennCare, as well as the American Academy of Pediatrics which are available online at: http://www.tnaap.org/EPSDT/EPSDTmanual.htm.

Additional information regarding EPSDT elements and documentation requirements is available in the *BlueCare Tennessee Provider Administration Manual* at http://bluecare.bcbst.com/Providers/Provider-Administration-Manual.html.

Requirements for Ordering Providers for Certain Services

For claims received on or after March 1, 2016, an Ordering Provider's NPI will be required on all professional claims submitted for durable medical equipment and medical supplies, home infusion therapy and specialty pharmacy services for BlueCare Tennessee and CoverKids members. The Ordering Provider should be submitted as follows:

- CMS-1500 Paper Claim Form
  - Block 17 – Qualifier DQ should be entered to the left of the vertical, dotted line and the provider's name should be entered to the right of the vertical, dotted line.

- Block 17b – Enter the NPI for the Ordering Provider

- ASC X12 837P Electronic Claim
  - Loop 2420E – ORDERING PROVIDER

In addition to the above requirement, the NPI for the Ordering Provider must be registered with BlueCross BlueShield of Tennessee as well as the Bureau of TennCare for all dates of service on the claim.

Claims submitted on or after March 1, 2016, without an Ordering Provider or with an Ordering Provider who is not properly registered will be rejected and returned to the provider unprocessed.

If you are a provider who orders these services for BlueCare Tennessee or CoverKids members and have questions on how to register with BlueCross, please contact Provider Service†. More information concerning registration with the Bureau of TennCare is available at http://tn.gov/tenncare/topic/provider-registration.

TennCare Changes Preferred Drug List (PDL) Effective Feb. 1

TennCare is making changes to the Preferred Drug List (PDL) that will become effective Feb. 1, 2016. Some of the medicines your patients take may be on the non-preferred list in the future. Please inform your patients who take these medications that switching to preferred drugs will decrease delays in receiving their medicine. A copy of the new PDL is available on the TennCare website at https://tenncare.magellanhealth.com

Click here to view a summary of the PDL changes effective Feb. 1, 2016.

Use of New Sterilization Consent Form Required *

Federal law requires a valid and current consent form for sterilization procedures. Make sure your office is using the most up-to-date sterilization consent form, which was recently updated and is available on the State of Tennessee website. Claims filed with out-of-date forms will be denied.

Download the latest sterilization consent form at
http://www.hhs.gov/opa/pdfs/consent-for-sterilization-english-updated.pdf

Instructions for completing the form are available at
https://tn.gov/assets/entities/tenncare/attachments/sterilizationconsentform.pdf

Be Aware of Hospital Guidelines for Perinatal and Neonatal Services

Tennessee hospitals providing perinatal and/or neonatal care services must comply with the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. The program is designed to help diagnose and treat certain life-threatening conditions in the perinatal period and decrease the high infant mortality rate and minimize life-long disabilities in surviving newborns.

Facilities should adhere to all relevant guidelines regarding care, transfer, and discharges for perinatal and neonatal patients. Each facility has designations (Level I, Level II, Level III or Perinatal) that indicate the appropriate level of care that should be available for high-risk conditions.

The current edition, (Seventh Edition) was prepared by the Workgroup on Regionalization Guidelines Revision and the Perinatal Advisory Committee, and can be found at http://www.tnafp.org/documents/Regionalization_Guidelines_Approved_2014.pdf.

Help Your Patients Keep TennCare Coverage

One of the biggest issues the Bureau of TennCare faces is maintaining an accurate database of member addresses. When your BlueCare Tennessee patients schedule office visits, please ask them if TennCare has their current address. If not, please ask them to call 1-855-259.0701 to update their address. It's free, easy and very important if they want to keep their coverage.

New Process for Submitting CoverKids Applications *

Children who apply for child (non-pregnant) coverage must now apply online at www.healthcare.gov or by calling 1-800-318-2596 toll free.

As of Jan. 1, 2016, pregnant women now have four application options:

- Online at www.healthcare.gov or by calling 1-800-318-2596 toll free.
- In-person application assistance is available at local health departments throughout the state. To find a list of local health departments visit www.tn.gov/health/topic/localdepartments
- Fax a paper application with a signed cover page to CoverKids at 1-866-913-1046
- Mail a paper application with a signed cover page to:
  CoverKids
  P.O. Box 305230
  Nashville, TN 37230-5230

The paper application and cover page are available at http://tn.gov/coverkids/topic/coverkids-application application or by calling 1-866-620-8864.

Reporting a CoverKids Birth
Births to women enrolled in CoverKids should be reported by calling 1-855-259-0701.

Registration for Referring Providers Required Soon

Beginning March 1, 2016, all Referring Providers submitted on professional and/or institutional claims for BlueCare Tennessee and CoverKids members must be registered with BlueCross as well as the Bureau of TennCare for all dates of service on the claim. Claims received by BlueCross on or after March 1, 2016, with a referring provider who is not properly registered will be rejected and returned to the provider unprocessed.

If you refer BlueCare Tennessee or CoverKids members for any type of service and have questions on how to register with BlueCross please call our

Provider Service Line†. More information concerning registration with the Bureau of TennCare is available at http://tn.gov/tenncare/topic/provider-registration.

Reminder: Treat Medical Record Requests as High Priority

BlueCare Tennessee and CoverKids sometimes need to access the medical records of our members while conducting audits or medical necessity reviews. When your office receives a request to review the medical records of our members, please make them a high priority and submit all requested information as soon as possible.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Reminder: Inpatient DRG Day Outlier Management Program

Consistent with the criteria in MCG (formerly Milliman Care Guidelines), BlueCross BlueShield of Tennessee's Medicare Advantage plan will reimburse acute inpatient hospitalization days outside of the initial inpatient DRG as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the outlier hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review is subject to the facility providing concurrent clinical information for review as contractually required.
- If clinical information is requested three times using at least two different notification methods, the days will be denied after review by a medical director for a lack of clinical information necessary to establish ongoing medical necessity. In situations where no clinical information has been provided at all for the days in question, these denied days will not be eligible for reconsideration review or peer-to-peer discussion, and the facility can follow standard facility appeal remedies.
- This requirement is outlined by CMS as follows: Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis." (*Reference: Internet Only Manual (IOM) Medicare QIO Manual Pub 100-10, Ch. 4, Sect 4110*)

The member cannot be held liable for payment of services received when not approved.

Vanderbilt Facilities and Doctors Not In-Network for BlueAdvantage and BlueChoice starting Jan. 1, 2016

As of Jan. 1, 2016, Vanderbilt University Medical Center (VUMC) facilities and physicians under Vanderbilt Medical Group (VMG) are not in the BlueCross Medicare Advantage networks for HMO and PPO. Participating providers should not refer or transfer BlueAdvantage and BlueChoice members to any VUMC facility or VMG provider for treatment unless there is not a network provider able to address the medical concern. In middle Tennessee, both St. Thomas Health System and HCA facilities and providers are in-network for these members.

Provider Performance Module: Important Dates and Deadline for 2015 Attestations

The deadline to submit Preventive Screening Attestations for 2015 dates of service is Feb. 13, 2016. Any attestations loaded for 2015 dates of service after this date will not count toward your 2015 quality incentive fee schedule. On Feb. 22, 2016, the 2015 Provider Performance Module (PPM) will transition to read only. You will be able to view your data but no longer able to load attestations. The 2015 PPM will be removed from view on April 30, 2016.

The 2016 PPM will be available for use on Feb. 22, 2016. Attestations and other information can start to be loaded at this time.

New Chronic Kidney Disease Case Management Program Seeks to Remove Barriers to Care, Increase Member Education

BlueCross' new Case Management program, which began Jan. 1, 2016, for BlueAdvantage and BlueChoice members with Chronic Kidney Disease (CKD) or End-Stage Renal Disease (ESRD) will work to reduce barriers to care and improve member awareness of diet and medication adherence.

The program is designed to help identify when members are in stage four or five CKD. Targeted interventions for the CKD program will increase an at-risk member's overall understanding about CKD and treatment modalities that include early consultation with a nephrologist, medication adherence, nutritional counseling, dialysis education, vascular access options and transplantation options. Promoting member self-management and compliance with an established treatment plan will result in a decrease in emergency room visits, inpatient admissions and readmissions for worsening of CKD.

Our case management program will offer education and support for our members identified with CKD and ESRD, provide tools and support to promote knowledge and self-management of their CKD and other chronic conditions, and resolve barriers to care.

Updates to Home Health Billing Code

Effective Jan. 1, 2016, home health billing code G1054 has been retired. Services provided by a Registered Nurse should now be coded G0299 and by a Licensed Practical Nurse coded as G0300.

The official instruction, CR9369 issued to your Medicare Administrative Contractor (MAC) regarding this change, is available on the CMS website at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3378CP.pdf**.

If you have any questions, please contact your MAC at their toll-free number, available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - "How Does It Work".

Concurrent Review Will Ease Transition of Care

Effective March 1, 2016, facilities that have an approved inpatient DRG will be asked to provide clinical updates starting on day six of the hospitalization. Ongoing concurrent review at this point will assist the facility with transition of care and help ensure compliance with the Centers for Medicare & Medicaid Services (CMS) expectation that inpatient care meet medical reasonableness for level of care at all times during the inpatient confinement.

Advance Care Planning Now an Option During Annual Wellness Exam

As of Jan. 1, 2016, the Centers for Medicare & Medicaid Services is including voluntary Advance Care Planning (ACP) as an optional element of a patient's annual wellness visit. ACP services furnished on the same day, by the same provider and filed on the same claim form as an annual wellness visit are considered a preventative service.

According to the guidelines set by CMS, when ACP services are provided as part of an annual wellness visit, providers should file CPT® code 99497 (plus 99498 for each additional 30 minutes) in addition to either of the annual wellness visit codes. Further, the ACP codes should be filed with modifier 33 for preventive services. Since payment for annual wellness visits is limited to once per year, the deductible and coinsurance for ACP can only be waived once a year.

As this is a new code for 2016, a fee allowance will be added to our system in the next few weeks. All claims from Jan. 16, 2016, forward will then be processed to allow payment for this important service.

Cologuard™ Multi-target Stool DNA Test Not Accepted by NCQA

The multi-target stool DNA test, or Cologuard, is not accepted by NCQA

for its HEDIS® standard for colorectal cancer screenings. This is despite Medicare adding the test to its list of covered services in 2014. The test, billed as G0464 through the end of 2015 and currently billed as 81528, is not sufficient to meet NCQA quality standards and will not close the colorectal cancer screening gap in care that is part of the Centers for Medicare & Medicaid Services (CMS) annual STAR quality ratings.

This service will also not earn Medicare Advantage members their member reward through BlueCross' MyHealthPath® program, which incentivizes members to receive colorectal cancer screenings.

As a reminder, the HEDIS® colorectal measure is satisfied by a fecal occult blood test, such as a 3 card guaiac test (gFOBT) or a 1 card fecal immunochemical test (iFOBT), for one year. Rigid or flexible sigmoidoscopy satisfies the measure as met for 5 years and a colonoscopy satisfies the measure as met for 10 years. Patients who have a history of colon cancer or have had a total colectomy for any reason, are not part of this HEDIS® measure.

Reminder: Reimbursement for Oxygen Equipment Rental Follows Medicare Guidelines

Per long-standing Medicare payment guidelines, reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories, delivery, back-up equipment, maintenance and repairs is included in the rental allowance. Oxygen contents are a lifetime rental item.

The supplier who provides oxygen equipment for the first month should continue to provide any necessary oxygen equipment and all related items and services through the 36-month period. If there is a transition in provider for the same equipment, then the 36-month rental limit for that equipment will still apply and not restart with the new provider.

After 36 monthly rental payments have been made, there is no further payment for oxygen equipment during the 5-year reasonable use lifetime of the equipment.

At any time after the end of the 5-year reasonable use lifetime the beneficiary may elect to receive new equipment and begin a new 36-month rental period, assuming the equipment is not functioning in some way.

Authorization Now Required for Two Medicare Advantage Specialty Pharmacy Medications

Effective Feb. 1, 2016 prior authorization is now required for two specialty pharmacy medications for BlueAdvantage and BlueChoice members:

- Darzalex (Daraumumab), J9999
- Dysport (abobotulinumtoxinA), J0586

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Pharmacotherapy Management of COPD

Let's make a difference together. COPD mortality is rising. According to the American Lung Association, **COPD is now the third leading cause of death in the United States**. Early diagnosis and aggressive treatment of your patient's conditions can improve their quality of life and lifespan.

Adequate control of COPD relies on the proper use of both short-acting and long-acting medications. The National Committee for Quality Assurance recommends that after a COPD exacerbation a patient be **prescribed and dispensed a systemic corticosteroid within 14 days of discharge, as well as a bronchodilator within 30 days of discharge**.

Tips to help increase COPD medication adherence:

- Incorporate prescriptions and medication instructions in discharge planning.
- Offer to "call in" prescriptions to your patient's home pharmacy to make picking up their prescriptions more convenient and increase the likelihood for medication adherence.
- If your hospital has an in-house pharmacy, encourage your patients to fill prescriptions before leaving.
- Explore reasons for non-compliance and initiate Case Management if needed.

February is American Heart month.

Healthy Heart

High blood pressure is one of the leading co-morbid causes of heart disease and stroke, which are the first and fourth leading causes of death respectively in Tennessee, according to the Tennessee Department of Health.

Help your patients take control of their heart health and manage their blood pressure. Keeping a blood pressure journal and practicing at-home blood pressure monitoring can help your patients maintain their blood pressure within the following ranges:

- **Ages 18-59:** <140/90
- **Ages 60-85:** Diabetic: <140/90
- **Ages 60-85:** non-Diabetic: <150/90

Decrease the Risk of a Second Heart Attack

A previous heart attack **increases the risk** of having a second. Beta-blockers are shown to lower the risk of having a second heart attack as well as helping to prevent sudden cardiac death.

For patients who have recently experienced a heart attack, it is important to encourage them to **take the prescribed beta-blocker medication for at least six months following their heart attack.**

Encourage the following healthy lifestyle changes:

- Quit smoking.
- Follow a healthy diet.
- Be physically active.
- Lose weight.

Heart Healthy Benefits for BlueAdvantage and BlueChoice Members

February is American Heart month, and BlueCross provides benefits to your BlueAdvantage and BlueChoice patients designed to keep their heart healthy. Talk to them about the importance of physical activity, and let them know about SilverSneakers, a free gym membership included with their BlueCross Medicare Advantage Health Plan. SilverSneakers has hundreds of participating locations across Tennessee.

Reminding your patients about the importance of physical activity, along with taking steps to make sure their blood pressure is under control, and keeping them adherent with their prescriptions for conditions such as high cholesterol or hypertension can help boost your quality scores and earn fee schedule bonuses from BlueCross.

Be sure your CAQH ProView™ profile is kept up to date at all times.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

*** C**hanges will be included in the appropriate 1Q 2016 provider administration manual update.

Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

CoverKids 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus℠ 1-800-299-1407
BlueChoice℠ 1-866-781-3489
SelectCommunity 1-800-292-8196
Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 5 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

March 2016

Bluealert SM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective April 8, 2016

- Computed Tomography Perfusion Imaging of the Brain (Revision)
- Genetic Testing, Including Chromosomal Microarray Analysis and Next-Generation Sequencing Panels, for the Evaluation of Developmental Delay/Intellectual Disability, Autism Spectrum Disorder and/or Congenital Anomalies (Revision)
- Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation (Revision)

Note: These effective dates also apply to BlueCare/TennCare*Select* pending State approval.

Reminder: Electronic Claims Submission

As previously communicated, beginning April 1, 2016, network providers (including oral surgeons) will be required to submit all claims to BlueCross electronically.

We have worked to make it easier for you to achieve 100 percent electronic claims submission, which should help eliminate any disruption to your current processes as a result of this transition.

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† at (423) 535-5717 (Option 2) to discuss your office's transition and any barriers that may prevent you from filing electronic claims.

Blue Distinction Total Care Adds Maternity Designation for Commercial Business

BlueCross is proud to recognize hospitals across the country as Blue Distinction Centers+ for Maternity Care as part of the Blue Distinction Specialty Care program.

Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care, an expansion of the national Blue Distinction Specialty Care program, are hospitals recognized for delivering quality specialty care safely and effectively based on objective measures developed with input from the medical community.

To receive a Blue Distinction Centers+ for Maternity Care designation, a hospital must meet the same quality criteria as Blue Distinction Centers while also meeting requirements for cost efficiency. The program also evaluates hospitals on overall patient satisfaction, including patient willingness to recommend the hospital to others.

Hospitals that receive a Blue Distinction Center+ for Maternity Care designation have agreed to meet requirements that align with principles that support evidence-based practices of care, as well as develop programs to promote successful breastfeeding.

For more information about the program, please visit www.bcbs.com/bluedistinction.

Web Submissions for Intensive Outpatient Services (IOP)

Providers may now send requests for authorization of Psychiatric and Substance Use IOP through BlueAccess℠ for all lines of business where authorization for this level of

care is required and is a covered service. When sent through BlueAccess, initial sessions of IOP will be automatically authorized based on information submitted when criteria are met for this level of care. This eliminates the need for the request to be reviewed by a care manager and will expedite the authorization process.

For additional information about the submission process, please contact your eBusiness Marketing Consultant.

Reminder: CT and MRI Associated With Joint Arthrogram

CT and MRI testing for Commercial and BlueAdvantage members associated with joint arthrogram procedure codes 23350, 27093, 27095, 27370, G0259, and G0260 can be authorized through the Musculoskeletal Program administered by Orthonet. Prior authorization requests can be submitted via BlueAccess at www.bcbst.com/blueaccess, via phone at 1-866-747-0586 or by fax to 1-866-747-0587. (When submitted via web, the musculoskeletal code must be the primary code.)

BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

Reminder: TennCare Kids Billing and Documentation

When a patient's primary reason for a visit is a well-child TennCare Kids exam and a significant abnormality is discovered that will need additional evaluation and management, the office visit code can be billed in addition to the preventive service. Modifier 25 should be included with the evaluation and management office visit code. Example: An ear infection is discovered during a well-baby exam.

Conversely, when a patient presents with symptoms, such as an ear infection, and is also due for a well-child exam, the complete well-child exam should be performed. You may bill for both codes, adding Modifier 25 to the office visit code.

Remember: In reference to billing and coding for EPSDT visits, please use the following educational link from the TNAAP educational coding resources for providers: www.tnaap.com.

All seven components of the TennCare Kids exam must be completed and documented in the patient's medical record, including documentation of the nutritional assessment and physical activity portion of the exam.

Quest Laboratory Exclusion List Update

The Quest laboratory exclusion list has been updated to reflect the following changes effective April 1, 2016:

- **Added Code G0477** - Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, capable of being read by direct optical observation only
- **Amended Code G0478** to state – Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, read by instrument-assisted direct optical observation
- Removed the following 12 codes from the list due to extremely low utilization:

81000	85060	88332
81002	85611	82803
82270	88177	89050
85002	88329	89321

Verify PCP Assignment in BlueAccess

While a member may present a member ID card that lists a Primary Care Provider (PCP) in your practice, make sure to verify member eligibility through BlueAccess. As a BlueCare Tennessee PCP, it is your responsibility to verify that the members you see are either assigned to you or another PCP in your group. PCPs will not be reimbursed for services provided to members who are not assigned to them directly or as a covering provider.

To Help Ensure Your Covering Information is Correct:

- Call our Provider Service† line at 1-800-924-7141 and select option 1.
- Submit your covering provider listing on business letterhead via fax to (423) 535-3066 or to (423) 535-5808.
- Mail your covering provider listing on business letterhead to:
  BlueCross BlueShield of Tennessee
  Attention: Provider Network Enrollment 2.4
  1 Cameron Hill Circle
  Chattanooga, TN 37402-0001

Billing Guidelines for Observation Services *

BlueCare Tennessee and CoverKids allows up to 36 hours for observation services if medically necessary and appropriate.

Observation services should be billed on a CMS-1450 claim form using Revenue Code 0762. When submitting ANSI 837 electronic claims, the institutional format must be used. Services are reimbursed based on one-hour increments. Each unit of service (Form Locator 46) should be equal to one hour in observation. (Example: 1 hour = 1 unit; 2 hours = 2 units, etc.)

For more information about the reimbursement rules that apply, please see the *BlueCare Tennessee Provider Administration Manual*.

CMS Changes Benefit Limits for Drug Screenings *

The Centers for Medicare & Medicaid Services added and deleted several Healthcare Common Procedure Coding System (HCPCS) codes that will impact drug screenings for BlueCare Tennessee members. The change became effective Jan. 1, 2016.

See the memo from the Tennessee Division of Health care Finance & Administration that lists the impacts to benefit limits for drug screens.

New Functionality for PCP Member Roster Tool

The Primary Care Provider (PCP) Member Roster Tool on BlueAccess has new functionality. We've updated your capabilities for the Current Member report, so instead of weekly updates, the report will be up to date as of the time of the download."

Providers Can Submit Verbal Orders for Home Health Services

BlueCare Tennessee now accepts verbal orders for home health services from physicians. To be valid, the orders must include the following:

- Services being ordered
- Quantity of services
- Date(s) of service
- Orders must be signed and dated
- Orders must be signed within the last calendar year. Orders older than 12 months are not considered valid.

It is the servicing provider's responsibility to ensure they obtain the ordering physician's signature and that the signed order is on file. Please see example below of a valid verbal order.

Order: Jim Jones DOB 12/1/15 HHA 34 hours a week 1/3/16 - 4/3/16
Signature: VORB Dr Sanders/Catherine Kirkpatrick, RN 1/2/16 1426

Bill Institutional Claims With Appropriate Modifier Codes

Institutional (UB04 and 837I) claims received on or after April 1, 2016, for BlueCare Tennessee, BlueCare Plus and CoverKids members with an invalid modifier code or modifier code not in effect for the date of service will be returned unprocessed.

Follow these three steps to download the list of valid modifiers in an Excel format:

1. Click here to visit the Centers for Medicare & Medicaid Services website
2. Select 2016 Alpha-Numeric HCPCS File to download ZIP file
3. Open the HCPC2016-CONTR-ANWEB Excel file to view the valid modifiers list

Reminder: Requirements for Certain Supplies and Services Beginning March 1

Beginning March 1, 2016, claims for durable medical equipment and medical supplies, home infusion therapy and specialty pharmacy services for BlueCare Tennessee and CoverKids members require the ordering provider's National Provider Identifier (NPI). Please submit claims as follows:

ASC X12 837P Electronic Claim

- Loop 2420E – ORDERING PROVIDER

CMS-1500 Paper Claim ◊

- Block 17 – Enter the Qualifier DK to the left of the vertical, dotted line and enter the provider's name to the right of the vertical, dotted line. **Note:** *The February BlueAlert incorrectly stated the Qualifier for Block 17 as "DQ". The correct Qualifier should be "DK".*
- Block 17b – Enter the NPI for the Ordering Provider.

Also, the ordering provider must be registered with BlueCross BlueShield of Tennessee, as well as the Bureau of TennCare, for all dates of service on the claim. If you have questions about how to register, please call BlueCross Provider Service†.

For more information about registration with the Bureau of TennCare see their website at http://tn.gov/tenncare/topic/provider-registration

◊ Beginning April 1, 2016, paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† at (423) 535-5717 (Option 2) to discuss your office's transition and any barriers that may prevent you from filing electronic claims.

Reminder: Preventive Health Care Guidelines for TennCare Kids

Comprehensive TennCare Kids screenings follow the current age-specific, preventive health care schedule recommended by the American Academy of Pediatrics (AAP). See the AAP/Bright Futures Periodicity Schedule available on the AAP website. In addition to covering scheduled periodic checkups, TennCare Kids covers other visits to health care providers, referred to as "inter-periodic screens," for children until they turn 21. These screens are used to determine whether a child has a condition that needs further care. Those outside the health care system, such as teachers or parents, can determine the need for an inter-periodic screening.

Children should have **12** TennCare Kids checkups before his or her third birthday. When children reach the age of 3, they should have a TennCare Kids checkup every year until the age of 21.

Reminder: Prior Authorization for Secondary Claims

Prior-authorization requirements also apply to secondary claims you submit to BlueCare or TennCare*Select* for payment.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

New Medicare Advantage Part B Drugs

New injectable and infusible drugs are approved and added for use periodically through the year as they receive approval from the U.S. Food and Drug Administration. These drugs are researched to determine if the drug is considered by the Centers for Medicare & Medicaid Services (CMS) to be a Part B or Part D drug for benefit coverage.
The following is a new Medicare Advantage Part B drug that has available Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria and requires prior authorization:

- Darzalex (Daraumumab), J9999

Additionally BlueCross is adding these drugs to the list for consistency among the therapeutic class:

- Dysport (abobotulinumtoxinA), J0586
- Eylea (aflibercept), J0178
- Lucentis (ranibizumab), J2778

The entire list of Medicare Advantage Part B drugs that require authorization may be reviewed on our Medicare Advantage provider facing website at: http://www.bcbst.com/providers/medicare-advantage/Medicare-Advantage-Specialty-Pharmacy-List.pdf

Authorization Required for Injection Procedure for Sacroiliac Joint with Anesthetic or Steroid as of April 1, 2016

As of April 1, 2016, prior authorization will be required for CPT® code 27096, Injection Procedure for Sacroiliac Joint with Anesthetic or Steroid.

Submit authorization requests online via BlueAccess, by phone at 1-866-747-0586 or by fax at 1-866-747-0587.

Reminder: Concurrent Review Will Ease Transition of Care

Effective March 1, 2016, facilities that have an approved inpatient DRG will be asked to provide clinical updates, starting on day six of the hospitalization. This will not change approval of the base DRG from a reimbursement standpoint. Ongoing concurrent review at this point will assist the facility with transition of care and help ensure compliance with the Centers for Medicare & Medicaid Services (CMS) expectation that inpatient care meet medical reasonableness for that level of care, at all times during the inpatient stay.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Weight Management Intervention for Children and Adolescents

A body mass Index (BMI) percentile assessment is an essential part of every child and adolescent annual wellness visit and an important component of quality health care. Conduct these recommended screenings yearly for children and adolescents ages 3 to 17 to help ensure proper growth and development, and remember to document the medical record appropriately.

Annual wellness visits represent the perfect times to address weight and nutrition with these young patients. Doing so can help them build a good nutrition and physical activity foundation for a healthy future. These healthy behaviors can result in improved health, positive self-image and prevention of chronic conditions later in life.

Here are some tips to help make sure good nutrition and physical activity are part of a health and wellness plan for your patients and their parents:

- Educate parents on optimal BMI for their child.
- Discuss current nutritional status and activity behaviors.
- Provide nutritional and physical activity materials when needed.
- Provide guidance for nutritional and physical activity recommendations.
- Consider weight or obesity counseling if needed.
- Because weight and height change during growth and development, as does relation to body fat, a child's BMI should be interpreted comparatively to other children of the same sex and age.

Early weight management interventions for children and adolescents will instill positive behaviors needed for healthy outcomes as adults.

Early Intensive Treatment of Rheumatoid Arthritis Can Help Patients Maintain Quality of Life

Like you, BlueCross Medicare Advantage wants to make sure our members with a diagnosis of Rheumatoid Arthritis (RA) maintain a high quality of life. In 2012, the American College of Rheumatology updated their recommendations, outlining an aggressive approach to treatment in order to maintain a high quality of life for RA patients.

According to HEDIS® and STAR specific measures, patients with two diagnoses on different dates of service during either an outpatient visit or non-acute inpatient discharge should receive at least one disease-modifying anti-rheumatic drug (DMARD) prescription.

- DMARD monotherapy is recommended for early rheumatoid arthritis patients with low disease activity.
- DMARD combination therapy is recommended for early rheumatoid arthritis patients with moderate or high disease activity.
- A TNF-blocker with or without methotrexate is recommended for early rheumatoid arthritis patients with high disease activity - *2012*

Update of the 2008 American College of Rheumatology. www.rheumatology.org

Singh, Dr. J.A. (2013, February 11) Updated Guidelines for RA Treatment. www.physiciansweekly.com

Encourage your Patients to Start 2016 with an Annual Wellness Exam

An annual wellness exam (AWE) is an important first step to a healthy 2016. Patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. And you can help your BlueAdvantage, BlueChoice℠ and BlueCare Plus patients earn rewards for their healthy living by scheduling a check-up early.

In 2016, an annual wellness exam will be required for returning members to receive various incentives for tests like colorectal cancer screening and mammograms (age, gender and frequency criteria also apply). In order for your patients to earn those rewards, a claim for an annual wellness visit must be filed with one of the following codes: G0402, G0438, G0439, 99387, 99397.

Note: The Annual Wellness Exam is a calendar year benefit, which means each member is entitled to one AWE in 2015, one in 2016, etc., regardless of the number of days between each exam. **It is not necessary to wait 365 days between exams.**

Help Diabetics Take Control & Take Care of Their Kidneys

National Health Observances (NHOs) are special days, weeks, or months dedicated to raising awareness about important **health** topics. March is "National Kidney" and "Save Your

Vision" month. Please promote and schedule preventive screenings for your diabetic patients. According to the Center for Disease Control and Prevention (CDC), in 2013, diabetes affected more than 9.3 percent of the U.S. population. Tennessee is above the national average with more than 11 percent in many counties. Uncontrolled diabetes can cause significant damage to the kidneys and lead to kidney failure causing a need for dialysis and diabetic retinopathy, which is a serious condition leading to blindness.

We need your help to improve quality of care for our diabetic members. You can help by ensuring they complete the following screenings annually:

- Diabetic Nephropathy Screening – screening can be done via urine specimen checks for microalbumin or by documentation of treatment for nephropathy, such as a visit to a nephrologist or member being prescribed an ACE inhibitor or ARB therapy.
- Hemoglobin A1c (HbA1C) testing
- Diabetic Retinal Eye Exam
- Blood pressure control (goal is <140/80 mm HG)

Performing the quality care checks above is essential to achieving the best health outcomes and quality of life for your patients with diabetes. BlueCross may be able to assist our diabetic members in getting optimal control with one of our Case Management or Disease Management programs.

Encourage these patients to call our "Member Service" phone number on the back of their member ID cards or to visit our website at www.bcbst.com for educational information and assistance. Additional information is available in our Health Care Practice

Recommendations on the company website at http://www.bcbst.com/providers/hcpr/.

March is National Colon Cancer Awareness Month

Reminder: Colorectal Cancer Screening

The American College of Gastroenterology (ACG) classifies colorectal cancer screening into two categories, **prevention** and **detection**. According to ACG the preferred colorectal cancer **prevention** screening is via colonoscopy and should be offered as the primary test every 10 years, beginning at age 50 or at age 45 years for African Americans.

Not all patients are willing to undergo colonoscopy for screening purposes. For patients who decline colonoscopy or another cancer prevention test, ACG recommends an **annual fecal immunochemical testing** (FIT) colorectal cancer **detection** screening (Note: FIT or FOBT are acceptable).Patients can receive a flexible sigmoidoscopy every five years if colonoscopy or FIT testing is not preferred. Additionally, a digital rectal exam is NOT counted as evidence of colorectal screening.

Benefits of FIT detection screening include:

- Superior performance characteristics when compared with older guaiac-based testing
- Requires no dietary restrictions prior to testing
- Single specimen/ease of collection
- Better patient compliance rates

FIT kits are available at patient service centers across the state such as LabCorp or Quest Diagnostics, and only require the ordering provider to fax a prescription or send the prescription with the patient. The patient will obtain the kit, collect the specimen at home and mail back to the service center in the self-addressed, stamped envelope.

***Please refer our members to the appropriate in-network lab.**

IMPORTANT REMINDER

CAQH Solutions | PROVIDER™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Archived editions of BlueAlert are available online at
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*** C**hanges will be included in the appropriate 1Q 2016 provider administration manual update.

Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

CoverKids 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus℠ 1-800-299-1407
BlueChoice℠ 1-866-781-3489
SelectCommunity 1-800-292-8196
Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
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eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
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Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

April 2016

BlueAlert SM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective May 14, 2016

- Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening - **(New)**
- Chromosomal Microarray Testing for the Evaluation of Early Pregnancy Loss and Intrauterine Fetal Demise **(Revision)**

Auditory and Visual Evoked Potentials – This medical policy will be archived (i.e., no longer active) 30 days after this *BlueAlert* notification is issued. http://www.bcbst.com/mpmanual/!SSL!/WebHelp/Visual_and_Auditory_Evoked_Potentials.htm

Somatosensory Evoked Potentials - This medical policy will be archived (i.e., no longer active) 30 days after this *BlueAlert* notification is issued. http://www.bcbst.com/mpmanual/!SSL!/WebHelp/Somatosensory_Evoked_Potentials_Non-intraoperative.htm

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

Changes to Prior Authorization Requirements for High Tech Imaging

Effective immediately, the following codes require prior authorization when providing high tech imaging services for pain management:

Codes: 74712, 74713, 78264, 78265, 78266, G0297

Prior to submitting prior authorization requests for high tech imaging services, please verify member benefits and eligibility through BlueAccess[SM], the secure area of our website or by calling the BlueCross Provider Service Line†.

Prior authorization requests can be submitted via fax to 1-888-693-3210 or through BlueAccess. When submitting requests online, the high tech imaging code must be the primary code.

Reminder: Electronic Claims Submission

As of April 1, 2016, network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Be Aware of Member Rights and Responsibilities

As a BlueCross network provider, you should know what our members are told to expect from you and what you have the right to expect from our members. To comply with regulatory and accrediting requirements, we periodically remind members of their rights and responsibilities. These reminders are intended to make it easier for members to access quality medical care and to attain services.

Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and BlueCare Tennessee Provider Administration Manuals, which are available online at www.bcbst.com and http://bluecare.bcbst.com/.

BlueAccess Enhancements Ease Prior Authorization Process

You may now send photos in PDF format when submitting outpatient prior authorization requests via BlueAccess for blepharoplasty and varicose vein procedures for our commercial members. Another new capability in BlueAccess is prior authorization for commercial outpatient therapy. This means less time on the phone and elimination of fax requests.

If you would like your office staff to learn more about using our online services, our eBusiness staff† can provide on-site training. For more information, email eBusiness_service@bcbst.com.

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Effective immediately, the following prior authorization codes have been updated for Commercial plans.

New codes that require prior authorization for pain management: 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22849, C1822

Deleted codes that are no longer used for pain management: S2360, S2361

Revised code for Generator, neurostimulator (implantable), non-high-frequency w/rechargeable battery and charging system: C1820

Prior to submitting prior authorization to the Musculoskeletal Program (administered by Orthonet), please verify member benefits and eligibility through BlueAccess or by contacting the BlueCross Provider Service Line†.

Prior authorization requests can be submitted via fax to 1-800-747-0587 or through BlueAccess, our secure area on www.bcbst.com. When submitted via the web, musculoskeletal must be the primary code.

New Online Behavioral Health Toolkit

New tools and resources to help you identify, assess, treat, and refer patients with behavioral health disorders are a click away. The BlueCross Behavioral Health Toolkit gives you easy access to screening tools for a range of conditions, including ADHD, substance use disorder, anxiety and more. The website also provides links to several training resources. An updated section on delivering evidence-based health care also offers resources for providing care in accordance with HEDIS® standards, as well as information you can download for your patients. Send your suggestions for new tools and resources to GM_PCP_BH_Toolkit@bcbst.com.

Have a question about medications, want information about local resources or need a referral for behavioral health services? Speak with one of our medical directors, who are available through our Behavioral Health Consultation and Referral Line (**1-800-367-3403**) from 9 a.m. to 5 p.m. (ET), Monday through Friday. Learn more in the Behavioral Health Toolkit.

UPDATE: CPT® Code 92250 Clarification

CPT® Code 92250 for Fundus Photography is not typically covered under vision plans insured or administered by BlueCross. However, most commercial BlueCross medical plans cover CPT® code 92250 when medically necessary, subject to member cost share. When filed with various diabetic diagnosis codes, preventive benefits apply; in most plans members will not have any cost share. A list of diabetic ICD-10 diagnosis codes is available on the provider page of our website www.bcbst.com/providers.

BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

Reminder: TennCare Kids Check-Ups

When a child visits your office for an EPSDT/TennCare Kids exam, be certain the examination includes these key elements and screenings:

- Comprehensive Health (Physical and Mental) and Developmental History
  - Initial and Interval History
  - Developmental/Behavioral Assessment
- Comprehensive Unclothed Physical Exam
- Vision Screening
- Hearing Screening
- Laboratory Tests
- Immunizations
- Health Education/Anticipatory Guidance

If the child is uncooperative or the examination was refused, be sure to include this information in the medical record.

For more information, as well as required medical record documentation criteria, please see the Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual.

Tennessee Health Care Innovation Initiative (THCII) Reporting Notification

Starting Jan. 1, 2015, BlueCross added Medicaid members in the Tennessee middle region. These members have been added to episode reporting as of the February 2016 reports.

As a result, some providers may have seen BlueCare reports for the first time in February or may have noticed an increase in the number of episodes on their BlueCare reports. This potential increase would apply to all episodes with the exception of perinatal.

Due to the extended pre-trigger window for the perinatal wave, we determined not to include Tennessee middle region perinatal episodes since these episodes will be missing data for any services rendered prior to 2015.

Closer Review of Reimbursement for Neonatal Services Begins in April

The *Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities* set standards for neonatal intensive care units (NICUs) in April 2014. The guidelines state that babies born with certain life-threatening conditions at a standard birth facility should be transferred to the nearest NICU. The facility should code the claim for the care provided and note the baby was transferred to a NICU. Even though these guidelines were established two years ago, the related reimbursement levels have not been enforced. Babies born in distress are often treated at the same standard birth center where they were born and these facilities are reimbursed for NICU-level care.

If your birth facility does not meet the NICU standards in the Tennessee Perinatal Care System Guidelines, please make sure your claims do not include codes for NICU-level care. All claims are subject to a post-payment audit. Payments for claims that do not comply with Tennessee Perinatal Care Guidelines will be recovered.

Temporary CoverKids Member ID Cards

Be aware that beginning in April your patients in the CoverKids plan may present a temporary paper member ID card. The temporary card carries some benefit changes and may require different handling on your part. A permanent card will be issued to these members in July.

TennCare Changes PDL Effective April 1

The Preferred Drug List (PDL) for TennCare has changed effective Apr. 1, 2016. The new PDL is available on the Magellan Health Services Portal at https://tenncare.magellanhealth.com. If you have TennCare patients taking medications that are on the non-preferred drug list, please inform them that switching to preferred drugs will decrease delays in receiving their medicines.

Quest Laboratory Exclusion List Update

The Quest laboratory exclusion list has been updated to reflect the following changes effective **Jan. 1, 2016**:

- **Added Code G0477** - Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, capable of being read by direct optical observation only

Update: Medicaid Requirements for Home Health Services, Durable Medical Equipment *

Effective immediately, the Centers for Medicare & Medicaid Services (CMS) has issued a final ruling that requires providers to document face-to-face encounters with Medicaid beneficiaries for authorization of home health services, as well as medical supplies, equipment and appliances, within certain timeframes.

Providers are not required to submit documentation of face-to-face visits to BlueCross.

Please refer to the following information and updated requirements for these services:

Home Health Services:

- Providers must document face-to-face visits with members *for the primary reasons home health services were deemed necessary.*
- Visits must have occurred any time **from 90 days before to 30 days after** home health services were ordered.

Medical Supplies, Equipment and Appliances:

- Providers must document face-to-face visits with members *for the primary reasons supplies, equipment or appliances were deemed necessary.*
- Visits must have occurred **no more than 6 months prior to** the order of supplies, equipment or appliances.

Telehealth visits are considered as face-to-face visits.

For more information about the requirement to document face-to-face encounters see the CMS website.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Members Auto-Enrolled in SilverSneakers® Gym Membership

It's no secret that remaining physically active is an important part of longevity and quality of life for senior citizens. That's why BlueCross includes a SilverSneakers membership with every BlueAdvantage and BlueChoiceSM health plan we offer.

SilverSneakers provides access to hundreds of fitness facilities across Tennessee, including:

- Group exercise classes designed specifically for older adults
- A variety of fitness equipment, pools, saunas and more
- Guidance and assistance from a program advisor
- Access to a variety of social activities with other older adults

Members are automatically enrolled in SilverSneakers when they join BlueCross and will receive a welcome kit from SilverSneakers that outlines the benefits. Members can also check for participating facilities and class schedules online at the SilverSneakers website or by calling 1-866-584-7389.

Changes to Musculoskeletal Prior Authorization Requirements for BlueAdvantage

As of April 1, 2016, prior authorization will be required for CPT® code 27096, injection procedure for sacroiliac joint with anesthetic or steroid.

Prior authorization is also required for a CT or MRI scan associated with the following joint arthrogram procedures (23350, 27095, 27370, G0259, G0260).

Prior authorization requests can be submitted via fax to the Musculoskeletal Program (administered by Orthonet), at 1-866-747-0587 or online via BlueAccess, our secure area on www.bcbst.com. When submitted online, the musculoskeletal code must be the primary code.

Pharmacy Resources

Your BlueAdvantage and BlueChoice patients have access to a suite of tools offered by Express Scripts, Inc. (ESI), our pharmacy vendor, to help ensure they have access to the medications they need and are taking them properly.

Through ESI, BlueCross Medicare Advantage members have access to:

- A specialist pharmacist available 24/7 who can answer questions related to drug interactions and side effects, affordability, dosing and the proper use of devices like inhalers, needles and syringes.
- Mail order fulfillment that offers significant savings on prescription drugs.
- An ESI mobile app that provides instant access to personalized information related to the medications.

Guidelines for Submitting a Provider Assessment Form

In 2016, physicians are eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service as E/M Code 99420 with a maximum allowable charge of:

- $200 for dates of service between April 1 and June 30, 2016
- $175 for dates of service between July 1 and Sept. 31, 2016
- $150 for dates of service between Oct. 1 and Dec. 31, 2016

Note: The incentive will be paid for a claim billed with 99420 only one time in the calendar year for each eligible member.

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the fillable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be placed in your patient's chart as part of his or her permanent record.

Stars Ratings Now Available; Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality Incentive Program offered providers enhanced reimbursement for closing defined gaps in care through Dec. 31, 2015. Providers may now visit BlueAccess to view their current Stars rating based on the clinical data received from their practice. After logging in to BlueAccess through www.bcbst.com/providers and accessing the Quality Rewards tool, a home screen will appear with the provider's Stars rating. Providers can click on the "Financial" tab on the main menu to see their new fee schedules.

Stars ratings, as calculated by the previous year's performance, will impact each provider's current reimbursement rates, effective April 1, 2016. Providers should refer to their contract amendments for information about their base rate, the quality escalator and total earning potential.

Submit Form CMS-2728 as Mandated by CMS for ESRD Patients

For all patients entitled to Medicare benefits with end stage renal disease (ESRD), the Centers for Medicare & Medicaid Services (CMS) requires their Form 2728 to be submitted within 45 days of the start of dialysis services. Instructions are available beginning on page four of the form.

The form can be submitted electronically through CROWNWeb, a web-based data collection system mandated by CMS to enable dialysis facilities to meet the requirements for collecting administrative and clinical data by all Medicare-certified dialysis facilities.

For more information, please contact Jennifer Cross at (423) 535-5969 or email Jennifer_Cross@BCBST.com.

Reminder: Annual CAHPS Survey Includes Questions About Member Experiences with Physicians

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted by the Centers for Medicare & Medicaid Services (CMS) every year and contains several questions directly related to a member's experience with their doctors. The specific questions are:

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed it?
- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often was it easy to get appointments with specialists?

The responses CMS receives from our Medicare Advantage members become part of BlueCross' network contracted physician's annual Stars quality rating score.

For more information about the CAHPS survey, please see the Quality Care Rewards page on our website.

Reminder: Medical Record Acquisition

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims be supported in medical records. BlueCross has partnered with ArroHealth (formerly known as MedSave USA) to obtain medical records on our behalf to meet this requirement.

ArroHealth will formally request medical records beginning in April. You will soon receive a letter, along with a list of requested member records and instructions on how to send medical records. Please follow the return instructions provided with your letter.

You may send the requested medical records to ArroHealth by:

- Fax: 1-866-790-4192
- Mail: ArroHealth
  Attn: MRR3 Unit – BlueCross BlueShield of Tennessee
  49 Wireless Blvd., Ste. 140
  Hauppauge, NY 11788

Note: Please mark the envelope "Confidential".

You also may request on-site assistance by calling ArroHealth at 1-855-651-1885 or by calling your Provider Relations Consultant.

Reminder: Concurrent Review Will Ease Transition of Care

Effective March 1, 2016, facilities that have an approved inpatient DRG are asked to provide clinical updates starting on day six of the hospitalization. This does not change

approval of the base DRG from a reimbursement standpoint. Ongoing concurrent review at this point will assist the facility with transition of care and ensure compliance with the Centers for Medicare and Medicaid Services (CMS) expectation that inpatient care meet medical reasonableness for that level of care, at all times during the inpatient confinement.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Encourage Your Patients to be Proactive with Their Health

A yearly preventive exam is necessary, even for your healthiest patients. Because people often live unaware of the state of their health it is important that you **schedule all patients for an annual wellness exam**.

Patients who complete wellness exams at the beginning of the year are more likely to continue with important tests and screenings throughout the year. At their annual wellness exam, it is important to appropriately document your patient's **body mass index (BMI)** value. Offering health counseling can also help them achieve and/or maintain a healthy weight.

According to national guidelines, a healthy weight depends on:

- Body mass index (or BMI)
- Waist measurement
- Risk factors for obesity-related diseases and conditions

Annual wellness exams do not have to be scheduled 365 days apart. Thank you for partnering with us to ensure your patients receive the best quality care this year and every year!

Let's Make a Difference Together

Every day, children are exposed to many harmful diseases without even realizing it. Without recommended vaccinations, these exposures could lead to serious illnesses. The American Academy of Pediatrics (AAP) suggests children receive the initial 10 recommended vaccinations by 23 months of age. Annual wellness visits are the best opportunity to address and administer these vaccinations.

You play an essential role in advising and guiding parents on the best clinical plan for their child. You can help ensure a high level of quality care for your patients 2 years of age and younger by:

1. Scheduling regular wellness visits, and assuring all 10 recommended immunizations are administered by 23 months of age
2. Teaching and advising parents on the importance of immunizations
3. Scheduling appointments in advance and sending reminders to avoid missed appointments and dosages
4. Submitting claims and encounter data quickly and accurately

If you provide care for BlueCare Tennessee members age 18 or younger, you are eligible to participate in the Tennessee Department of Health's Vaccines for Children (VFC) Program which will benefit your patients and your practice. This program reduces your vaccine cost by providing free vaccine serum for BlueCare Tennessee patients 18 or younger.

For more information or to participate, email VFC Enrollment at VFC.Enrollment@tn.gov or call (615) 253-4072 or (615) 532-8501.

Schedule Follow-Up Visits for Patients with ADD/ADHD

The treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) often includes stimulants. Because these drugs can have serious side effects, quality measures include follow-up recommendations from the American Academy of Pediatric & Adolescent Psychiatry (AACAP).

Following these tips will help your practice meet quality standards:

- Schedule a follow-up visit for your patient **within 30 days** of the initial diagnosis. Consider scheduling the appointment while the patient is in your office.
- When writing prescriptions for new ADHD medication therapy, consider writing only a 30-day prescription. If prescription refills are written for more than 30 days remember to schedule the two additional required follow-up appointments at the time each refill is due. After the first 30-day follow-up visit, **you can conduct one of the two continuation follow-up visits via phone consultation** as long as it is coded appropriately when billed.
- Ask the parent what amount of medication they already have on hand if a 90-day prescription is written.
- If you prescribe a 90-day medicine supply after the initial prescription, schedule a follow-up visit before the 90-day prescription runs out. A gap of more than 120 days between follow-up visits will identify your

patient as being "newly diagnosed" requiring an **additional 30-day follow-up visit**. *This is more common after summer break***.**

Make sure to code the visit accurately and timely.

Polycystic Ovarian Disease No Longer Exclusion for Diabetes Quality Measures

Polycystic ovarian disease is no longer considered an exclusion for the 2016 HEDIS® diabetes quality measures. Those quality measures are the HbA1c blood test, kidney function screening and retinal eye exams.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

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***** Changes will be included in the appropriate 2Q 2016 provider administration manual update.

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BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus℠ 1-800-299-1407
BlueChoice℠ 1-866-781-3489
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of Tennessee

May 2016

BlueAlert SM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective June 11, 2016

- Complementary and Alternative Medicine (Revision)
- Cytochrome P450 Genotyping (Revision)
- MRI-guided Laser-induced Thermotherapy for Neurological Indications (New)

Effective June 18, 2016

- Bariatric Surgery (Revision)
- Pembrolizumab (Revision)
- Virtual Colonoscopy (Computed Tomography Colonography (Revision)

Intradialytic Parenteral Nutrition – This medical policy will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued. This document is no longer utilized by BlueCross' Commercial and BlueCare Utilization Management departments. http://www.bcbst.com/mpmanual/!SSL!/WebHelp/Intradialytic_Parenteral_Nutrition.htm

Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening – BlueCross has decided that it will not implement an investigational medical policy position as initially indicated in the April 2016 BlueAlert article.

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

NOTICE: National Consumer Cost Transparency Data Available

National Consumer Cost Transparency (NCCT) data is currently available for review on the BlueAccess℠ portal for providers in our commercial networks. The Spring 2016 cost data review period will extend through June 1, 2016.

BlueCross Changing Opioid Prescription Policy July 1

BlueCross is supporting the growing national effort toward more appropriate use of opioids by issuing a new administrative policy. Effective July 1, 2016, patients covered by BlueCross Commercial plans must have prior authorization (PA) before filling a prescription for long-acting opiate pain medications. This PA applies only to your patients who are new to long-acting opioid drug therapy. The new administrative policy will assist in the therapeutic treatment of chronic pain and prevent misuse of opioid analgesics.

This change will not apply to patients with BlueAdvantage and BlueCare Tennessee plans or patients who are already on prescriptions for long-acting opioids. However, further changes regarding opioid prescriptions are likely later this year and in early 2017.

To view the new policy on the Use of Opioids in Control of Chronic Pain, please see http://www.bcbst.com/UpcomingMPs/upcoming_mps.htm

New Regulations for Improved Provider Directory Data Quality

The federal government, states and other regulatory bodies require health plans to contact participating health care providers on a quarterly basis to review, update and confirm their information in provider directories.

If you receive a Data Verification Form, please verify your demographic information, sign and return the form

promptly even if all information on the form is accurate. If the Data Verification Form requires changes, please mark through the incorrect information, print the correct details in the space beside that field and fax to (**423) 535-3066**. We ask that all providers respond promptly to update the information required for provider directories.

If you have any questions, or need assistance with the Data Verification Form, please call the Provider Service Line† at **1-800-924-7141**. To help ensure your call is routed to the appropriate department, select the option "Provider Network Services" when prompted.

We are assessing more efficient means of electronic verification, including working with the Council for Affordable Quality Healthcare (CAQH) to help meet these requirements by using **CAQH ProView™**. We plan to implement more improvements to help simplify the process of updating provider directories throughout 2016.

Update: BlueCross Telehealth Billing Guidelines

BlueCross allows telehealth services statewide for all appropriate providers in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines and defers to CMS for establishing the following telehealth definitions:

- **Originating Site Provider**— providers who manage member care at the time/location the service furnished via a telecommunications system occurs.
- **Distant Site Provider**— providers at the distant site who may furnish and receive payment for covered telehealth services.

Please note, however, that BlueCross **does not** apply the CMS guideline that limits originating site reimbursement to rural settings.

Ancillary Reminder: Disposable Elastomeric Pain Pumps

Post-operative disposable elastomeric pain pumps are considered a bundled service when inserted at the time of surgery. These items are not separately reimbursable and are considered paid for as part of the appropriate facility grouper payment.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Clinical Information Required for Prior Authorization Requests

When submitting Commercial prior authorization requests, please provide clinical information at the time of the request. This information is used to help determine the appropriate response to the request for prior authorization. If complete clinical information is available on the initial call, fax or web submission, the authorization can be completed without delay.

BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding CoverKids and dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

See BlueCare Tennessee Member PCP Assignments in Real Time with BlueAccess

Using BlueAccess, you can now verify, in real time, if a BlueCare Tennessee member is assigned to your practice. The following reports are also available online anytime and updated Tuesday of each week:

- **Previously Assigned Members**
  Lists members assigned to the provider on the previous membership listing
- **Members Transferred from Provider**
  Lists members transferred to another PCP or MCO
- **Disenrolled Members**
  Lists members who have either changed MCOs or are no longer eligible for TennCare

If you have questions about BlueAccess or if you would like to use the secure provider section of our website, we can help. Please contact the eBusiness Solutions staff† member in your region.

West Tennessee – Debbie Angner
Phone: (901) 544-2285
Email: Debbie_Angner@bcbst.com

Middle Tennessee – Faye Mangold
Phone: (423) 535-2750
Email: Faye_Mangold@bcbst.com

East Tennessee – Faith Daniel
Phone: (423) 535-6796
Email: Faith_Daniel@bcbst.com

Quest Diagnostics: Exclusive Lab for BlueCare Tennessee

Quest Diagnostics is the exclusive in-network lab provider for BlueCare Tennessee. To help ensure your BlueCare Tennessee patients receive all the benefits of using an in-network lab provider, tests must be ordered directly through Quest Diagnostics and not through any other laboratories.

It is easy to place lab orders for Quest through Care360® Lab & Meds, a free online tool that allows you to order labs electronically and access results on a PC, tablet or smartphone. Quest interfaces with most electronic health record systems. Ordering lab services directly through Quest ensures timely access to results, which will be sent directly from Quest to the ordering provider.

With Quest Diagnostics, you have more resources to meet your goal of improving patient health outcomes. A broad array of more than 3,500 tests—from routine to advanced genetic, molecular and specialty tests—are at your fingertips. Online appointment scheduling and a network of more than 2,200 patient service centers make it easy for your patients to complete testing. You can also receive professional support from more than 700 MDs, PhDs and genetic counselors to help select and interpret appropriate tests.

To learn more, please visit Quest Diagnostics website.

Report Unexpected Deaths of Members Under Age 21*

If a BlueCare Tennessee/CoverKids member under age 21 dies unexpectedly, please report this to us as soon as possible after the death. Providers should use the following criteria to determine if the death of the member is unexpected:

- **Accidental**
- **Medical**
- **Suicide**
- **Mistreatment/Abuse/Neglect**
- **Homicide**
- **Suspicious**

Report unexpected member deaths by phone or by email.

Email:
BCQultyCaseOversight@bcbst.com

Phone:

BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141

If reporting by email, include the Unexpected Member Death Form available on our website. As part of the Quality Review Process, medical records related to the death may be requested.

TennCare MCOs Adopt Universal PCP Change Form*

BlueCare Tennessee, Amerigroup and United Healthcare are now using a universal primary care provider (PCP) change form. While each MCO has adopted the universal form, each MCO has a specific version of the form. For example, BlueCare Tennessee versions of the form should only be used for BlueCare Tennessee members.

The form is ready for use and available at bluecare.bcbst.com.

Reminder: It is not necessary to submit a PCP change form if a member changes providers within your practice. Our covering provider logic will apply.

Three Options to Ensure Your Covering Information is Correct

1. Call the Provider Service† line at 1-800-468-9736 for BlueCare or 1-800-276-1978 for TennCare*Select*.

2. Submit your covering provider listing on business letterhead by faxing to (423) 535-3066 or (423) 535-5808.

3. Mail your covering provider listing on your business letterhead to:
   BlueCare Tennessee
   Attention: Provider Network Enrollment 2.4
   1 Cameron Hill Circle
   Chattanooga, TN 37402

Denials for NICU Claims from Non-NICU Facilities Begins in June*

Babies born with certain life-threatening conditions at a standard birth facility should be transferred to the nearest neonatal intensive care units (NICU) facility. The facility should code the claim for the care provided as: stabilization of the baby for the purpose of transferring the child to a NICU facility (DRG 385/789; Discharge Status 02 or 05). Beginning June 1, 2016, BlueCare Tennessee will deny claims for NICU services (DRG 386/790) billed by a non-NICU facility.

The Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities set new standards for neonatal intensive care units in April 2014. If your birth facility does not meet the NICU standards, please make sure your claims do not include codes for NICU-level care. BlueCare will monitor

adherence to this requirement through medical record review and billed claims.

CoverKids ASH Benefits and Requirements to Change June 1*

CoverKids benefits will include coverage for abortions, sterilizations and hysterectomies (ASH) beginning June 1, 2016. The benefits, rules and required forms will match those in place for BlueCare Tennessee members. While members will have new benefits at the start of June, the federal and state guidelines for waiting periods and forms submissions that apply for the procedures must still be followed. (Example: there must be 30 days between a member signing the sterilization consent form and the procedure.)

To review the ASH guidelines that apply to BlueCare Tennessee members, please see the current Provider Administration Manual. The 2016 second quarter Provider Administration Manual update will indicate the same ASH guidelines to apply to CoverKids members.

CoverKids Reminder: File Routine Nursery Care for Newborns to Mother's ID

CoverKids member benefits include routine nursery care and physician charges for newborns while the mother is confined to the hospital. This care should be filed under the mother's CoverKids membership ID.

Reminder: Register and Revalidate Medicaid ID with TennCare

The Bureau of TennCare℠ requires providers to register for a Medicaid ID and revalidate the ID number every three years. If you have not registered for a Medicaid ID or revalidated within the past three years, please do so soon. If you do not have a valid Medicaid ID on file, the Bureau of TennCare intends to remove you from all TennCare Managed Care Organization networks.

To be reimbursed for the care you provide to BlueCare, TennCare*Select* and CoverKids members, your Medicaid ID must be active for all dates of service.

Providers can easily register or revalidate online at the TennCare Provider Registration website.

Reminder: Timely Filing for Corrected Bills

Corrected bills must be submitted within 120 days of the BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. For more information about corrected bills see the Billing and Reimbursement section of the BlueCare Tennessee Provider Administration Manual.

Medicare Advantage

This information applies to BlueAdvantage (PPO)℠ and BlueChoice (HMO)℠ plans. BlueCare Plus (HMO SNP)℠ is excluded unless stated otherwise.

Vanderbilt Facilities Out of Network for BlueAdvantage and BlueChoice Members

Effective Jan. 1, 2016, Vanderbilt Medical Center facilities were no longer included in the BlueCross Medicare Advantage network. However, some BlueCross members are still being referred to Vanderbilt facilities for care. Please remember that your patients will receive the highest level of benefits by accessing care at an in-network facility.

BlueCross appreciates your willingness to encourage your patients to seek care from a participating network provider. If you have questions, please call Medicare Advantage Provider Service†, or contact your local provider relations consultant. Additionally, our "Find A Doctor" tool on bcbst.com is another good resource to help you locate network providers.

Steps to Scheduling a Peer-to-Peer Review

Follow the steps below to request a physician peer-to-peer review by phone. The review must be requested within two days of receiving fax notification of an adverse determination. You must provide two dates and times during which the requesting physician has availability.

To schedule:
1. Call 1-800-924-7141.
2. Choose voice by saying "voice" or touch tone by pressing 1.

3. Choose option 1 for providers or say "provider."
4. Enter provider ID/NPI/tax number.
5. Enter the contact phone number.
6. Press 1 for information on a specific member, or say "member."
7. Disclaimer information will be given.
8. Say the member ID number including the alpha prefix. Verify the member ID by pressing 1.
9. Enter the member's date of birth.
10. Press 9 to schedule a peer-to-peer review.

Host the BlueCross Mobile Unit On Site

The BlueCross Mobile Unit is available to support your efforts to provide quality care. For BlueCross Medicare Advantage members, the mobile unit staff can provide information about their plan benefits, including our partnership with SilverSneakers® to help seniors remain active. Members also have the opportunity to receive some of their needed screenings like bone density and retinal eye exams, kidney function tests and HbA1c blood sugar screenings for diabetic patients.

The member's attributed provider/practice receives quality score credit for these screenings. To find out more about how hosting the Mobile Unit can help your BlueCross Medicare Advantage patients, please contact Carmen LeVally at (423) 535-8325. Scheduling is subject to availability.

Clarification of Claim Filing Guidelines for Inpatient Readmissions Reduction Program

As you know, BlueCross BlueShield of Tennessee began a Medicare Advantage specific Readmissions Reduction program in September 2014. As a reminder, if a member is readmitted to the same contracted entity (facility or health system) within 3 to 31 days of discharge with a same or similar diagnosis and evaluation of a modifiable or preventable cause, facilities are only reimbursed for a single inpatient DRG (the higher weighted of the two admissions) with approved days from the opposite stay being treated as additional days of the approved DRG claim.

Submitting a corrected bill or combining the services from the readmission with those of the initial admission will result in all services on the claim being disallowed. Also, billing with a "leave of absence" revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim.

A same or similar diagnosis readmission to the same contracted entity that occurs within 48 hours of an acute care hospital discharge will not be reimbursed regardless of the length of stay or the intensity of services.

Submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate, and services will be disallowed.

Reminder: Members Auto-Enrolled in SilverSneakers Gym Membership

It's no secret that remaining physically active is an important part of longevity and quality of life for senior citizens. That's why BlueCross includes a SilverSneakers membership with every BlueAdvantage, BlueChoice℠ and BlueCare Plus health plan we offer.

SilverSneakers provides access to hundreds of fitness facilities across Tennessee, including:

- Group exercise classes designed specifically for older adults
- A variety of fitness equipment, pools, saunas and more
- Guidance and assistance from a program advisor
- Access to a variety of social activities with other older adults

Members are automatically enrolled in SilverSneakers when they join BlueCross and will receive a welcome kit from SilverSneakers that outlines the benefits. Members can also check for participating facilities and class schedules online at the SilverSneakers website or by calling 1-866-584-7389.

Reminder: Female Patient with a Fracture? Schedule a Bone Density Test within Six Months

As you know, often the first symptom of osteoporosis in an older patient is a broken bone. Because seniors, especially senior women, are susceptible to osteoporosis, it is important to schedule a bone density test for any patients who have suffered a fracture.

According to the Centers for Medicare & Medicaid Services (CMS), women between the ages of 67 and 85 who have had a fracture should receive either a bone density test or prescription to treat osteoporosis (if documented) within six months post fracture.

Best Practices:

- Advise your patients to include adequate amounts of calcium in their diet.
- Recommend regular weight-bearing exercises like walking or dancing.

- Talk to your patients about risk factors for falls.
- Measure height annually.
- Perform a bone mineral density test on women 65 and older and men 70 and older.
- Prescribe appropriate medication for patients with a documented hip or vertebral fracture.

Reminder: Guidelines for Submitting a Provider Assessment Form

In 2016, physicians are eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage and BlueChoice patients.

BlueAdvantage will reimburse the service as E/M Code 99420 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2016
- $200 for dates of service between April 1 and June 30, 2016
- $175 for dates of service between July 1 and Sept. 31, 2016
- $150 for dates of service between Oct. 1 and Dec. 31, 2016

Note: The incentive will be paid for a claim billed with 99420 only one time in the calendar year for each eligible member.

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the fillable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be placed in your patient's chart as part of his or her permanent record.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

COMING SOON: Member Scorecards Highlight Needed Care

BlueCross and BlueCare Tennessee members will soon receive a scorecard outlining specific preventive screenings that are appropriate for their age and gender and needed in 2016. These scorecards are intended to encourage your patients to contact you to get the care they need to stay healthy this year – and in the future.

The scorecard is customized for each member by highlighting screenings they've already received in 2016 and screenings that are still needed in 2016. The goal is to empower members to play an active role in their health.

Note: Medicare Advantage and BlueCare Plus members may also earn rewards from BlueCross by completing the recommended tests. To be eligible for any incentives in 2016, these members must complete an annual wellness visit and have a claim filed with one of the following codes: G0402, G0438, G0439, 99387, 99397.

Medication Management for Asthma

The Medication Management for Asthma quality measure focuses on making sure people ages 5 through 85 with persistent asthma remain compliant with their asthma medication and ensuring these patients are taking the right medicine to manage their conditions. Please review medications, techniques and adherence at each follow-up visit, and confirm your patients with persistent asthma understand:

- The importance of asthma self-management, identifying triggers and the importance of adhering to the medicine to prevent asthma flare ups.
- Some medicines help prevent asthma symptoms, however that patient needs to follow their treatment plans and asthma action plans all the time, even when they feel well.

Quality asthma care involves not only initial diagnosis and treatment to achieve asthma control, but also long-term regular follow-up care to maintain control. That means taking the right medicine at the right time using the proper technique.

As the incidence and prevalence of asthma continues to increase across the country, the importance of appropriate disease monitoring and medication therapy is essential to help combat the major causes of morbidity and mortality for this population.

Help Your Patients Manage their Depression

It is important to encourage your patients age 18 or older who have recently been diagnosed with major depression and are undergoing treatment with antidepressant medications to remain on their prescribed medications for at least 180 days during treatment.

The American Psychiatric Association advises that physicians only use a diagnosis of major depression if a patient has experienced at least five of the following nine symptoms for two weeks or more, almost every day:

- Depressed or irritable mood for children and adolescents
- A significantly reduced level of interest or pleasure in most or all activities
- A considerable loss or gain of weight when not dieting, and/or an increase or decrease in appetite
- Difficulty falling or staying asleep or sleeping more than usual
- Agitated or slowed down behavior that others can observe
- Feelings of fatigue or diminished energy
- Thoughts of worthlessness or extreme guilt
- Reduced ability to think, concentrate, or make decisions
- Frequent thoughts of death or suicide, or attempt of suicide

The biggest barrier to successful treatment of depression is medication non-adherence. Patients who receive extra support from their provider, such as counseling or written materials, are typically more compliant and have better outcomes.

TNAAP EPSDT and Coding Training Resources

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) offers resources and reference materials that can help you improve the quality of the preventive health screenings you perform, maximize reimbursement, reduce administrative costs and improve audit outcomes.

TNAAP's resource and reference materials include:

- Free Early and Periodic Screening, Diagnosis and Treatment (EPSDT) training programs at your office
- Downloadable age-specific chart documentation forms
- Sample forms and
- A comprehensive EPSDT manual.

Post-Hospitalization Mental Illness Follow up

Completing a **follow up appointment within 7 days of discharge** from an acute inpatient stay **due to a mental health disorder** is an essential component in helping ensure high quality health care for your patients. A few **sample diagnoses** that would warrant this follow up include:

- Dementia
- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- PTSD
- ADHD
- Other mental illnesses.

Here are a few quick tips to **help increase patient follow-up visits after discharge:**

- Schedule follow up appointments with patients right after discharge and within 7 days.
- Ensure hospital staff is aware of a member's discharge needs/identify any barriers so they can assist at discharge if needed.
- Ensure the member understands the discharge plan and the importance to keeping aftercare appointments.
- Advise office staff/schedulers about the importance of making sure members have an appointment that falls within the 7-day window.
- Follow up with "no-shows" and attempt to reschedule.

Thank you for partnering with us to help ensure your patients receive the best quality care.

Reminder: Diabetes Screenings that Can Affect Your Quality Score

The Centers for Medicaid & Medicare Services (CMS) has several measures in place related to diabetes that can affect your quality score. According to CMS, everyone between the ages of 18 and 75 with a diabetes diagnosis should receive the following each year:

- HbA1c blood test
- Diabetic retinal eye exam
- Kidney function screening

We understand it sometimes can be hard to get elderly and disabled BlueAdvantage and BlueChoice patients into your office. That's why we offer in-home services for each of these diabetic screenings. Our health partners can mail in-home kits to your diabetic patients for HbA1c and kidney function screenings, and schedule in-home eye exams as well. And if you are the patient's attributed provider, you get the quality credit for the service.

Be sure your CAQH ProView™ profile is kept up to date at all times.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386 العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

*** C**hanges will be included in the appropriate 2Q 2016 provider administration manual update.

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueCross BlueShield of Tennessee

PROVIDER NEWS FLASH

of Tennessee

June 2016

BlueAlert SM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective July 9, 2016

- **Azacitidine (Revision)**
- **Orthopedic Applications of Stem Cell Therapy (Revision)**

The following medical policies will be archived (i.e., no longer active) 30 days after this *BlueAlert* notification is issued.

- **Extracorporeal Shock Wave Therapy for the Treatment of Peyronie's Disease –**This document is no longer utilized by BlueCross Commercial and BlueCare Utilization Management departments.
- **Thermal Shrinkage as a Treatment of Joint Instability –** BlueCross Commercial and BlueCare Utilization Management departments are no longer seeing claims for this procedure.
- **Poly-L-Lactic Acid Injectable Implant Device –** This procedure is rarely performed.

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee Health Care Practice Recommendations have been updated; the *Global Initiative for Chronic Obstructive Lung Disease - COPD* has a 2016 revision. This and other updates can be viewed in their entirety on the company website at http://www.bcbst.com/providers/hcpr/.

Paper copies of any clinical practice guideline can be obtained by calling 1-800-924-7141, ext. 6705.

Addressing Opioid Addiction Prevention and Treatment

Federal Perspective
Opioid abuse is a serious public health issue, but preventive actions, treatment for addiction, and proper response to overdoses can help. For more information about this issue, click on the links below from the U.S. Department of Health and Human Services and the White House to read more about this issue.

The U.S. Department of Health & Human Services recently published an overview of the opiod abuse epidemic, including information on abuse prevention, treatment for addiction, and responding to an overdose.

Further information on the epidemic can be found in this recent White House memorandum.

Local Perspective
The Substance Abuse and Mental Health Services Administration released its revised toolkit to help providers, communities and local governments respond to the nation's opioid epidemic. Updates include new information on the first FDA-approved nasal spray version of naloxone hydrochloride, a life-saving medication that can reverse the effects of an opioid overdose.

Content specifically for prescribers includes information on minimizing risk, treating opioid overdose, legal and liability considerations, claims coding and billing, and other resources. The toolkit also has components for patients and family members, overdose survivors, community members, and first responders.
Click here to download the free toolkit.

All Blue 2016 Provider Workshops

Coming to a City Near You!

Join us for our annual state-wide All Blue workshops in September! Talk with BlueCross professionals who will share information about issues important to you and your practice. You can also visit our Resource Centers and take advantage of one-on-one discussions. Look for more details and registration information online soon. Watch your mail for invitations!

Johnson City	Sept. 14
Knoxville	Sept. 15
Memphis	Sept. 21
Jackson	Sept. 22
Chattanooga	To be determined
Nashville	To be determined

Reminder: New Regulations to Improve Provider Directory Data Quality

The federal government, states and other regulatory bodies require health plans to contact participating health care providers on a quarterly basis to review, update and confirm their information in provider directories.

If you receive a Data Verification Form, please verify your demographic information, sign and return the form promptly even if all information on the form is accurate. If the Data Verification Form requires changes, please mark through the incorrect information and print the correct details in the space beside that field and fax to (**423) 535-3066**. We ask that all providers respond promptly to update the information required for provider directories.

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We are assessing more efficient means of electronic verification, including working with the Council for Affordable Quality Healthcare (CAQH) to help meet these requirements by using CAQH ProView™. We will implement improvements to simplify the process of updating provider directories throughout 2016.

FREE Quality Training for Network Providers

BlueCross is offering a two-day class to promote health care quality. The training class is scheduled Aug. 4 and 5, 2016, and will be held in the BlueCross BlueShield of Tennessee Community Room in Chattanooga, TN. The class is designed to help those planning to take the Certified Professional in Healthcare Quality (CPHQ) examination, and also delivers intermediate quality improvement content that can benefit anyone working in the field of health care quality. Get more information at: http://www.bcbst.com/providers/Free-cphq-training-class.pdf

The usual cost for this training is $399; however BlueCross is offering the class to its network providers at no cost. Space is limited, so please contact us soon to register. To qualify for the training you must meet the following criteria:

- Currently employed in a role related to quality improvement or management
- Currently employed by a BlueCross BlueShield of Tennessee network provider

Network providers will be limited to two participants per group/facility for the 2016 class. To register e-mail tawanda_malone@bcbst.com.

Reminder: Physician Quality Information Application Available Until July 12, 2016

The Physician Quality Information Application on BlueAccess℠ will be available for physician review and self-reporting until July 12, 2016. After July 12, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available on the company website for our members.

Home Health Services Request for Proposals Coming Soon

BlueCross will soon release a Request for Proposals for Home Health Services for all lines of business. Home Health agencies are encouraged to respond. More information will soon be available on www.bcbst.com/providers.

Nurses Bring Better Health Every Day

At BlueCross, we have nearly 850 nurses on staff, the majority of whom work directly with our 3.3 million members to help ensure they get the right care at the right time – focusing on prevention and disease management to improve quality of life.

BlueCross experts are tackling issues in a series of guest editorials in *The Tennessean* that affect our communities and our members' peace of mind. Dr. Andrea Willis, senior vice president and chief medical officer, had a guest op-ed article in the May 8 edition highlighting the value BlueCross nurses bring to our members. She mentions three unusual cases where care managers went above and beyond expectations, while explaining the many ways our nurses help ensure members get the right care at the right time. Read the full article here.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Changes to Provider Service Phone Lines

As of Jan. 1, 2016, BlueCross updated the menu prompts you hear when you call us on the Provider Service Line. Please listen carefully to all the prompts so your call will be routed to the appropriate area and help ensure that you receive the needed information in a more efficient manner.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

New CoverKids Provider Network Begins July 1

Since the beginning of 2016 you've seen the preparation for our new CoverKids provider network. New ASH requirements, a 3.2 percent rate increase and temporary member ID cards have all come in advance of the new network's July 1, 2016 launch.

CoverKids members already visit providers in the TennCare*Select* network. We will offer these same providers contracts to participate in the CoverKids network. While a new network is big news, the difference is very small for providers.

What Stays the Same

- Reimbursement fees
- CoverKids members visit the same providers
- Members do not lose any benefits

What Changes

- Member ID Cards – new cards will show CoverKids network, and no longer show TennCare*Select*

Employment and Community First CHOICES Program to Launch in July

The State of Tennessee will launch a new program on July 1, 2016, to help provide long-term services and support to people with intellectual and developmental disabilities (I/DD). The program, called Employment and Community First (ECF) CHOICES, is different than any existing program in Tennessee. It will be a different way to think, plan and support people with I/DD. With ECF CHOICES, Tennessee will be the first state to develop a program specifically geared to promote and support integrated, competitive employment and independent living as the first and preferred option for people with I/DD.

Last Chance to Enroll in TennCare EHR Provider Incentive Program

Program Year 2016 is the final year in which providers and facilities can begin participation in the Medicaid Electronic Health Record (EHR) Incentive Program. Benefits of program participation include:

- Eligible providers can receive up to $63,750 for full participation in the program.
- Achieve measurable improvements in patient health care delivery and performance to promote better patient outcomes through the use of Certified Electronic Health Record Technology.

Check Your Eligibility
To verify your eligibility for the program see the CMS Eligibility Widget. Email any questions to TennCare.EHRIncentive@tn.gov.

How Do I Get Started?
Click here to register and get started with your 2016 Program Year attestation.

For more information about the incentive program, please visit the CMS or Bureau of TennCare websites.

Note: This program is not applicable to CoverKids plans.

Prior Authorization Required for Secondary Claims

Please remember that prior-authorization requirements apply when submitting claims for secondary payment from BlueCare or TennCare*Select*. Prior authorization is not necessary if the primary carrier has provided benefits and there are no plans to file a secondary claim.

Retraction of Medicaid Requirement Article in April BlueAlert

BlueCare Tennessee providers should disregard the article that appeared on page three of the April edition of BlueAlert under the headline: Update: Medicaid Requirements for Home Health Services, Durable Medical Equipment.

The ruling issued by the Centers for Medicare & Medicaid Services (CMS) that requires providers to document face-to-face encounters with Medicaid beneficiaries for authorization of home health services **applies to fee-for-service providers, not managed care providers.** We apologize for any confusion.

Incorporate Well Child Visit When Performing Sports Physicals

When patients under age 21 with TennCare Kids coverage are in your office for a sports or camp physical, we encourage you to complete a comprehensive TennCare Kids screening if their medical history determines this exam is due. Children ages 6 to 9 years are the most common age group to miss annual screenings.

Details for billing with modifier 25 are found in the TennCare Kids Billing Guidelines section of the *BlueCare Tennessee Provider Administration Manual*. TennCare Kids services provided should be documented during the office visit as appropriate for age and condition. The American Academy of Pediatrics (AAP) periodicity schedule of Recommendations for Preventive Pediatric Health Care is available on the AAP website.

Tennessee Lifts Buprenophrine Limit for BlueCare Tennessee Members

Last year, Tennessee passed a law that would put a two-year limit on benefits for the drug buprenorphine. During this year's legislative session that limit was lifted and funding beyond the two-year lifetime limit was restored.

Reminder: Quest Diagnostics Laboratory Billing Guidelines*

All outpatient laboratory testing for BlueCare Tennessee or CoverKids members must be referred to Quest Diagnostics with the following limited exceptions:

- Lab testing included on the approved Exclusion List
- Proprietary lab tests without a comparable alternative through Quest Diagnostics (Requires prior authorization)
- Outpatient dialysis clinics
- Third party liability claims
- Emergency room
- Outpatient observation
- Inpatient claims
- Complications of pregnancy claims

BlueCare Tennessee's arrangement with Quest is not all-inclusive. A detailed list of tests and corresponding CPT® codes excluded from the arrangement are found in BlueCare Tennessee Lab Exclusion List.

Claims for covered services submitted by other suppliers or providers except for those services described in Exclusion List will be denied. Providers not currently using Quest Diagnostics for lab services will need to establish a lab ordering and reporting account. To request an account contact a Quest Diagnostics physician representative at 1-866-MY-QUEST (1-866-697-8378) option 1, then option 8 to set up Quest's lab ordering and reporting system.

Update: Tennessee Health Care Innovation Initiative

Tennessee Health Care Innovation Initiative (THCII) May Episode of Care reports are now available in the BlueAccess℠ portal on the BlueCare Tennessee website at http://bluecare.bcbst.com/providers/. If you have problems accessing your THCII Episode of Care reports, please contact eBusiness Technical Support† by calling (423) 535-5717, Option 2.

Wave 1 episodes of care, which include Perinatal, Asthma Exacerbation and Total Joint Replacement (hip and knee), were in the Performance period calculating an aggregate of claims data from Jan. 1, 2015, to Dec. 31, 2015. Risk and gain sharing outcomes (recoupment and payments) will be realized after the August reports.
If you have any questions related to your THCII Episode of Care report, please go to the BlueCare Tennessee THCII webpage at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html.

By 2019, approximately 75 episodes of care will be rolled out in 11 different Waves. Each wave will include a specific number of episodes of care assigned by the State of Tennessee. To see each wave and the episodes of care within each wave, please go to the State of Tennessee website at http://www.tn.gov/hcfa/topic/episodes-of-care.

For additional questions, contact your Provider Relations Consultant.
If you do not know your Provider Relations Consultant, please go to the BlueCare Tennessee website provider page at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/index.html and click on "Find My BlueCross Contact."

Monthly Screening Requirements for TennCare Providers to Change July 1*

Providers who care for patients covered by TennCare plans will have new monthly screening requirements to follow starting July 1, 2016. All owners, contractors, subcontractors and providers, whether contracted or not, must be screened against the Excluded Parties List System (EPLS), HHS-OIG List of Excluded Individuals/Entities (LEIE) and Social Security Master Death File (SSDMF) each month. Currently, providers can screen their employees and subcontractors against either of the federal exclusion databases, EPLS and LEIE. As of July 1, the amendment will require both databases to be searched in addition to the SSDMF.

CMS to Hold Training for 2016 PERM Reviews

The Centers for Medicare & Medicaid Services (CMS) reviews each state's Payment Error Rate Measurement (PERM) every three years and Tennessee is due for review in 2016. CMS will host four PERM provider educations sessions to help providers who serve Medicaid and Children's Health Insurance Program (CHIP) communities understand their responsibilities during the PERM cycle.

The presentations will be repeated for each session. You will have the opportunity to ask questions live through the conference lines, webinar, and the dedicated PERM Provider email address at: PERMProviders@cms.hhs.gov.

To learn more about these upcoming provider education sessions, please visit the CMS website.

Provider Education Session Schedule

- Tuesday, June 21
- Wednesday, June 29
- Tuesday, July 19
- Wednesday, July 27

All sessions begin at 3 p.m. (Eastern).

Medicaid ID Numbers

Please note that to participate in the BlueCare and TennCare*Select* networks, providers must have a valid Medicaid ID number on file with the Bureau of TennCare. The Bureau of TennCare's weekly notice of active Medicaid providers is BlueCare Tennessee's sole source for this information. To obtain a new Medicaid ID or to revalidate your existing Medicaid ID, please visit the Bureau of TennCare's provider registration website at http://tn.gov/tenncare/topic/provider-registration.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

We Can Help Your Patients Manage Their Diabetes

As you know, the key to living with diabetes is properly managing the disease over the long term. That's why BlueCross offers tools and rewards to our BlueChoice℠ and BlueAdvantage members to help them take the necessary steps to follow your plan of care and maintain a healthy lifestyle.

For details regarding the rewards members can receive for completing diabetes screenings view this comprehensive list on the Quality Care Rewards website.

Have a diabetic patient who has trouble making it to your office? At BlueCross, we understand that it's not always easy getting home-bound patients the screening tests they need. We can schedule in-home visits with our health partners to help your patients complete each of the following screenings annually:

- Blood Sugar (HbA1c)
- Kidney Function
- Retinal Eye

Call us at 1-800-841-7434 to schedule an in-home visit.

Reminder: High Tech Imaging Codes Requiring Prior Authorization

As previously communicated, three procedure codes for high tech imaging procedures have been recently added to the prior authorization requirement list to synchronize requirements with other services in these code ranges:

- 78264
- 78265
- 78266

Prior authorization requests can be faxed to 1-888-693-3210, or through BlueAccess at bcbst.com. When submitting requests online, the high tech imaging code must be the primary code.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Early Intensive Treatment of Rheumatoid Arthritis Can Help Patients Maintain Quality of Life

Rheumatoid Arthritis can be a debilitating disease. In 2012, the American College of Rheumatology updated their recommendations outlining aggressive treatment to improve quality of life and control disease progression.

According to the Centers for Medicare & Medicaid Services (CMS), patients with two diagnoses on different dates of service (during either an outpatient visit or non-acute inpatient discharge), should receive at least one disease-modifying anti-rheumatic drug prescription.

See the complete list of anti-rheumatic drugs for our BlueChoice℠ and BlueAdvantage members online.

Chlamydia Screenings Aid in Prevention of Serious Health Conditions

Chlamydia is a disease with typically mild or absent symptoms. In fact, a screening may be the only way your patients know they have it. The United States Preventive Services Task Force (USPSTF) recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection.

This easily treated disease can lead to more serious health conditions such as cervical cancer and infertility, if left untreated. Please remember to address this topic with all applicable patients yearly.

Chlamydia Screening Tests are a Covered Benefit:

BlueCare Tennessee Coverage:
BlueCare Tennessee covers chlamydia screenings for females 16-24 years of age annually, and when medically necessary chlamydia screening coverage is extended up to 29 years of age.

Commercial Coverage:
For most women with private insurance, the cost of chlamydia screening is covered without copayments or deductibles. However, your patients should contact their health plan to confirm coverage benefits.

Talk to your patients today about getting chlamydia screenings.

Prenatal and Postpartum Care

Prenatal care visits are a great opportunity to counsel expecting mothers on good choices and positive behaviors throughout all stages of pregnancy. It is important that you **schedule the expectant mother's first prenatal care visit within her first trimester or as soon as she suspects she is pregnant.**

Tips for improving success in pregnancy:

- Help pregnant patients schedule regular prenatal care visits.
- Send appointment reminders to avoid missed appointments.
- Schedule postpartum visits within 21 to 56 days after delivery, and try to schedule before she leaves the hospital.
- Counsel pregnant patients about proper nutrition and pregnancy wellness tips.
- Document all prenatal and postpartum visits.
- Submit claims in a timely manner to allow for early interventions in the case of high-risk pregnancies.

Effective Detection for Breast Cancer

Getting a high-quality screening mammogram and clinical breast exam regularly are the most effective ways to detect breast cancer early.

Breast cancer screenings are recommended every 2 years for women ages 50 to 74. Members should be encouraged to follow their physician's advisement regarding frequency of breast cancer screening due to personal history and other contributing factors.

Breast Cancer Screenings are a Covered Benefit:

BlueCare Tennessee Coverage:

- Mammography is covered at least once for women ages 35 to 40.
- Every two years, or more often if medically necessary, for women ages 40 to 50
- Each year for women who are age 50 and older
- Mammogram screenings are free. There is no copay. BlueCare members can call Customer Service at 1-800-468-9698 for help scheduling appointments and transportation.

Medicare Advantage Coverage:

- Annual screening mammograms for all female Medicare beneficiaries age 40 or older
- One baseline mammogram for female beneficiaries between the ages of 35 and 39
- There is no deductible requirement for this benefit.

Commercial Coverage:

- For most women with private insurance, the cost of screening mammograms is covered without copayments or deductibles.
- Patients should contact their mammography facility or health plan to confirm coverage benefits.

Talk to your patients today about getting their mammograms.

Reminder: Consider Safer Alternatives for Patients Prescribed High-Risk Medications

At BlueCross, we know one of your priorities is the safety of your patients. We want to partner with you to minimize the use of medications considered high risk for those 65 years of age and older – especially when there may be safer alternatives.

High-risk medications (HRMs) are those identified by the American Geriatric Society and by the Pharmacy Quality Alliance as possibly causing adverse side effects in older adults due to their pharmacologic properties and the physiologic changes associated with aging. The Centers for Medicare & Medicaid Services (CMS) has adopted this list as a best practice in caring for older adults.

Use of HRMs by your attributed BlueAdvantage, BlueChoice or BlueCare Plus patients is one of the measures used to determine your Star quality score and has been associated with a greater risk of diminished mental alertness, sleep walking and other abnormal behavior. HRMs can make everyday activities like driving a car more risky for elderly patients. See our website for a complete list of high-risk medications, the concerns associated with them and recommendations for safe alternatives.

Be sure your CAQH ProView™ profile is kept up to date at all times.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386 العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Nguơi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

***** **C**hanges will be included in the appropriate 2Q or 3Q 2016 provider administration manual update.

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

of Tennessee

Bluealert℠

July 2016

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Aug. 13, 2016

- Hydroxyprogesterone Caproate for Injection Belinostat (Revision)
- Pancreas/Pancreas-Kidney /Pancreatic Islet Cell Transplantation (Revision)

Effective Aug. 20, 2016

- Belinostat (Revision)
- Cetuximab (Revision)
- Epidural Steroid Injections for Treatment of Back Pain (Revision)
- Obinutuzumab Belinostat (Revision)
- Panitumumab (Revision)
- Pneumatic Compression Pumps for Outpatient Use for Lymphedema, DVT Prophylaxis, and Venous Ulcers (New)
- Siltuximab (Revision)
- Temozolomide for Injection (Revision)
- Ustekinumab (Revision)

Note: These effective dates also apply to BlueCare /TennCare*Select* pending state approval.

Utilization Management (UM) Guideline Updates/Changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming changes to select Management Guidelines. These upcoming changes to the UM Guidelines can be viewed on the Utilization Management Web page.

Effective August 20, 2016

The following Utilization Management Guideline related to Ambulatory Care will be archived:

- Ambulatory/Day Surgery Criteria

The following Utilization Management Guideline related to Ambulatory Care will be updated:

- Cognitive Communication Disorders Rehabilitation

The following Utilization Management Guideline related to Home Care will be updated:

- Hyperemesis Gravidarum

The following Utilization Management Guidelines related to Inpatient & Surgical Care will be updated:

- Inpatient Goal Length of Stays Customized to Lower Range

Note: These effective dates also apply to BlueCare /TennCare*Select* pending state approval.

BlueAccess℠ Improvements Coming Soon

Providers using the Quality Care Rewards application on BlueAccess to submit attestations and provider assessments, review quality metrics and monitor open gaps in care will soon see the following new features:

- Unified Provider View – Selecting a contract and provider will allow you to view all quality program data in the same session across all programs in which you are enrolled.
- Improved Navigation – A new tabbed layout allows for easy switching between member rosters and quality programs.
- New Filter Options – Typing in the search field on a member roster view allows for easy filtering by available data elements.
- Program and Attribution Information – Member rosters will include the reason for a patient attribution to a particular provider as well as all programs under which they are covered.
- Practice Notes – Users can enter free-form notes to track member details not otherwise documented in other data entry fields.

These changes will launch mid-to late third quarter. Resource materials and reference guides will be updated to guide users through the new application features. If you have questions about these changes, you may contact your Quality Care Rewards field staff, your Regional eBusiness Marketing Representative or the eBusiness Service Center.

All Blue 2016 Workshops

Join us for our annual state-wide All Blue workshops! Talk with BlueCross professionals who will share information about issues important to you and your practice. You can also visit our Resource Centers and take advantage of one-on-one discussions. Online registration begins soon!

Region	Date
Nashville	8/17
Chattanooga	8/31
Johnson City	9/14
Knoxville	9/15
Memphis	9/21
Jackson	9/22

Reconsideration, Appeal and Binding Arbitration

Providers who are not satisfied with the outcome of a claim or a prior authorization reconsideration request may submit a written appeal within 30 days of the reconsideration decision. If the dispute is regarding a Medical Management determination, the dispute must be submitted through the applicable Utilization Management appeals process, which varies by line of business.

No additional appeals options exist after the initial reconsideration and appeals steps have been completed. Providers who are still not satisfied with the outcome of an appeal may request the dispute be submitted to binding arbitration. The provider is responsible for the costs associated with arbitration.

Information about the reconsideration, appeal and binding arbitration processes can be found in the Provider Dispute Resolution Procedure section of the provider administration manuals.

Additionally, TennCare Providers may file a request for independent review of disputed claims. See the State of Tennessee website for more information about the independent review process.

Update: Enhancements Made to Discharge Date Process

BlueCross BlueShield of Tennessee routinely seeks feedback from providers and hospital systems on how we can improve the way we work together to provide the most effective, efficient care for our members. Based on direct input from hospitals, we have made enhancements to the method by which we collect discharge dates.

Please note the following updated process for discharge dates for all lines of business:

- Each facility will produce one comprehensive list of discharges each day.
- All lines of business may be included on the list, as long as indicators for the appropriate line of business are also included.
- Coversheets should include facility name and NPI number.
- Discharges lists may be submitted two ways:
  - Email to dcdates@bcbst.com
  - Fax to (423) 591-9501
- Web submissions are also available for individual discharge entries.

Additional updates will be outlined in future issues of *BlueAlert*.

The Power of Partnerships

Fostering healthy, happy communities across the state is a fundamental element of BlueCross BlueShield of Tennessee's mission.

Each year, the BlueCross Health Foundation and Community Trust partners with organizations in each of Tennessee's 95 counties to improve access to health services, inspire individuals to get and stay active, enhance addiction counseling and treatment programs, supplement education, arts, culture and economic development programs.

Our charitable investments totaled $14.8 million in 2015.

To learn more about the impact BlueCross is making in your community, visit our new, interactive partner map at BetterTennessee.com/Partners. The map provides detailed information about BlueCross partners in each county, including the:

- Organizations we support in each of Tennessee's 95 counties
- Categories of philanthropic work we support
- Grant amounts for each project
- Web and social media information for each organization

You can also read stories about the human impact of these programs in each issue of Better Tennessee magazine or online at BetterTennessee.com.

Changes Coming to Chiropractic Reimbursement

BlueCross BlueShield of Tennessee will soon send contract amendments to chiropractic providers in our Commercial networks. These amendments will outline changes being made to the reimbursement schedule for chiropractic services, which will be effective Oct. 1, 2016. More information will be communicated soon.

Reminder: FREE Quality Training for Network Providers

BlueCross is offering a two-day class to promote health care quality. The training class is scheduled for Aug. 4 and 5, 2016, in the BlueCross BlueShield of Tennessee Community Room in Chattanooga, Tenn. The class is designed to help those planning to take the Certified Professional in Healthcare Quality (CPHQ) examination, and also delivers intermediate quality improvement content that can benefit anyone working in the field of health care quality. Get more information at: http://www.bcbst.com/providers/Free-cphq-training-class.pdf

The usual cost for this training is $399; however, BlueCross is offering the class to its network providers at no cost. Space is limited, so please contact us soon to register. To qualify for the training you must meet the following criteria:

- Currently employed in a role related to quality improvement or management
- Currently employed by a BlueCross BlueShield of Tennessee network provider

Network providers will be limited to two participants per group/facility for the 2016 class. To register, email tawanda_malone@bcbst.com.

Reminder: Up-to-Date Data Verification Forms Necessary to Improve Provider Directory Quality

Health plans are required by the federal government, states and other regulatory bodies to contact participating health care providers on a quarterly basis to review, update and confirm the accuracy of their information in provider directories.

If you receive a Data Verification Form, please verify your demographic information, sign and return the form promptly, even if all information on the form is accurate. If the Data Verification Form requires changes, please mark through the incorrect information and print the correct details in the space beside that field and fax to (**423) 535-3066** or email to **PNS_GM@bcbst.com**. We ask that all providers respond promptly to update the information required for provider directories.

If you have any questions or need assistance with the Data Verification Form, please call the Provider Service Line† at **1-800-924-7141**. To help ensure your call is routed to the appropriate department, select the option "Provider Network Services" when prompted.

We are assessing more efficient means of electronic verification, including working with the Council for Affordable Quality Healthcare (CAQH) to help meet these requirements by using CAQH ProView™.

Throughout 2016 we will be implementing improvements to simplify the process of updating provider directories.

Don't Get Caught in the Queue: Listen Carefully to Provider Service Line Prompts

If you find you're on hold with our Provider Service Line longer than usual, be sure you are listening carefully to the new menu prompts. We recently updated the prompts to help your call get routed to the appropriate area and help ensure you get the needed information quickly.

Please note: If you need to reach **Network Contracts or Credentialing** after dialing BlueCross' Provider Service line at 1-800-924-7141, choose "touchtone" (Option 1), then "provider" (Option 1 again). Then simply follow the prompt instructions to be routed to Network Contracts or Credentialing.

Reminder: Physician Quality Information Application Available Until July 12, 2016

The Physician Quality Information Application on BlueAccess℠ will be available for physician review and self-reporting until July 12, 2016. After July 12, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available on the company website for our members.

Reminder: Prior Authorization Needed for Many Advanced Imaging Procedures

As previously communicated, please remember that prior authorization for Commercial members is required for many advanced imaging services. Services that require prior authorization are listed on our website at www.bcbst.com.

Before submitting prior authorization requests for advanced imaging services, please verify member benefits and eligibility through BlueAccess, the secure area of our website, or by calling the Provider Service Line†.

Prior authorization requests can be submitted via fax to 1-888-693-3210 or through BlueAccess. When submitting requests online, the advanced imaging code must be the primary code.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

Claims for Pediatric Behavioral Health Services Require Proper CPT® Codes

If your claims include services involving the Pediatric Behavioral Health Symptoms Checklist, make sure you're using the proper codes. Developmental screenings should be coded using 96110, while 96127 should be used for behavioral/emotional assessments.

For more information on correct coding see the Bright Futures and Preventive Medicine Coding Fact Sheet available on the American Academy of Pediatrics website.

TennCare Behavioral Health Guidelines to Change Later this Year

Please be aware of changes that will take place later this year related to **Level 2 Mental Health Case Management** services and the implementation of Health Homes for qualifying individuals with behavioral health needs, as outlined as follows:

- The Bureau of TennCare will not allow reimbursement for Level 2 Mental Health Case Management services rendered after Sept. 30, 2016.
- Beginning Oct. 1, 2016, your patients who are receiving Level 2 Mental Health Case Management will transition to a Health Home (known as a Tennessee Health Link, or THL) for care coordination activities. They will receive care coordination services from the THL to which they are assigned and attributed.
- Only TennCare designated THLs will be allowed to contract with MCOs for care coordination/THL activities.

You can find the updated medical necessity guidelines for Level 2 and Assertive Community Treatment (ACT)/Program of Assertive Community Treatment (PACT) in the Provider section of our website.

Children with Special Needs Require TennCare Kids Services Too

Children with special needs often receive extra care and visits to specialists or Primary Care Providers for specific reasons. While the reasons for the visits may not be for a check-up, children with special needs should also have TennCare Kids well-child check-ups every year.

You can find a schedule of recommended visits at the American Academy of Pediatrics website.

If you have questions about coding or billing, please see *Preventive Services Billed with Evaluation & Management Codes* in the **TennCare Kids** section of the *BlueCare Tennessee Provider Administration Manual*.

Reminder: TennCare Kids Billing and Documentation

When a patient's primary reason for a visit is a well-child TennCare Kids exam and a significant abnormality is discovered that will need additional evaluation and management, such as an

ear infection in a well-baby exam, the office visit code can be billed in addition to the preventive service. Modifier 25 should be attached to the evaluation and management office visit code. Conversely, when a patient presents with symptoms such as an ear infection and is due for a well-child exam and the complete well-child exam is performed, then both codes may be billed using the modifier 25 added to the office visit code. Remember, all seven components of the TennCare Kids exam must be completed and documented in the patient's medical record, including documentation of the nutritional assessment and physical activity portion of the exam.

CMS to Hold Training for 2016 PERM Reviews

The Centers for Medicare & Medicaid Services (CMS) reviews each state's Payment Error Rate Measurement (PERM) every three years and Tennessee is due for review in 2016. CMS will host two PERM provider education sessions in July to help providers who serve Medicaid and Children's Health Insurance Program (CHIP) communities understand their responsibilities during the PERM cycle.

The presentations will be repeated for each session. You will have the opportunity to ask questions live through the conference lines, webinar and the dedicated PERM Provider email address at: PERMProviders@cms.hhs.gov.

To learn more about these upcoming provider education sessions, please visit the CMS website.

Provider Education Session Schedule

- Tuesday, July 19
- Wednesday, July 27

Both sessions begin at 3 p.m. (ET).

Update: Quest Lab Exclusion List

As of April 1, 2016, several Quest diagnostic codes were removed from the BlueCare Tennessee lab exclusion list due to underutilization. Upon further review however, it has been determined that a technical error caused several commonly used codes to be unnecessarily removed.

Of the 12 codes removed in the April 1 update, 7 have been returned to the exclusion list as of April 1, 2016. These codes include:

- 81000 – Urinalysis non-auto w/ scope
- 81002 – Urinalysis non-auto w/o scope
- 82270 – Occult blood feces
- 85060 – Blood smear
- 88177– Cytopathy, evaluation of fine needle aspirate
- 88329 – Pathology consultation during surgery
- 88332 – Pathology consultation during surgery; each additional tissue block

BlueCare Tennessee will adjust claims denied for these codes for dates of service April 1, 2016, to present. No further action is required on your part.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Include Obesity and Malnutrition Codes When Appropriate

With a rising number of patients having multiple chronic conditions, providers are using multiple ICD-10 codes to accurately reflect the condition of the patient. Two common but diverse diagnosis codes often omitted from claims are obesity and malnutrition.

While the codes listed below don't include all codes associated with obesity and malnutrition, they do represent common conditions. When appropriate, please use these codes so the full medical condition of your patient is reflected:

Overweight & Obesity
Morbid Obesity due to excess calories: E66.01
Other Obesity due to excess calories: E66.09
Overweight: E66.3
Other Obesity: E66.8

Malnutrition
Mild protein calorie malnutrition (weight for age is 75 - 89 percent of standard): E44.1
Moderate protein calorie malnutrition (weight for age is 60 – 74 percent of standard): E44.0

Limited by the Number of Diagnosis Codes You Can Report?

Because we don't have the benefit of sitting with our members in an exam room, the claims we receive serve as a picture of that particular patient's visit with you. This helps us inform the Centers for Medicare & Medicaid Services (CMS) of the conditions of the Medicare beneficiaries you treat and allows us to maintain the full scope of benefits our members enjoy. It's important to accurately provide the specific diagnosis codes that represent the patient's health, including ongoing chronic conditions that may also impact that visit.

Recognizing that some practices have system limitations from either electronic medical records or claims

clearinghouse, we accept CPT® code 99080 for zero dollar claims providers can use to submit additional ICD-10 codes. **Note:** This code is not reimbursable and has no patient responsibility.

Medicare Advantage Case Management Program

The BlueCross Medicare Advantage Case Management program exists to help our sickest members, and those suffering from chronic conditions to effectively manage their illnesses and help them live the highest quality of life possible.

Our programs are designed to assist members with catastrophic health care needs, understanding or limited knowledge about their chronic conditions and those needing general assistance with medications, transportation or any other barriers to care.

All BlueCross Medicare Advantage members are eligible for case management. It is an opt-out program, meaning a member can choose to quit the program at any time. However, we encourage our members to participate in the program to receive the support they need to live happy and healthy lives.
You can help your patients by also encouraging them to participate. Refer them to case management by calling 1-800-611-3489 or faxing 1-800-727-0841.

New, Simpler Provider Assessment Form

An updated Provider Assessment Form (PAF) for Medicare Advantage members and is now available to download on the Quality Care Rewards website. The form has been shortened to six pages (instead of 11), and is in a fillable PDF format that allows you to complete it electronically or print and complete manually then fax to 1-877-922-2963. You will receive an incentive payment* for submitting a completed form and a claim with CPT® code 99420, (for each complete PAF) based on the date of service as noted below:

- Jan. 1 – March 31: $250
- April 1 – June 30: $200
- July 1 – Sept. 31: $175
- Oct. 1 – Dec. 31: $150

* Incentives are available for one completed PAF per member, per calendar year and will be paid to the provider who submits the first completed PAF for the member.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Readmission Rates-Are they an Indicator to Quality Care?

According to a report from the Agency for Healthcare Research and Quality (AHRQ), U.S. hospitals spent a total of $41.3 billion between January and November 2011 to treat patients readmitted within 30 days of discharge (3.3 million readmits). The AHRQ also reports that in 2013, approximately two-thirds of U.S. hospitals were charged financial penalties by the Centers for Medicare & Medicaid Services (CMS) due to excessively high 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia.

What can you do to improve this quality measure?

- **Patient Education**: Patients discharged from the hospital with a clear understanding of after-hospital care instructions, including how to take their medicines and when to make follow-up appointments, are 30 percent less likely to be readmitted or to visit the emergency department than patients who lack this information, according to an AHRQ-funded study.

- **Follow-up Appointments**: A follow-up visit should be scheduled upon discharge from the hospital with a written reminder provided. A phone call is also helpful to remind patients to keep their appointment.

Use Conservative Measures for Patients with Newly Diagnosed Low Back Pain

Each year, 25-50 percent of American adults experience low back pain which makes it one of the most common reasons for seeking health care services. According to the National Committee for Quality Assurance (NCQA), low back pain improves within the first two weeks after onset for the majority of adults (unless there is obvious trauma or other contributing comorbidities). For adults ages 18-50 who have been diagnosed with uncomplicated low back pain, the National Committee for Quality Assurance (NCQA) recommends **waiting 28 days from the time of diagnosis before obtaining imaging studies** unless the member **at any time has a history of cancer,** or in the previous 12 months has **experienced trauma, abused IV drugs or has evidence of neurologic impairment.**

Tips to ease symptoms include:

- Anti-inflammatory medications
- Over-the-counter pain relievers
- Physical therapy
- Ice
- Rest

New CPT® Category II Code Payment Opportunity for Prenatal/Postpartum Care

Effective Aug. 1, 2016, BlueCare Tennessee and CoverKids will offer a new Prenatal/Postpartum Incentive Program that allows providers to receive a bonus incentive when submitting Category II code 0500F with the following specifications:

- Include the date of the last menstrual period (LMP) on your claim submission
- Send a completed Maternity Notification form via web or fax **and**
- Bill with the appropriate E&M code within 30 days of the visit that confirmed the pregnancy

BlueCare Tennessee and CoverKids will pay providers a bonus incentive when submitting Category II code 0503F with the following specifications:

- Include the date of delivery on your claim submission
- Postpartum visit must occur within 21-56 days after delivery
- Bill with the appropriate postpartum visit procedure code

Additionally, BlueCare Tennessee and CoverKids will reimburse separately for insertion of Intrauterine Device (IUD) (procedure code 58300) when performed at the time of delivery.

More information on this Incentive Program will be announced in the coming weeks.

Reminder: In-Home Test Kits Available for Homebound Members

Getting to the doctor's office can be a challenge for some of your patients. That's why BlueAdvantage offers in-home test kits for three of the most common annual screenings Medicare Advantage members need.

With a simple phone call to our independent health partner, Home Access, your BlueAdvantage, BlueChoice℠ and BlueCare Plus members will receive an in-home test kit by mail for a:

- Immunochemical Fecal Occult Blood Test (iFOBT) for colorectal cancer
- Kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

The member then follows the detailed instructions on how to properly use and to mail the kit back to Home Access for testing. The written results are then sent to you and your patient. The screenings are at no cost to the patient and count toward your practice's quality rewards incentive for attributed members.

Your patient can order a kit by contacting Home Access at 1-866-435-4372, Monday through Friday, 7 a.m. to 8 p.m. (ET).

Patient Information Needed to Help Ensure Health After Inpatient Discharge

To help ensure smooth transitions of care for our BlueAdvantage members, submit discharge information including the facility name, member name, date of birth, member ID, reference number and discharge date by fax to (423) 591-9501 or email to dcdates@bcbst.com. Timely and accurately communicating information is critical to effective care transitions and decreased readmissions.

Discharge dates play an integral role in claims processing and BlueCross' quality assurance initiatives. After a BlueAdvantage member is discharged from your care, BlueCross care transition and case management staff contact the patient to identify post-discharge gaps, such as home care needs and required follow-up appointments. This process helps reduce patient readmission and improves overall care, but confirmation of discharge is required for this to take place.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386 العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Nguơi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
ECF CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard

Benefits & Eligibility	**1-800-676-2583**
All other inquiries	**1-800-705-0391**

Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage	**1-800-841-7434**
BlueAdvantage Group	**1-800-818-0962**

Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

August 2016

BlueAlert SM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Sept. 11, 2016

- **Diagnosis and Treatment of Sacroiliac Joint Pain (Revision)**
- **Laser Therapy for Onychomycosis and Active Acne (Revision)**

Allograft Cruciate Ligament Reconstruction – This medical policy will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued. The document is being archived based on the American Academy of Orthopaedic Surgeon's (AAOS) position that advocates the use of both autograft and allograft tissue.

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

Changes Coming to Chiropractic Reimbursement*

BlueCross BlueShield of Tennessee recently communicated changes being made to the reimbursement schedule for Commercial chiropractic services, which will be effective Oct. 1, 2016.

If you provide chiropractic services to our Commercial members and are not aware of this planned change, please contact your BlueCross contracting representative. A listing of all Contracting and Service representatives can be found here: http://www.bcbst.com/providers/mycontact/

New Prior Authorization Requirements for Provider-Administered Specialty Medications*

As part of our efforts to support physicians' treatment plans that are consistent with consensus and evidence-based best practices, we are changing the way we manage select specialty medications used to treat multiple sclerosis, rheumatoid arthritis, cancer and other serious, chronic conditions.

Effective Nov. 7, 2016, BlueCross, in partnership with Magellan Rx Management, will implement new prior authorization requirements for provider-administered specialty medications under the medical benefit for all lines of business. Prior authorizations obtained prior to Nov. 7, 2016, will still be valid and effective as originally approved by BlueCross.

Magellan Rx will assist us with a new process for reviewing and approving these specialty medications, which involves the use of current medical criteria, consensus and evidence-based guidelines, as well as clinical pharmacists and board-certified physicians to advance quality care. See our website for the Specialty Drug List.

Prior authorization review will be required for the specialty medications when administered in the following settings:

- Physician office
- Outpatient hospital
- Home infusion

Note: Prior authorization for these medications *will not be required* when they are administered during an inpatient stay, in an emergency room or in an observation room setting.

Let's Strategize to Immunize

As partners in health, it is our responsibility to help ensure children, pre-teens and teens are protected against serious but preventable illnesses. You play an essential role in

advising and guiding parents on the best immunization strategy for their kids. Here's how you can help keep them protected.

For patients under the age of 2 years:

- Schedule these patients for regular wellness visits and confirm they receive **all 10 recommended immunizations by 23 months of age.**
- Ensure they get their **first flu vaccination starting at 6 months of age and another before 23 months.**

For pre-teens and teens:

- Make sure adolescents turning 13 complete **all doses of the recommended adolescent immunizations BEFORE their 13th birthday.** This includes 1 dose Meningococcal Vaccine, 1 dose Tdap Vaccine, 3 doses of HPV Vaccine (within 6 month period) and the influenza (flu) vaccine. Teens may also need a booster of a vaccine that requires more than one dose to be fully protected.
- Look for each opportunity to immunize adolescents apart from just vaccination appointments. If you have a child in your office already for a well-visit, or to complete a camp physical, school physical, etc. consider offering immunizations at that time.

For all of your young patients:

- Give parents an up-to-date shot record they can keep for their own documentation.
- Teach and advise parents on the importance of immunizations and discuss the importance of preventive care. Give parents a copy of a current immunization schedule and information on the different vaccines, dosages, and what they prevent, along with a reputable source to reference (www.cdc.gov/vaccines)
- Schedule appointments in advance (or before leaving the office) and send reminders to avoid missed appointments and dosages.
- Follow up on missed appointments so that rescheduling can occur.
- Submit claims and encounter data quickly and accurately.
- Make sure to code the procedure accurately and timely.

If you provide care for BlueCare or TennCare*Select* members age 18 or younger, you are eligible to participate in the Tennessee Department of Health's Vaccines for Children (VFC) Program. The VFC Program will benefit your patients and your practice. This is a program that reduces your vaccine cost by providing free vaccine serum for BlueCare Tennessee and TennCare*Select* patients in this age group. For more information, or to participate, contact the VFC Enrollment Desk via e-mail at VFC.Enrollment@tn.gov or call (615) 253-4072 or (615)532-8501.

***Note:** The VFC Program is not available to your patients in the CoverKids plan.*

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Suicide Prevention for Primary Care and Emergency Departments

On average, there are about 950 recorded suicide deaths in the state of Tennessee each year with about 100 of these involving teens and young adults ages 10 to 24.

What Can You do?

- Learn the risk factors associated with suicide and the warning signs that someone may be thinking of harming themselves or others. Free training programs are available by contacting the Tennessee Suicide Prevention Network (TSPN) at (615) 297-1077 or tspn@tspn.org.
- Conduct a suicide risk assessment for every patient that comes in to your office. See the Columbia Suicide Risk Assessment: http://cssrs.columbia.edu/.
- Keep a list of crisis intervention numbers. The state's toll-free crisis line is 1-855-CRISIS-1 and the National Suicide Prevention Lifeline is 1-800-273-TALK.
- A free online continuing education training for hospital emergency department staff, Suicide Prevention in the Emergency Department, can be accessed at this link: http://tinyurl.com/tspn-ed.

Reimbursement for Intrauterine Device (IUD)

Providers should only submit claims for reimbursement for procedures associated with the insertion or removal of an IUD when the device is supplied by the member's pharmacy benefit

manager (PBM). Charges submitted by providers for the cost of the IUD when supplied by the PBM are subject to be denied as a duplicate charge.

Reminder: FREE Quality Training for Network Providers

There is still time to register! BlueCross is offering a two-day class to promote health care quality. The training class is scheduled for **Aug. 4 to 5, 2016**, and will be held in the BlueCross BlueShield of Tennessee Community Room in Chattanooga, Tenn. The class is designed to help those planning to take the Certified Professional in Healthcare Quality (CPHQ) examination, and also delivers intermediate quality improvement content that can benefit anyone working in the field of health care quality.

The usual cost for this training is $399, however BlueCross is offering the class to its network providers at no cost. To qualify for the training you must meet the following criteria:

- Must currently be employed in a role related to quality improvement or management
- Must currently be employed by a BlueCross BlueShield of Tennessee network provider

Network providers will be limited to two participants per group/facility for the 2016 class. To register e-mail tawanda_malone@bcbst.com.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

THCII Episodes of Care Reports Available Soon

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Reports for August will soon be available in the BlueAccess℠ portal on the BlueCare Tennessee website. The report will reflect your final performance for Wave 1 episodes of care (perinatal, acute asthma exacerbation and total hip/knee joint replacement) for the period Jan. 1 to Dec. 31, 2015, including risk and gain sharing outcomes. Risk/gain share payments and/or recoupments will be made in mid-September. If you have problems accessing your THCII Episodes of Care Reports, contact eBusiness Technical Support†.

For more information about your report, see our BlueCare Tennessee THCII webpage. If you have questions, contact your Provider Relations Consultant. If you do not know your Provider Relations Consultant, click Find My BlueCross Contact on the BlueCare Tennessee provider page.

Latest TennCare Preferred Drug List Includes Changes for Pain Management Drugs

The latest release of the TennCare Preferred Drug List (PDL) includes changes that may affect some of the medicines your patients take. Some of the most notable changes are related to prior authorizations for both long-acting and short-acting narcotics. Changes also include some quantity limits that became effective July 20, 2016. Click here to view a summary of the PDL changes, including those for narcotics.

Please inform your BlueCare and TennCare*Select* patients who take these medications that switching to preferred drugs will decrease delays in receiving their medicine. The most current TennCare PDL is available online.

Changes for Reporting Home Health Critical Incidents *

Effective July 1, 2016, the State of Tennessee has new requirements for reporting home health critical incidents. If a critical incident occurs during the delivery of home health services for BlueCare Tennessee, and CHOICES or non-CHOICES members, the incident should be reported to BlueCare Tennessee within 24 hours of discovery. The following are all considered critical incidents:

- Life-threatening medical emergency –**NEW**
- Medication error – **NEW**
- Financial exploitation – **NEW**
- Theft against a member – **NEW**
- Unexpected death (regardless of whether the death occurs during the provision of home health services)
- Major/severe injury
- Safety issues
- Suspected physical, mental or sexual abuse
- Neglect

Use the **Home Health Agency Critical Incident Form** available in the *Forms* section of the BlueCare Tennessee provider page, to report all critical incidents and fax the completed form to our BlueCare Quality of Care Oversight Department at 1-855-339-3022.

To learn more about reporting home health critical incidents, see the *BlueCare Tennessee Provider Administration Manual*.

New THCII Programs Coming Soon

The State of Tennessee is continuing its development of the Tennessee Healthcare Innovation Initiative (THCII) through the expansion of its Patient-Centered Medical Home program and the development of the Tennessee Health Link.

Please refer to the State's website for more information:
https://www.tn.gov/hcfa/article/patient-centered-medical-homes
https://www.tn.gov/hcfa/article/tennessee-health-link

Additional updates will be provided in the September and October issues of *BlueAlert*.

Back to School – Perfect Time to Provide Checkups

As parents and guardians are getting ready for school to start, they may call your office for an immunization appointment or to get copies of shot records. This is a great time to remind them that the American Academy of Pediatrics recommends a comprehensive checkup each year for school age children up to age 21.

Encourage parents to schedule a checkup, especially if they're already making an immunization visit for their kids.

Electronic and Information Technology Accessibility Requirements

The Rehabilitation Act of 1973 requires electronic and information technology (EIT) be accessible to people with disabilities. Under Section 508, agencies must give disabled individuals access to information that is comparable to access available to others unless it would be an undue burden.

If an undue burden is created, the individual with the disability must receive the information or service involved by an alternative means of access that allows these individuals to use or access the information or service. In addition, the provider would need to document why and to what extent compliance creates an undue burden.

To comply with the accessibility requirements for web content and non-web electronic documents and software see Web Content Accessibility Guidelines ("WCAG") 2.0 AA (For the W3C's guidelines see:*http://www.w3.org/TR/WCAG20/*) *(Two core linked resources are Understanding WCAG 2.0 http://www.w3.org/TR/UNDERSTANDING-WCAG20/ and Techniques for WCAG 2.0 http://www.w3.org/TR/WCAG20-TECHS/).*

Trouble Contacting Your TennCare Patients? We Can Help

Disconnected phone numbers and incorrect addresses are a frequent barrier between providers and their patients covered by TennCare. To help our members get the care they need and promote care coordination, BlueCare Tennessee has a new process in three easy steps to help providers when they have trouble contacting their patients.

1. **Call** – If you are not able to get in touch with one of your BlueCare Tennessee patients, you can call Customer Service for assistance.
2. **Confirm** – Following all HIPAA guidelines, our staff will validate the request and locate the member's information based on their latest claim.
3. **Contact** – Our staff will then share the name, address and phone number with the provider so they can contact the member and provide the care they need.

Due to privacy concerns, any claims related to Behavioral Health Services will not be released.

Key Requirement for Hospital Inpatient Claims to be Paid

For BlueCare Tennessee hospital inpatient service claims to be paid, physicians are required by federal law to certify by signature that the inpatient care is reasonable and necessary. Physician certification includes the practitioner order and is considered along with other documents in the medical record as evidence that hospital inpatient service(s) are reasonable and necessary.

You can find more information about this certification requirement at the Centers for Medicare & Medicaid Services website.

Last Chance to Enroll in TennCare EHR Provider Incentive Program

2016 is the final year providers and facilities can begin participation in the Medicaid Electronic Health Record (EHR) Incentive Program.

Benefits of program participation include:

- Eligible providers can receive up to $63,750 for full participation in the program.
- Achieve measurable improvements in patient health care delivery and performance to promote better patient outcomes through the use of Certified Electronic Health Record Technology.

Check Your Eligibility
To see if you are eligible, check the CMS Eligibility Widget. If you have questions about program eligibility, please contact TennCare.EHRIncentive@tn.gov.

How Do I Get Started?
Click here to register and get started with your 2016 Program Year attestation.

More Details
For more information about the incentive program, visit the CMS or TennCare websites.

Revised: Changes to Monthly Screening Requirements for TennCare Providers

Providers who care for patients covered by TennCare plans will have new monthly screening requirements to follow starting July 1, 2016. All owners, contractors, subcontractors and providers, whether contracted or not, must be screened against the Excluded Parties List System (EPLS) and HHS-OIG List of Excluded Individuals/Entities (LEIE).

The June edition of the BlueAlert indicated that in addition to the two lists above, providers must also screen against the Social Security Master Death File (SSMDF) each month. While providers are now required to screen both the EPLS and LEIE, we received clarification that they are NOT required to screen the SSMDF. BlueCare Tennessee will continue to check the SSMDF.

Billing Claims for TennCare Enrollees with Third-Party Coverage

The billing and claims process can be confusing, especially when you have a patient who is enrolled in TennCare and also has coverage through a Commercial plan. When you provide care for patients covered by TennCare and a third-party plan, you may only collect from TennCare enrollees the copay allowed by TennCare for that service. TennCare enrollees should not be billed for any commercial insurance copays, coinsurance or deductible amounts. This is true even if the third-party payer is paying in full for the service and TennCare is making no payment. Your office should bill the third-party insurer before billing TennCare.

Visit the following links to learn more about:

- Third-Party Copays and Deductibles, Managed Care Contractors and Provider Responsibilities
- When a Provider May Bill a TennCare Enrollee

Prior Authorization Required for Asthma/COPD Combination Inhalers

TennCare's Pharmacy Benefits Manager (PBM), Magellan Health Services, requires prior authorization (PA) for asthma/COPD combination inhalers: Advair, Breo, Dulera, and Symbicort. If you have questions or need to request prior authorization for BlueCare and TennCare*Select* members related to any of these medications, please contact Magellan Health Services Clinic Call Center at 1-866-434-5524 or fax request to 1-866-434-5523.

Click here for TennCare's Preferred Drug List (PDL). Drugs requiring prior authorization are identified by (PA).

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Case Management Program Helps Your Patients Stay Out of ER

Emergency room (ER) utilization by patients who are not experiencing emergency health situations is expensive and makes it harder to coordinate care between physicians. BlueCross' Medicare Advantage (MA) ER Case Management program educates members about proper use of the ER and encourages them to see primary care physicians when they need care that is not urgent.

The program focuses on our MA members who have visited the ER three times or more in the past 90 days. We

help these members make appropriate decisions regarding their health care, assist them with connecting to their primary care physician and partner with the primary care physician to create a plan of care to help these members achieve their goals.

How you can help

We need your help to encourage our MA members to use this resource that's included in their health plan at no extra cost. Lower ER utilization means lower costs for your patients and increase emergency availability during truly urgent situations – as well as care that is better coordinated by their primary care physician. For more information about this program, call 1-800-611-3489.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Reminder: BlueAccess Improvements Coming Soon

Providers using the Quality Care Rewards application on BlueAccess to submit attestations and provider assessments, review quality metrics and monitor open gaps in care will soon see the following new features:

- Unified Provider View – Selecting a contract and provider will now allow you to view all quality program data in the same session across all programs in which you are enrolled.
- Improved Navigation – A new tabbed layout allows for easy switching between member rosters and quality programs.
- New Filter Options – Typing in the search field on a member roster view allows for easy filtering by available data elements.
- Program and Attribution Information – Member rosters will now include the reason for a patient attribution to a particular provider as well as all programs under which they are covered.
- Practice Notes – Users can enter free-form notes to track member details not otherwise documented in other data entry fields.

These changes will launch mid-to-late third quarter. Resource materials and reference guides will be updated to guide users through the new application features. If you have questions about these changes, you may contact your Quality Care Rewards field staff, your Regional eBusiness Marketing Representative, or the eBusiness Service Center.

Help Your Patients Earn Rewards by Completing Annual Wellness Exams

In 2016, new and existing BlueAdvantage members can earn a reward for completing an annual

wellness exam. Existing members must also complete the annual wellness exam to qualify for additional rewards for preventive screenings like mammograms and colonoscopies.

IMPORTANT: For your patients to earn these rewards, you must file a claim for an annual wellness visit using one of the following codes: **G0402, G0438, G0439, 99387, 99397, 99342, 99385, 99395, 99386, 99396.**

You can find additional incentive eligibility criteria on the BlueCross Quality Care Rewards web page.

Note: The annual wellness exam is a calendar-year benefit, which means each member is entitled to one exam in 2015, one in 2016, etc. regardless of the number of days between each exam. **It is not necessary to wait 365 days between exams.**

Help Us Help You - Host a Diabetic Retinal Eye Exam Day

Do you have diabetic patients who need diabetic retinal eye exams? BlueCross can help. We partner with HealPros to provide mobile diabetic retinal eye exams for BlueAdvantage members.

Our health partner will bring diabetic retinal eye equipment to your office, making it convenient to get patients' blood sugar, kidney function and retinal eye screenings completed in one visit. Interested? Contact Carmen LeVally at BlueCross at (423) 535-8325.

Need help scheduling patients? Our Member Outreach team can schedule your attributed diabetic Blue Advantage patients. Just let us know if you'd like assistance with scheduling when you inquire about an eye exam day at your practice.

All Your BlueAdvantage Patients Have a Free Fitness Membership

BlueCross BlueShield of Tennessee includes a SilverSneakers℠ fitness benefit with all BlueAdvantage plans. SilverSneakers provides full access to

more than 13,000 fitness facilities like the YMCA across Tennessee and nationwide. Your patients can stay active on their own or participate in fitness classes led by certified SilverSneakers instructors.

Sometimes seniors who haven't been physically active think it will be too difficult to start, or think they're not in good enough shape, but there's a spot for everyone in SilverSneakers. Their certified instructors work specifically with seniors and can customize their recommendations for anyone, even patients who use wheelchairs.

Take a few minutes to talk to your patients about the importance of physical activity. Ask if they have any questions about starting or maintaining a fitness program, and encourage them to visit www.silversneakers.com or call 1-866-584-7389 for more information.

Educational materials for members are available for in-office distribution and can be found on the BlueCross Quality Care Rewards web page.

Fall Prevention Key to High Quality of Life for Seniors

One out of three older adults fall each year, and many older adults don't know they have balance problems because symptoms are often mild or seem unrelated. Because even a minor fall can be serious, please take a moment to talk to your patients about fall prevention and what they can do to make sure their homes are safe environments.

Fall prevention tips:

- Remove loose rugs from the floor.
- Add non-skid surfaces in the shower.
- Remove clutter, especially in hallways.
- Move electrical cords that run across the floor.
- Maintain good lighting, especially in stairwells and halls.
- Install handrails near the toilet, tub and stairways.
- Move things on high shelves to lower ones.
- Wear shoes in the house instead of slippers or bare feet.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your **CAQHProView™ profile is kept up to date at all times. We depend on this vital information.**

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386 العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Nguơi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

***Changes will be included in the appropriate 3Q or 4Q 2016 provider administration manual update.**

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or press 1. Then press 1 again if you are a provider and follow the prompts to reach **Network Contracts or Credentialing** to update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
ECF CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

PROVIDER NEWS FLASH

of Tennessee

Bluealert

September 2016

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Oct. 8, 2016

- **Endothelial Function Assessment (New)**
- **Home Pulse Oximetry (Revision)**
- **Genetic Testing for Epilepsy (Revision)**
- **Nonoperative Diagnostic Spinal Ultrasound (Echography/Sonogram) (Revision)**

Effective Nov. 23, 2016

- **Brentuximab Vedotin (Revision)**
- **Spinal Cord Stimulation and Peripheral Subcutaneous Field Stimulation for the Treatment of Pain (Revision)**

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee **Health Care Practice Recommendations** have been revised. A **2015 ACC/AHA/SCAI Focused Update** has been added to the **2013 Guideline for ST-Elevation MI**. This and other updates can be viewed in their entirety on the company website at http://www.bcbst.com/providers/hcpr/ . Paper copies of any clinical practice guideline can be obtained by calling 1-800-924-7141, ext. 6705.

All Blue 2016 Workshops

You still have time to register for our annual All Blue Workshops:

Johnson City	Sept. 14
Knoxville	Sept. 15
Memphis	Sept. 21
Jackson	Sept. 22

Register today at http://www.bcbst.com/providers/workshops/index.page.

BlueCross Updating Opioid Prescription Policy Jan. 1

BlueCross continues to support the growing national effort toward more appropriate use of opioids. Beginning Jan. 1, 2017, long-acting opioid drug therapy will require prior authorization for members with pharmacy benefits in our Commercial and Medicare Part D plans.

This requirement assists the therapeutic treatment of chronic pain and prevents misuse of opioid analgesics. Authorization is required and will be granted for patients receiving cancer treatment or those under hospice or end of life care.

In compliance with the Centers for Medicare & Medicaid Services guidelines, newly defined quantity limits on long-acting and short-acting opiates will also be implemented on Jan. 1. In addition to a set number of units per prescription for these drugs, there will be a maximum 200mg Morphine Equivalent Dose (MED) over the previous 30 days for combined opiate therapy.

We will provide additional details when the official change to the Administrative Policy is published in November.

Preventive Care Saves Lives and Saves Patients Money

Preventive care improves quality of life — in many cases, it saves lives — and helps manage health care costs. At BlueCross BlueShield of Tennessee, our approach to encouraging prevention includes a combination of data-driven and personal outreach, along with strategic partnerships. We use data insights to drive hundreds of thousands of personalized outreach contacts each year by mail, phone, email and even text message.

Because we know health care providers are an essential link, we encourage our members to establish and maintain a relationship with a primary care doctor. And we support our physician partners by providing data and education about members' needs and quality standards.

See the full editorial on preventive care by Dr. Andrea Willis, BlueCross' Sr. Vice President and Chief Medical Officer in *The Tennessean.*

Encourage Preventive Measures to Combat Flu

Flu season is upon us and as you know, it is very unpredictable and can vary in length and severity. Because flu viruses constantly change, please encourage your patients to take the appropriate preventive care measures to protect themselves.

Patients 65 and older are at greater risk for serious complications from the flu and have the option to receive the standard vaccine or a newer higher-dose vaccine. The higher-dose vaccine is 24 percent more effective for people in this age group according to *The New England Journal of Medicine*.

Please make every effort to schedule your high-risk patients to get a flu shot as early as possible for the flu season. To avoid missed opportunities for vaccination, offer immunizations during routine health care visits and hospitalizations as soon as the vaccine is available.

The following influenza immunization and reimbursement guidelines apply for BlueCross.

Commercial

- ***Vaccine and administration***
  The influenza vaccine, including intradermal is a covered benefit if offered under the member's health care plan. Verify coverage by calling our Provider Service Line†.

BlueCare or TennCare*Select*

- ***Vaccine and administration***
  - Intramuscular flu vaccine is a covered benefit for those 6 months of age and older.
  - Intradermal-administered vaccine is recommended for persons 18 through 64 years of age.

  Note: Flu vaccines are available through the Tennessee Department of Health's Vaccines for Children (VFC) Program with the exception of the intradermal-administered vaccine which is not available under VFC.

  For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m.

Medicare Advantage

- ***Intradermal vaccines***
  Covered benefit

CoverKids

- ***Vaccine and administration***
  The influenza vaccine, including intradermal is a covered benefit.

NEW REQUIREMENT: Credentialing for Nurse Practitioners and Physician Assistants*

BlueCross will soon require all nurse practitioners and physician assistants to complete the credentialing process before providing services to our members. All providers must be credentialed, even if they are employed by a physician or group contracted to provide services to BlueCross members. To begin the credentialing process, please complete the online Provider Enrollment Form. If you have questions please call us at 1-800-924-7141 and select Option 2.

Have the Member ID Number Ready When Calling Us

To improve the quality of service you receive when calling the BlueCross Provider Service Line (1-800-924-7141), you will soon notice a small change when speaking the member ID number. You will first be prompted to speak the alpha prefix portion of the ID number. The *next* prompt will ask you to speak the numeric portion of the ID. If the ID does not contain an alpha prefix, please enter an asterisk (*) on the phone keypad which will then prompt you to speak the numeric member ID.

Care Coordination and Exchange of Information

Coordination of care between Primary Care Physicians (PCP) and the Behavioral Health Care Practitioners (BHP) is critical to the well-being of the member. Individuals with mental health and substance use disorder often have poorer physical health status and outcomes, and also have significantly more gaps in care.

To support your efforts in providing the best medical care, BlueCross provides both behavioral and primary care providers with information about needed screenings and services for members. Additional resources are available for PCPs who are treating members with behavioral issues. Our PCP Consultation and Referral Line can put you in direct contact with a licensed psychiatrist when you have questions about mental health or substance abuse treatment and medications. This help line is staffed by people familiar with local resources who can arrange for care and save you or your office staff valuable time. Call 1-800-367-3403, Monday through Friday, 9 a.m. to 5 p.m. (ET).

Please Encourage Patients Not to Split Pills

Some of your patients may split their pills trying to save money by making their medications last longer. Pill-splitting can be dangerous, and it’s important for you to encourage your patients not to do it.

Pill-splitting makes it difficult for both the patient and their physician to know how much of each medication has been taken and when, making it appear the patient is non-adherent to their prescription regimen. Patients may also not have the physical dexterity to split their pills accurately, or split the wrong medication.

Not every tablet can be split safely, for example extended release medications, those with narrow therapeutic windows like lithium, warfarin and enteric coated medications. This can result in a patient receiving a sub-therapeutic or supra-therapeutic dose and can also result in an increased risk for side effects.

It is important to remind patients to continue to take their medication as prescribed to ensure maximum effectiveness.

Updated: Coming Soon – Improved Prior Authorization Process for Provider-Administered Specialty Medications

BlueCross recently communicated we are changing the way we manage select specialty medications used to treat multiple sclerosis, rheumatoid arthritis, cancer and other serious, chronic conditions in order to help ensure our members get access to medically appropriate medications as quickly as possible.

BlueCross will be working with Magellan Rx Management to facilitate the prior authorization process for provider-administered specialty medications under the medical benefit for all lines of business. Magellan Rx is expected to begin managing this process for BlueCross Dec. 1, 2016.

Just as before, you may request prior authorizations online through our secure BlueAccess portal or by phone. These direct interactions with clinical pharmacists and board-certified physicians will help ensure we get all the information required to make the most informed and timely determination possible.

Please note that after Dec. 1, 2016, we will not be able to accept prior authorization requests for specialty medications by fax. Because more detailed information is being requested through the prior authorization process, and because we want to ensure you get faster responses from us, we are requiring online or phone prior authorization submissions. For assistance submitting your authorizations online using BlueAccess, please contact your eBusiness Marketing Consultant.

The Provider-Administered Specialty Drug Lists vary by lines of business and are located online:

- **Medicare Advantage:** www.bcbst.com/providers/medicare-advantage/Medicare-Advantage-Specialty-Pharmacy-List
- **Commercial:** http://www.bcbst.com/docs/pharmacy/2017-Provider-Administered-Specialty-Pharmacy-List.pdf .
- **BlueCare Tennessee:** http://bluecare.bcbst.com/forms/Provider%20Information/2017-Provider-Administered-Specialty-Pharmacy-List.pdf

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Effective immediately, the following CPT® codes will no longer be included on the musculoskeletal pain management prior authorization list for Orthonet to review:

Codes: C1767, C1778, C1787, C1816, C1820, C1822, C1883, C1897

The deleted codes **are subject to** medical necessity review with BlueCross.

Reminder: Claim Denials Due to Incorrect Submission

Since BlueCross implemented the CMS1500 Claim Form (02/12 Version) in January 2014, we continue to have a high volume of rejections due to changes made to several boxes on the form. For help to avoid claims denials, refer to the *NUCC 1500 Claim Form Instruction Manual* by clicking here. The manual provides details for completing all boxes on the CMS1500 Claim Form.

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Out-of-area Members May Have Member ID Cards With the "Blue Choice" Product Name

Products from other Blue Plans may have the same or similar names but can vary in product types. You may see "Blue Choice" on out-of-area member ID cards (i.e., Blue Cross Blue Shield of Texas), or during eligibility and benefits verification. Out-of-area BlueChoice plans are not the same as our BlueAdvantage products, BlueChoice (HMO)SM and BlueChoice Plus (HMO)SM.

Checking for eligibility and benefits before every member visit is the most reliable way to determine whether a patient is *in* or *out of network*, or is an *out-of-area* member.

Remember, out-of-area members have access to providers through the BlueCard® Program which links participating health care providers and the independent BlueCross and or BlueShield plans across the country and around the world through a single electronic network for claims processing and reimbursement. Out-of-area benefits are determined by the member's Home Plan and are paid based on the member's eligibility, contract provisions, the provider's network status, and the maximum allowable.

For additional information regarding out-of-area benefits, please see the BlueCard Program section in the *BlueCross BlueShield of Tennessee Provider Administration Manual*.

Proof of Timely Filing

Proof of timely filing for a returned paper claim is the black and white copy of the claim with error codes listed at the top of the claim that was returned to the provider. Providers should always maintain a copy of the returned claim in case there is a question about timely filing. With new imaging technology, images of all rejected and accepted claims are maintained in our archives for future reference.

BlueCross generates the 277CA Health Care Information Status Notification (277CA) as proof of timely filing for electronically submitted claims. The 277CA supplies providers with the assigned payer claim control number of each claim received electronically. This control number should be maintained by the provider as proof of timely filing. Electronic claims submitted either directly or through a billing service/clearinghouse will automatically receive the 277CA in their electronic mailbox.

Contact eBusiness Technical Support† to learn more about retrieving your electronic reports.

Note: *Submission dates of claims filed electronically that are not accepted by BlueCross due to transmission errors are not accepted as proof of timely filing.*

Improvements to Provider Reconsideration and Appeals Process Coming Soon

It will soon be easier for providers to go through the formal process of asking BlueCross to reconsider claims outcomes or denials, and to file formal appeals when necessary. Information will be shared on our provider web pages and training is being offered through the All Blue Workshops and other venues as available. More details will be communicated in the October issue of BlueAlert.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)[SM] unless stated otherwise

Quest Diagnostics Lab Test Discontinued

As of Oct. 19, 2015, Quest Diagnostics no longer offers procedure code 86677-H. pylori serology/antibody testing. The recommended replacement tests are:
83013 - H. pylori ureau breath test, or
87338 - H. pylori antigen enzyme immunoassay (EIA), stool.

Additional information can be found on Quest's website at
http://www.education.questdiagnostics.com/insights/61 and
http://www.education.questdiagnostics.com/insights/74.

New THCII Programs Coming Soon

The State of Tennessee is continuing its development of the Tennessee Healthcare Innovation Initiative (THCII) through the expansion of its Patient-Centered Medical Home program and the development of the Tennessee Health Link.

Please refer to the State's website for more information:
https://www.tn.gov/hcfa/article/patient-centered-medical-homes
https://www.tn.gov/hcfa/article/tennessee-health-link

Additional updates will be provided in the October issue of BlueAlert.

Revenue Code 0636 Required Detailed Coding

Facilities should use the appropriate procedure/HCPCS codes when filing revenue code 0636. Providers can refer to the Uniform Billing Editor published by Optum for correct coding. Drugs filed with revenue code 0636 incorrectly will be denied.

TennCare Kids Screening Assistance Needed

In 2015, Tennessee's EPSDT screening rates dropped to an average of 71% across all age groups.

We need your help to:

- Schedule appointments and provide reminders to your patients.
- Partner with BlueCare Tennessee to conduct outreach events.
- Document all seven components of the TennCare Kids exam in the patient's medical record, including documentation of the nutritional assessment and physical activity portion of the exam.
- Bill appropriately to maximize reimbursement.
- Capitalize on opportunities during sick visits and sports physicals to perform TennCare Kids screens when possible.
- Ensure special needs members are getting their checkup.
- Bill us even if the member has other insurance. It is important that we capture the claim information. Even though you may not receive payment, claims data is collected that documents an increase in overall screening rates.

Note: Infants/toddlers should have 12 well-care checkups before their 3rd birthday. Children ages 3 through 20 should get a TennCare Kids well-care checkup every year.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Home Health Therapy Revenue Codes Added to Avoid Incorrect Denials

To reduce the number of incorrect line item denials for home health therapy evaluations, the following revenue codes have been added to easily distinguish the evaluation visit from the actual therapy services. The revenue codes for the evaluations will be reimbursed the same rate as the corresponding therapy service outlined in the provider contract agreements.

Revenue Code Additions:
Home Health Agency Physical Therapy Evaluation – 0424
Home Health Agency Occupational Therapy Evaluation – 0434
Home Health Agency Speech Therapy Evaluation – 0444

There are no authorization requirements for the evaluation services, however prior authorization *is* required on all other home health therapy services. Prior authorization requests can be submitted via:

Phone: 1-866-747-0586
Fax: 1-866-747-0587
BlueAccess: www.bcbst-medicare.com

New Part B Specialty Medications Requiring Authorization

The following Part B specialty medications will require authorization for Medicare Advantage patients as of Dec. 1, 2016.

- Actemra, Tocilizumab, J3262
- Bendeka, Bendamustine Inj., J9033
- Carimune NF, Intravenous Immune Globulin, J1566
- Cinqair, Reslizumab, J3590
- Elaprase, Idursulfase, J1743
- Entyvio, Vedoluzumab, J3380
- Flebogamma, Intravenous Immune Globulin, J7323
- Gammagard S/D (powder), Immune Globulin, J1566
- Gammaked, Intravenous Immune Globulin, J1561
- Gammaplex, Intravenous Immune Globulin, J1557
- Gel-Syn, Hyaluronan or Derivative, J7328
- Genvisc, Hyaluronan or Derivative, Q9980
- Hymovis, Hyaluronan or Derivative, C9471
- Hyqvia, Immune Globulin Infusion 10%, J1575
- Mircera (ESRD on dialysis), Methoxy polyethylene glycol-epoetin beta, J0887
- Mircera (non ESRD), Methoxy polyethylene glycol-epoetin beta, J0888
- Monovisc, Hyaluronic acid, J7327
- Mozobil, Plerixafor, J2562
- Privigin, Intravenous Immune Globulin, J1459
- Procrit/Epogen (non ESRD), Epoetin Alfa, J0885
- Simponi Aria, Golimumab, J1602
- Stelara, Ustekinumab, J3357
- Tecentriq, Atezolizumab, J9999
- Xeomin, Incobotulinumtoxin, J0588
- Yervoy, Ipilimumab, J9228

Help Your Patients Earn MyHealthPath® Rewards

Coding Requirements for Annual Wellness Exams

In 2016, new and existing BlueAdvantage, BlueChoice℠ and BlueCare Plus℠ members can earn a reward for completing an annual wellness exam (AWE). Existing members must also complete the AWE to qualify for additional rewards for preventive screenings like mammograms and colonoscopies.

IMPORTANT: In order for your patients to earn those rewards, a claim for an annual wellness exam must be filed with one of the following codes: **G0402, G0438, G0439, 99387, 99397, 99342, 99385, 99395, 99386, 99396.**

Additional incentive eligibility criteria can be found on the Quality Care Rewards website.
Note: The annual wellness exam is a calendar year benefit, which means each member is entitled to one AWE in 2015, one in 2016, etc. regardless of the number of days between each exam. **It is not necessary to wait 365 days between exams.**

BlueAdvantage Case Management Offers Social Services

In addition to clinical nurses, BlueCross Medicare Advantage Case Management has licensed social workers on staff to assist your patients who are facing barriers with their environmental, medical and behavioral health care, and who require assistance finding community resources and support services.

Our social workers can provide assistance with:

- Complicated discharge planning from acute care and post-acute care admissions.
- Medication – Information available for your patients on manufacture or foundation assistance programs, as well as application information for Low Income Subsidy (LIS), Qualified Medicare Beneficiary Program (QMB), Specific Low Income Medicare Beneficiary Program (SLMB) and Medicaid.
- Caregiving – Information about the CHOICES/Options programs and area caregiving agencies.
- Finances – Local agencies that provide emergency financial assistance to those that qualify.
- Food – Local food banks and pantries, as well as information about applying for food stamps.
- Transportation – Contact information and applications for local transportation services.
- End of life – Advanced Directive information and Appointment of Healthcare Surrogate forms.
- Support Groups – Information on local support groups.
- Vision/Hearing – Obtaining eye glasses and hearing aids.
- Dental – Information on sliding scale clinics in the patient's area.

Reminder: Submit Form CMS-2728 as Mandated by CMS for ESRD Patients

For all patients entitled to Medicare benefits with end stage renal disease (ESRD), the Centers for Medicare & Medicaid Services (CMS) requires their Form 2728 to be submitted within 45 days of the start of dialysis services. Instructions are available beginning on page four of the form.

The form can be submitted electronically through CROWNWeb, a web-based data collection system mandated by CMS to enable dialysis facilities to meet the requirements for collecting administrative and clinical data by all Medicare-certified dialysis facilities.

For more information, please contact Jennifer Cross at (423) 535-5969 or email Jennifer_Cross@BCBST.com.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Host a Screening Day for Your Patients

Do you have patients who need screenings that you can't provide in your office? BlueCross can help. Our health partners are able to provide mobile screening services for members. Mobile units offer diabetic retinal eye exams, bone density screenings, imaging services and more at your office, making it convenient for your patients to get more of their needed screenings completed at the same visit.

Interested?
Medicare Advantage: Contact Carmen LeVally at BlueCross, (423) 535-8325
Commercial: Contact: Dustin Knight, (423) 535-8153

We can schedule patients for you too
Our Member Outreach teams can help schedule these events for patients who are attributed to your office. Just let us know if you'd like assistance with scheduling when you inquire about hosting a screening day at your practice.

Important Screenings for Men's Health

According to the American Cancer Society (ACS), prostate cancer is the second most common cancer among men. However, it can often be treated successfully, especially with early detection.

Recommending prostate-specific antigen, (PSA), testing in conjunction with in-office digital rectal exams, is especially important for your male patients ages 50-69 or as early as age 40 for those with increased risk factors. ACS guidelines for screening frequencies encourage yearly testing for men with PSA levels 2.5 and above, rather than retesting every two years.

The National Committee for Quality Assurance recommends PSA screenings for men 70 and older who are clinically appropriate in accordance with the following conditions:

- There was a diagnosis of prostate cancer during the measurement year
- There was a dysplasia of the prostate diagnosis during the measurement year or year prior
- A PSA value of >4.0 during the year prior to the measurement year
- Member has been dispensed prescription for 5-alpha reductase inhibitor during the measurement year (dutasteride or finasteride--- Brand examples: Avodart, Propecia, Jalyn, Proscar)

Help increase awareness by promoting this important screening to your patients. For more information on prostate cancer, contact the American Cancer Society**.**

Annual Wellness Exams Key to Optimal Care

Preventive health maintenance starts with scheduling your patients for their annual wellness visit. Help your patients remember to take time for their yearly checkup. It is important to monitor their health and any chronic condition(s) they may have, as well as a great opportunity to make sure all their screenings are up to date.

To deliver optimal quality care, e**ncourage all patients 20 years old and older to have at least one or more preventive care visits with a primary care provider every year**. Optimal quality care includes:

- Educating your patients on the importance of regular checkups and preventive care screenings
- Documenting a visit and evidence of the following in your patient's medical record:
  - Complete history and physical exam, appropriate screenings tests, immunizations
  - BMI with height and weight clearly documented
  - Education/anticipatory guidance for nutrition, smoking cessation, alcohol and/or drug avoidance, fall prevention, birth control and spacing, physical activity and fitness, advance health directives, etc.
- Submitting claims in encounter data quickly and accurately

With your help, we can help improve overall health outcomes and deliver peace of mind through better health.

Fall Prevention Key to High Quality of Life for Older Adults

One out of three older adults falls each year and many older adults don't know they have balance problems because symptoms are often mild or seem unrelated. Because even a minor fall can be serious, please take a moment to talk to your patients about fall prevention and what they can do to make sure their homes are safe environments.

Fall prevention tips

- Remove loose rugs from the floor.
- Add non-skid surfaces in the shower.
- Remove clutter, especially in hallways.
- Move electrical cords that are running across the floor.
- Maintain good lighting, especially in stairwells and halls.
- Install handrails near the toilet, tub and stairways.
- Move things on high shelves to lower ones.
- Wear shoes in the house instead of slippers or bare feet.

Visit https://www.cdc.gov/steadi/ for provider oriented practices to help your patients prevent dangerous falls.

Heart Healthy Benefits for BlueAdvantage and BlueChoice Members

Heart health is critically important and BlueCross provides benefits to your BlueAdvantage and BlueChoice patients designed to keep them 'heart healthy'. Talk to them about the importance of physical activity and let them know about SilverSneakers®, a free gym membership that is included with their BlueAdvantage Health Plan. SilverSneakers has hundreds of participating locations across Tennessee.

In addition to physical activity, reminding your patients about taking steps to make sure their blood pressure is under control and maintaining adherence with their prescriptions for conditions like high cholesterol or hypertension, can help boost your Quality Rewards scores.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQHProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386

العربية *(Arabic);* Bosanski *(Bosnian) ;* كوردی — بادینانی *(Kurdish-Badinani);* كوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

***Changes will be included in the appropriate 3Q or 4Q 2016 provider administration manual update.**

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or press 1. Then press 1 again if you are a provider and follow the prompts to reach **Network Contracts or Credentialing** to update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
ECF CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard

Benefits & Eligibility	**1-800-676-2583**
All other inquiries	**1-800-705-0391**

Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage	**1-800-841-7434**
BlueAdvantage Group	**1-800-818-0962**

Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

PROVIDER NEWS FLASH

of Tennessee

BlueAlert

October 2016

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Nov. 12, 2016

- **Botulinum Toxin (Revision)**
- **Genetic Testing for Mental Health Conditions (Revision)**
- **Microwave Tumor Ablation (Revision)**
- **Multi-gene Expression Assay for Predicting Recurrence in Colon Cancer (Revision)**
- **Noninvasive Techniques for Evaluation and Monitoring of Chronic Liver Diseases (New)**
- **Positron Emission Tomography (PET) for Oncologic Applications (Revision)**

Effective Nov. 23, 2016

Erythropoiesis-Stimulating Agents (ESAs) (Revision)
Rituximab (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Serum Biomarker Tests for Multiple Sclerosis – This medical policy will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued. This particular test is no longer commercially available and no CLIA labs have plans to develop a new test of this type.

Link to policy: http://www.bcbst.com/mpmanual/Serum_Biomarker_Tests_for_Multiple_Sclerosis_MS.htm

Improved Provider Reconsideration and Appeals Process Now in Effect*

It is now easier for providers to go through the formal process of asking BlueCross to reconsider claims outcomes or denials, and to file formal appeals when necessary. An overview of the new process and all applicable forms are located online at http://www.bcbst.com/providers/forms/reconsideration-and-appeals.shtml.

At a Glance:
Providers may first request reconsideration if dissatisfied with a claims outcome, or if they simply need to ask questions about a particular claim. Reconsiderations must be requested and completed using the **Provider Reconsideration Form** before filing a formal appeal.

If dissatisfied after reconsideration, providers may use the **Provider Appeals Form** to file an appeal to formally dispute the denial and provide additional documentation to BlueCross.

Support Materials:
A helpful guide offers more details and guidance about when and how to request reconsiderations or appeals. Depending on the line of business, there are some variances in the processes which are outlined in this guide.

Reminder: Utilization Management - Options for Denials

Providers who receive a Utilization Management denial may either request a peer-to-peer call with a BlueCross BlueShield of Tennessee medical director to discuss the case **or** a chart review by a specialty-matched reviewer (a standard appeal).

If the case remains denied after a peer-to-peer call with one of our medical directors, providers may also request a standard appeal. These options are applicable to all lines of business. Please refer to the BlueCross provider administration manuals for information on how to initiate peer-to-peer calls with our medical directors and how to file a standard appeal.

BlueCross Updating Opioid Prescription Policy Jan. 1, 2017

BlueCross continues to support the growing national effort toward more appropriate use of opioids. Beginning Jan. 1, 2017, long-acting opioid drug therapy will require prior authorization for members with pharmacy benefits in our Commercial and Medicare Part D plans.

This requirement assists the therapeutic treatment of chronic pain and prevents misuse of opioid analgesics. Authorization is required and will be granted for patients receiving cancer treatment or those under hospice or end of life care.

In compliance with the Centers for Medicare & Medicaid Services guidelines, newly defined quantity limits on long-acting and short-acting opiates will also be implemented on Jan. 1. In addition to a set number of units per prescription for these drugs, there will be a maximum 200mg Morphine Equivalent Dose (MED) over the previous 30 days for combined opiate therapy.

To view the new Administrative Policies on the use of opioids in control of pain, please see http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm.

Be Prepared for the 2016 – 2017 Flu Season!

It is important that you take the appropriate preventive care measures to protect your patients during this time of year. Please educate all patients or parents of children older than 6 months of age on the importance of getting a yearly flu vaccine.

Because patients 65 and older are at greater risk for serious complications from the flu, they have the option to receive the standard vaccine or a newer higher-dose vaccine. The higher-dose vaccine is 24 percent more effective for people in this age group according to *The New England Journal of Medicine*.

Please make every effort to schedule your patients that are high risk to get a flu shot as early as possible for the flu season. To avoid missed opportunities for vaccination, offer immunizations during routine health care visits and hospitalizations once the vaccine is available.

The following influenza immunization and reimbursement guidelines apply for BlueCross.

Commercial

- ***Vaccine and administration***
  The influenza vaccine, including intradermal is a covered benefit if offered under the member's health care plan. Verify coverage by calling our Provider Service Line†.

BlueCare Tennessee

- ***Vaccine and administration***
  Intramuscular flu vaccine is a covered benefit for those 6 months of age and older.

  Intradermal-administered vaccine is recommended for persons 18 through 64 years of age.

  Note:
  - Flu vaccines are available through the Tennessee Department of Health's Vaccines for Children (VFC) Program for children 18 years of age and younger. The intradermal-administered vaccine is not available under VFC.
  - For BlueCare or TennCare*Select* bill procedure code 90674 for the vaccine Flucelvax for dates of service on, or after Aug. 1, 2016.

For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m.

Medicare Advantage

- ***Intradermal vaccines***
  Covered benefit

CoverKids

- ***Vaccine and administration***
  The influenza vaccine, including intradermal is a covered benefit.

Note: For all lines of business, except BlueCare or TennCare*Select*, bill procedure code 90749 for dates of service through Dec. 31, 2016.

Behavioral Health Predeterminations

With BlueCross BlueShield of Tennessee contracting directly for behavioral health services for Commercial and Medicare Advantage networks, behavioral health providers can now obtain a predetermination form for behavioral health services on our website at http://www.bcbst.com/providers/forms/Commercial_Predetermination_Request_RE.PDF

Please fax the completed form to: (423) 591-9091 or mail to:

BlueCross BlueShield of Tennessee
Predetermination/ODM
1 Cameron Hill Circle, STE 0014
Chattanooga, TN 37402-0014

Coming Soon – Improved Prior Authorization Process for Provider-Administered Specialty Medications

BlueCross began communicating in August the way we manage certain provider-administered specialty medications would be changing.

BlueCross will be working with Magellan Rx Management to facilitate the prior authorization process for provider-administered specialty medications under the medical benefit for all lines of business. Magellan Rx will begin managing this process for BlueCross Dec. 1, 2016.

Just as before, you may request prior authorizations online through our secure BlueAccess℠ portal or by phone. These direct interactions with clinical pharmacists and board-certified physicians will help ensure we get all the information required to make the most informed and timely determination possible.

Please note that after Dec. 1, 2016, we will not be able to accept prior authorization requests for specialty medications by fax. Because more detailed information is being requested through the prior authorization process, and because we want to ensure you get faster responses from us, we are requiring online or phone prior authorization submissions. For assistance submitting your authorizations online using BlueAccess, please contact your eBusiness Marketing Consultant.

The Provider-Administered Specialty Drug Lists vary by lines of business and are located online:

- **BlueCare Tennessee:** http://bluecare.bcbst.com/forms/Provider%20Information/2017-Provider-Administered-Specialty-Pharmacy-List.pdf
- **Commercial:** http://www.bcbst.com/docs/pharmacy/2017-Provider-Administered-Specialty-Pharmacy-List.pdf
- **BlueCare Plus (HMO SNP)℠:** http://bluecareplus.bcbst.com/docs/2017/BlueCarePlus-Specialty-Pharmacy-List.pdf
- **Medicare Advantage:** http://www.bcbst.com/providers/medicare-advantage/Medicare-Advantage-Specialty-Pharmacy-List.pdf

Utilization Management Guidelines Updates/Changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming changes to select Utilization Management (UM) Guidelines. These upcoming changes to the UM Guidelines can be viewed on the Utilization Management Web page.

Effective Nov. 23, 2016
The following Utilization Management Guideline related to Ambulatory Care will be updated:

- Hyperbaric Oxygen

Note: This effective date also applies to BlueCare Tennessee pending state approval.

Providers are Encouraged to Review Reimbursement Guidelines for Bilateral Procedures in the Provider Administration Manuals

The maximum allowable for eligible bilateral procedures billed for the same patient, on the same date of service and by the same provider will be based on the bilateral procedure indicator published by Medicare in the *National Physician Relative Value Fee Schedule* and/or program memorandums/transmittals. These documents can be found online at www.cms.gov. Bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. Only one (1) unit should be reported. Inappropriate billing or use of modifier 50 may result in incorrect or delayed reimbursement. Incorrect billing is subject to review.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Clinical Information Required for Prior Authorization Requests

When submitting Commercial prior authorization requests, please provide clinical information at the time of the request including, but not limited to: CPT® code, ICD-10 diagnosis code and appropriate medical documentation. This information is used to help determine the appropriate response to the request for prior authorization. If complete clinical information is available on the initial call, fax or web submission, the authorization can be completed without delay.

Reminder: Credentialing Soon Required for Nurse Practitioners and Physician Assistants

BlueCross will soon require all nurse practitioners and physician assistants to complete its credentialing process before providing services to our members. These providers must be credentialed even if they are employed by a physician or group that is contracted to provide services to BlueCross members. To begin the credentialing process, please complete the online Provider Enrollment Form.

If you have questions, please call us at 1-800-924-7141 and select "Contracting and Credentialing."

Reminder: DME and Supplies with Place of Service 11

Providers are reminded that certain durable medical equipment (DME) items and medical supplies allow $0.00 reimbursement when billed with the place of service (POS) 11. These items such as syringes, gauze, tape, etc. are not separately reimbursed if incident to a physician's service.

Additional information is available on the Centers for Medicare & Medicaid Services (CMS) website, https://www.cms.gov/.

Note: Physicians are not eligible for DME contracts but can bill for DME services under their physician contract.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

Population Health Management Offers Quality and Effective Coordination of Care

Population Health Management offers quality and effective coordination of care for members with complicated care needs, chronic illnesses, and catastrophic illnesses or injuries. We use referrals, claims, health risk assessments and other sources to identify members for specific programs based on risk, rather than disease-specific categories. Activities include behavioral and physical health and, when appropriate, are integrated with CHOICES care coordination processes.

Our clinical teams empower members regarding health care decisions, member education on health conditions and options, and provide the tools and resources necessary to assist the member and family when making health care decisions. (CHOICES services are not available to CoverKids members.)

To refer your patients to a Population Health Management program, please call 1-888-416-3025.

Free EPSDT and Coding Program Training Can Help Reduce Costs and Improve Quality

The Tennessee Chapter of American Academy of Pediatrics (TNAAP) offers free EPSDT and Coding Program training and educational resources. These programs can help your practice:

- Improve the quality of preventative health screens you perform
- Optimize reimbursement
- Reduce administrative costs
- Improve audit outcomes
- Assist with pediatric coding issues for both general and specialty practices

Educational training programs are available at individual practices with customized topic-specific sessions. TNAAP also offers annual EPSDT and Coding Update Trainings in each region of the state.

To learn more about their many educational opportunities, please visit the TNAAP website at http://tnaap.org/coding.

TennCare Changes Rules for DME Definition*

The Bureau of TennCare made changes to the rules and definitions for Durable Medical Equipment (DME) that became effective Sept. 28, 2016. The changes make it easier for a patient to receive DME at their home, but clarified that a hospital or skilled facility does not meet the definition of a patient's home for DME purposes. Additionally, DME provided to a member in a hospital or nursing facility that is covered as part of the per diem is not covered or reimbursable under Medicaid.

For more details and information, please see Tennessee Rules and Regulations 1200-13-13 and the complete TennCare standard.

Accepting Alternative DME Requires Physician Order

Most providers are aware that an authorization request for durable medical equipment (DME) or service must also include a doctor's order. Sometimes a specific DME is denied because there is an alternative lower cost option for the DME that will work just as well for the patient. **The alternate DME will also require a doctor's order.** If you choose to accept the alternate DME option, please make sure to:

- Withdraw the original DME request.
- Submit the request to accept the alternate DME.
- Include a new doctor's order for the alternate DME.

Following these steps will help ensure your patient receives the equipment or service they need as quickly as possible.

Key Changes to Home Health Critical Incident Reporting

A Home Health Critical Incident includes significant events involving a BlueCare Tennessee and CoverKids member that is receiving authorized home health services. This includes both CHOICES and non-CHOICES members receiving home health services. However, please note that Critical Incidents for CHOICES members not relating to Home Health are handled through a different Critical Incident Process as detailed in your provider agreement.

A member's death is always considered a critical incident, regardless of whether the death occurs during the provision of home health services.

Home Health Critical Incidents include the following when they occur during the provision of Home Health Services:

Critical Incident	Example
Major or severe injury	Broken bones or severe bleeding
Life-threatening medical emergency	Heart attack or unconsciousness
Medication error	Member takes too much medicine at one time
Safety issues	Improper use of Hoyer Lift – member fell out of lift, but was not severely injured
Suspected physical, mental or sexual abuse	Agency staff hits, inappropriately touches, yells at or intimidates a member
Neglect (a lack of care that could harm the member)	Worker does not bathe member for a week, or the member fell because staff member did not help member with walking
Theft	Worker stealing medication
Financial exploitation - improper use of funds	Agency staff used member's debit card for personal use

Click here to download a copy of the Home Health Critical Incident Report form.

Email completed forms to: BlueCareQOC@bcbst.com. If email is not available, please fax the form to 1-855-339-3022.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Inpatient and Physician Certification Audits

As mandated by the Centers for Medicare & Medicaid Services (CMS) beginning Dec. 1, BlueAdvantage will audit medical record documentation for valid inpatient orders and physician certification which is required for a claim to be eligible for acute inpatient DRG reimbursement.

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Requirements of an inpatient order:

- The order must specify admission for inpatient services.
- Anyone who receives a verbal order must document the verbal order in the medical record at the time it is received. The order must identify the qualified "admitting practitioner" and be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge.
- The inpatient admission order cannot be a standing order.
- Retroactive orders must be provided at or before the time of the inpatient admission. Medicare does not permit retroactive orders (inpatient order must be written before discharge.)
- The order must specify the admitting practitioner's recommendation to admit 'to inpatient,' 'as an inpatient,' 'for inpatient services,' or similar language specifying his or her recommendation for inpatient care.

For more information see the Hospital Inpatient Admission Order and Certification document on the CMS website.

Note: See Section (A) (2) for guidance regarding the definition of discharge time.

Reminder: Additional Part B Specialty Medications Requiring Authorization

The following Part B specialty medications require prior authorization for Medicare Advantage patients as of Dec. 1, 2016:

- Actemra, Tocilizumab, J3262
- Bendeka, Bendamustine Inj., J9033
- Carimune NF, Intravenous Immune Globulin, J0585
- Cinqair, Reslizumab, J3590
- Elaprase, Idursulfase, J1743
- Entyvio, Vedoluzumab, J3380
- Flebogamma, Intravenous Immune Globulin, J7323
- Gammagard S/D (powder), Immune Globulin, J1566
- Gammaked, Intravenous Immune Globulin, J1561
- Gammaplex, Intravenous Immune Globulin, J1557
- Gel-Syn, Hyaluronan or Derivative, J7328
- Genvisc, Hyaluronan or Derivative, Q9980
- Hymovis, Hyaluronan or Derivative, C9471
- Hyqvia, Immune Globulin Infusion 10%, J1575
- Mircera (ESRD on dialysis), Methoxy polyethylene glycol-epoetin beta, J0887
- Mircera (non ESRD), Methoxy polyethylene glycol-epoetin beta, J0888
- Monovisc, Hyaluronic acid, J7327
- Mozobil, Plerixafor, J2562
- Privigin, Intravenous Immune Globulin, J1459
- Procrit/Epogen (non ESRD), Epoetin Alfa, J0885
- Simponi Aria, Golimumab, J1602
- Stelara, Ustekinumab, J3357
- Tecentriq, Atezolizumab, J9999
- Xeomin, Incobotulinumtoxin, J0588
- Yervoy, Ipilimumab, J9228

Replacement Oxygen Equipment After 60 Months

Per Local Coverage Article A52514 for Oxygen and Oxygen Equipment, members may elect to have their oxygen equipment replaced after the Reasonable Useful Lifetime (RUL). The RUL for oxygen equipment is 60 months. Oxygen contents are a lifetime rental under Medicare guidelines.

If members elect to have their equipment replaced at month 61 or after, their cost share for the new equipment will begin again. Therefore, DME companies should not routinely replace equipment once the RUL has been reached.

If a request for "Replacement" oxygen equipment is received, the following documentation will be required:

- An Initial Certificate of Medical Necessity (CMN) must be obtained for the replacement equipment (repeat testing is not required). The initial date should be the date the replacement equipment is initially needed, generally understood to be the date of delivery.

Per the Affordable Care Act (ACA) sect. 6407, a face-to-face examination is required for the following equipment: E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443 and E0444. Additionally, a new face-to-face examination is required each time a new prescription for one of the specified items is ordered. Per Medicare guidelines, a new prescription is required when an item is replaced. If a replacement request is received for one of the listed items, the following documentation will be required:

- Face-to-face examination within six months prior to the order. This examination must document the beneficiary was evaluated and/or treated for a condition that supports the need for the DME item(s) ordered.

Replacement equipment will not be eligible for Administrative Approvals.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Effective Detection for Breast Cancer

Getting a high-quality screening mammogram and clinical breast exam regularly are the most effective ways to detect breast cancer early.

Breast cancer screenings are recommended every two years for women ages 50 to 74. Encourage your patients to follow your advice about frequency of breast cancer screening due to personal history and other contributing factors.

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Breast Cancer Screenings are a Covered Benefit:

BlueCare Tennessee Coverage:

- Mammography covered at least once for women ages 35 to 40.
- Every two years, or more often if medically necessary, for women ages 40 to 50.
- Each year for women who are age 50 and older.
- Mammogram screenings are free. There is no copay. BlueCare Tennessee members can call Customer Service at 1-800-468-9698 for help scheduling appointments and transportation.

Blue Advantage Coverage:

- Annual screening mammograms covered for all female Medicare beneficiaries age 40 or older.
- One baseline mammogram for female beneficiaries between the ages of 35 and 39.
- There is no deductible requirement for this benefit.

Commercial Coverage:

- For most women with private insurance, the cost of screening mammograms is covered without copayments or deductibles.
- Patients should contact their mammography facility or health plan to confirm coverage benefits.

Talk to your patients today about getting their mammograms.

Best Practice for ADHD Treatment

The American Academy of Pediatrics (AAP) Practice Guidelines for treatment of ADHD in children:

- **Primary Care Clinicians** should evaluate children 4 through 18 years of age for ADHD who present with academic/behavioral problems and symptoms of hyperactivity, inattention or impulsivity.
- Treatment recommendations vary depending on the patient's age:
  - For *preschool-aged children (4–5 years of age)*, the first line of treatment should be behavioral intervention.
  - For *school–aged children and adolescents (6–11 years of age)*, PCPs should prescribe approved medications for ADHD along with behavior therapy.
  - For adolescents (12-18 years of age), PCPs should prescribe approved medications and may prescribe behavior therapy.
- **Children initially diagnosed with ADHD and prescribed ADHD medication, or those who are restarting ADHD medication after a summer break, should receive one follow-up visit with a prescribing practitioner within 30 days of the initial visit.**
- **Children continuing on ADHD medication should have at least two visits with their prescribing practitioner within 270 days (nine months) following the 30-day visit.**

If you need assistance referring a patient covered by a BlueCross BlueShield of Tennessee plan for behavioral health services, please call 1-800-367-3403.

Smoking Cessation Drugs on the Preferred Drug List

BlueCare Tennessee encourages practitioners to prescribe products on the TennCare Preferred Drug List (PDL). Designed by the Bureau of TennCare and its pharmacy benefit manager, Magellan Health, the PDL helps improve the quality of care for your patients while reducing TennCare program drug costs.

In a continuing effort to encourage smoking cessation, this article is to remind you about cessation agents on the auto-exempt list: bupropion (Zyban), nicotine (Nicorette, Nicoderm, Commit, Nicotrol) and varenicline (Chantix) as well as other formulations of the above agents that are subject to quantity limit.

You can find the TennCare PDL at **tenncare.magellanhealth.com**. Drugs that require prior authorization are identified by (PA).

If you have questions or need to request a prior authorization for BlueCare Tennessee members related to these medications, please contact Magellan Health Services Clinic Call Center at 1-866-434-5524 or fax a request to 1-866-434-5523.

Deaf Health Initiative Advocating Awareness and Offering Support

Hearing loss is the third most common chronic condition behind diabetes and heart disease. In America, nearly one in five individuals over the age of 12 has hearing loss in one or both ears and the number only grows as we get older. One in three individuals over the age 65 is affected by hearing loss.

Deaf Health Initiative is an organization advocating awareness to help eliminate communication barriers to deaf and hard-of-hearing individuals in the health care setting.

See the Deaf Health Initiative website to learn how you can help improve communication with your deaf and hard-of-hearing patients at your workplace.

Additionally, DeafMD.org has a variety of videos available that include explanations of diseases, tests and procedures.

DeafMD.org
Health Education in American Sign Language

Help Your Patients Earn MyHealthPath® Rewards®

Coding Requirements for Annual Wellness Exams

In 2016, new and existing BlueAdvantage, BlueChoice and BlueCare Plus members can earn a reward for completing an annual wellness exam (AWE). Existing members must also complete the AWE to qualify for additional rewards for preventive screenings like mammograms and colonoscopies.

IMPORTANT: For your patients to earn those rewards, a claim for an annual wellness exam must be filed with one of the following codes: **G0402, G0438, G0439, 99387, 99397, 99342, 99385, 99395, 99386, 99396.**

Additional incentive eligibility criteria can be found on the Quality Care Rewards website.

Note: The AWE is a calendar year benefit, which means each member is entitled to one AWE in 2015, one in 2016, etc. regardless of the number of days between each exam. **It is not necessary to wait 365 days between exams.**

Reminder: Provider Bonus for Prenatal/Postpartum Care

BlueCare Tennessee and CoverKids now offer a $10 Prenatal/Postpartum Incentive Program that allows providers to receive a bonus incentive when submitting Category II code 0500F with the following specifications:

- Include the date of the last menstrual period (LMP) on your claim submission
- Send a completed Maternity Notification form via web or fax, **and**
- Bill with the appropriate E&M code within 30 days of the visit that confirmed the pregnancy

BlueCare Tennessee and CoverKids will pay providers a $10 bonus incentive when submitting Category II code 0503F with the following specifications:

- Include the date of delivery on your claim submission
- Postpartum visit must occur within 21-56 days after delivery, **and**
- Bill with the appropriate postpartum visit procedure code

Additionally, BlueCare Tennessee and CoverKids will reimburse separately for insertion of Intrauterine Device (IUD) (procedure code 58300) when performed at the time of delivery.

If you have questions or would like more information about this new bonus, please call our Provider Service Lines:

- BlueCare℠ Providers: 1-800-468-9736
- TennCare*Select* Providers: 1-800-276-1978
- CoverKids Providers: 1-800-924-7141

New THCII Program – Tennessee Health Link*

The State of Tennessee is continuing its growth of the Tennessee Healthcare Innovation Initiative (THCII) through the development of the Tennessee Health Link (THL). The State is working with providers to improve integrated and value-based behavioral and primary care services for people with Severe and Persistent Mental Illness through the THL. THL providers have been selected and the program is expected to launch Dec. 1, 2016. More information will be shared on the provider web pages at www.bcbst.com/providers in the coming weeks.

Please refer to the State's website for details on the THL and the Patient-Centered Medical Home program, which is expected to launch in early 2017:
https://www.tn.gov/hcfa/article/patient-centered-medical-homes
https://www.tn.gov/hcfa/article/tennessee-health-link

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQHProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386

العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

***Changes will be included in the appropriate 3Q or 4Q 2016 provider administration manual update.**

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or press 1. Then press 1 again if you are a provider and follow the prompts to reach **Network Contracts or Credentialing** to update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
ECF CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail**: eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

PROVIDER NEWS FLASH

of Tennessee

Bluealert

November 2016

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Dec. 10, 2016

- **Bio-Engineered Skin and Soft Tissue Substitutes (Revision)**
- **Intravenous Immune Globulin (IVIG) Therapy (Revision)**
- **Nerve Graft Prostatectomy (Revision)**
- **Subcutaneous Immune Globulins (New)**

Effective Dec. 21, 2016

- **Nivolumab (Revision)**
- **Transcranial Magnetic Stimulation (TMS) (Revision)**

Note: These effective dates also apply to BlueCare Tennessee pending State approval.

ICD-10 Coding Requirements

BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) guidelines for ICD-10 coding. On Oct. 1, 2016, the grace period ended, now requiring the highest level of ICD-10 coding specificity. Claims submitted without this coding requirement will be denied. See the CMS website at www.cms.gov for additional information on ICD-10 coding guidelines.

NDC Required for All Provider-Administered Medications

Provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format must include the National Drug Code (NDC) of the drug(s) administered, along with the quantity and unit. The NDC has been required on all CMS-1500 claims for provider-administered medications for all lines of business since Jan. 1, 2014.

The qualifier code **N4** (NDC) or **ZZ** (Narrative description of unspecified code) and a description of supplemental information must be entered in the **shaded** lines of Block 24 in the CMS-1500 form. To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

The following qualifiers are to be used when reporting NDC units:

- **F2** International Unit
- **ME** Milligram
- **ML** Milliliter
- **GR** Gram
- **UN** Unit

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N450242006001 ME1.25 ZZ Avastin														1B	12345678901
10	01	05	10	01	05	11		J1563		13	500 00	20	N	NPI	0123456789

Please note, submitting claims without the appropriate NDC could delay your reimbursement payments.

Non-Discrimination Notice*

BlueCross BlueShield of Tennessee participating providers, through their contracts with us and in compliance with existing federal and state laws, rules and regulations, agree not to discriminate against members in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

Section 1557 of the Affordable Care Act (ACA) and its implementing regulations (Section 1557) prohibits "*covered entities*" from discriminating against individuals on the basis of race, color, national origin, sex, age, or disability in any health program or activity. "*Covered entities*" include health insurance issuers and health care providers that receive federal financial assistance.

Participating providers should review their respective obligations and the requirements of Section 1557 to ensure their respective compliance. Information about Section 1557 of the ACA and compliance is available from the Department of Health and Human Services at http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

Be Prepared for the 2016 – 2017 Flu Season!

It is important that you take the appropriate preventive care measures to protect your patients during this time of year. Please educate all patients or parents of children older than 6 months of age on the importance of getting a yearly flu vaccine.

Because patients 65 and older are at greater risk for serious complications from the flu, they have the option to receive the standard vaccine or a newer higher-dose vaccine. The higher-dose vaccine is 24 percent more effective for people in this age group according to *The New England Journal of Medicine*.

Please make every effort to schedule your patients that are high risk to get a flu shot as early as possible for the flu season. To avoid missed opportunities for vaccination, offer immunizations during routine health care visits and hospitalizations once the vaccine is available.

The following influenza immunization and reimbursement guidelines apply for BlueCross.

Commercial

- ***Vaccine and administration***
  The influenza vaccine, including intradermal is a covered benefit if offered under the member's health care plan. Verify coverage by calling our Provider Service Line†.

BlueCare Tennessee

- ***Vaccine and administration***
  Intramuscular flu vaccine is a covered benefit for those 6 months of age and older.

  Intradermal-administered vaccine is recommended for persons 18 through 64 years of age.

  Note:
  - Flu vaccines are available through the Tennessee Department of Health's Vaccines for Children (VFC) Program for children 18 years of age and younger. The intradermal-administered vaccine is not available under VFC.
  - For BlueCare or TennCare*Select* bill procedure code 90674 for the vaccine Flucelvax for dates of service on, or after Aug. 1, 2016.

For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m.

Medicare Advantage

- ***Intradermal vaccines***
  Covered benefit

CoverKids

- ***Vaccine and administration***
  The influenza vaccine, including intradermal is a covered benefit.

Note:
For all lines of business, except BlueCare, TennCare*Select* or CoverKids, bill procedure code 90749 for dates of service through Dec. 31, 2016, and bill procedure code 90674 for dates of service on, or after Jan. 1, 2017.

Due to concerns regarding the effectiveness of the FluMist Quadrivalent, the Centers for Disease Control and Prevention (CDC) recommends this vaccine **not** be used during the 2016 – 2017 flu season.

Help Bust Flu Shot Myths

There are several common misconceptions about the flu shot. You play an important role in making sure our members have accurate information about flu immunizations.

It might give me the flu
The flu shot cannot cause the actual flu. Randomized, double blind studies show the only difference between the flu shot and a placebo is soreness and redness at the injection point.

It will make me sick
A few people may have a low-grade fever or minor achiness, but double blind studies showed no difference in symptoms between those who received the flu vaccine and those who received a placebo.

It won't protect me
The flu shot only protects against influenza. There are several illnesses, like the common cold, that cause symptoms similar to the flu. Sometimes people develop symptoms because they are exposed to the flu before their vaccine becomes fully effective, which can take a few weeks.

Potential Side Effects for Children taking Antipsychotic Medication

Many medications used to treat younger patients with mental illness are safe and effective. In recent years, the use of antipsychotic medications has risen dramatically. Particular caution should be exercised when these medications are used due to the unknown effects on the developing brain and health risks.

A recent study in JAMA Psychiatry (August, 2016), demonstrated that those between the ages of 6 and 24 years taking antipsychotics were three times more likely than their peers to develop type 2 diabetes. The type of antipsychotic medication they took did not seem to matter. Furthermore, the risk for type 2 diabetes remained for one year after being taken off of the medication.

Use of antipsychotic medications should only be considered after an appropriate initial evaluation, consideration of the young person's general health, assessment of family health history, and consideration of or attempts to use alternative medications and therapeutic interventions.

Reminder: Improved Provider Reconsideration and Appeals Process Now in Effect

It is now easier for providers to go through the formal process of asking BlueCross to reconsider claims outcomes or denials, and to file formal appeals when necessary. An overview of the process and the two new forms are located online at http://www.bcbst.com/providers/forms/reconsideration-and-appeals.shtml.

A helpful guide offers more details and guidance about when and how to request claims reconsiderations or appeals. Depending on the line of business, there are some variances in the processes which are outlined in this guide.

Upcoming Prior Authorization Changes to Specialty Pharmacy Listing for Commercial and BlueCare Members

Certain Specialty Pharmacy drugs have not previously required prior authorization but will as of Dec. 1, 2016, the following specialty pharmacy drugs **will require** prior authorization.

Adagen®	
Aloxi®	
Aralast™, Aralast NP, Glassia, Prolastin®, Prolastin-C, Zemaira®	
Arranon®	
Botox®	
Cerezyme®	
Cuvitru™, Gammagard® Liquid, Gamunex®-C, Hizentra®and HyQvia®	
Carimune® NF, Flebogamma® 5% DIF, Gammagard® Liquid, Gammagard® S/D, Gammaplex® 5% Liquid, Gamunex®-C, Octagam® 5% , and Privigen®	
Dysport®	Orthovisc®
Elaprase®	Ozurdex®
Eligard®	Proleukin®
Euflexxa	Retisert®
Fabrazyme®	SandoSTATIN® LAR
Firmagon®	Somatuline®
Fusilev®	Supartz®
Gel-One®	Supprelin® LA
Herceptin®	Synvisc®/Synvisc® One
Hyalgan®	Testopel®
Iluvien®	Thyrogen®
Ixempra®	Torisel®
Leukine®	Trelstar®
Lupron Depot®	Vantas®
Monovisc®	Vidaza®
Mozobil®	Visudyne®
Myobloc®	Vpriv®
Myozyme®	Xeloda® (Medicare Advantage only)
Lumizyme®	Xeomin®
Naglazyme®	Xiaflex®
Nplate®	Zoladex®

NOTE: Beginning Nov. 23 through Dec. 31, 2016, providers using the web to submit prior authorization requests will not see the BlueCross medical policy criteria and should use the free form box to provide clinical rationale for their requests.

The Provider-Administered Specialty Drug Lists vary by lines of business and are located online. The websites below will provide information on **all** provider administered specialty medications requiring prior authorization.

- **BlueCare Tennessee**
- **Commercial**
- **BlueCare Plus (HMO SNP)SM**
- **Medicare Advantage**

BlueCross to Change Opioid Prescription Policy Jan. 1, 2017

Now Accepting Prior Authorization Requests

BlueCross continues to address the growing national effort toward more appropriate use of opioids. Earlier this year, BlueCross made a policy change requiring your patients who are new to long-acting opioid pain medication therapy and covered by BlueCross Commercial plans to have prior authorization (PA) for these drugs. To further promote prescription safety, BlueCross is making other significant changes that will go into effect in January.

Opioid Prescription Policy Changes Effective Jan. 1, 2017
(Applies to your patients with BlueCross Commercial, BlueAdvantage(PPO)℠, BlueChoice(HMO)℠ and BlueCare Plus(HMO SNP)℠ plans)
Prior authorization required for all long-acting opioid prescriptions
Quantity limits for both short-acting and long-acting opioids prescriptions
The combined morphine equivalent dose (MEqD) of all prescriptions cannot exceed 200mg/day
Note – Opioid treatment for members in hospice care or undergoing cancer treatment will receive approval, but still require a prior authorization request.

To view the policies in their entirety on the Use of Opioids in Control of Chronic Pain, see the Administrative Services page of the *BlueCross BlueShield of Tennessee Medical Policy Manual*.

Now Accepting Prior Authorization Requests for Jan. 1 Effective Dates
For your patients taking long-acting opioids, and for whom you expect to need the medicines in January, you may request the prior authorization for a Jan. 1 effective date now. The maximum length of a prior authorization for long-acting opioid is six months. **When you make your request, please specify that the request is for prescriptions obtained on or after Jan. 1, 2017.**

How to Obtain Prior Authorization

- For your patients with **BlueCross Commercial** plans, please call 1-877-916-2271 or fax your request to 1-800-837-0959.
- For your patients who are covered by **BlueAdvantage, BlueChoice℠** or **BlueCare Plus** plans, please call 1-844-648-9628 or fax your request to 1-877-328-9799.

Reminder: Refer Your Patients with BlueCross Plans to Network Providers

Our members get the most from their health benefits when they visit participating network providers. As one of our network providers, please remember you are contractually obligated to refer your patients with BlueCross BlueShield of Tennessee health insurance plans to contracted network providers. This is especially important when referring our members to hospitals, for lab work, DME and any other ancillary service. Our "Find a Doctor" tool on bcbst.com can be used to easily locate other participating network providers. Genetic testing not performed by a network provider requires prior authorization, and other out-of-network services may require review.

Reminder: Credentialing Required for Nurse Practitioners and Physician Assistants*

BlueCross is requiring all nurse practitioners and physician assistants to complete the credentialing process before providing services to our members. Nurse practitioners and physician assistants must be credentialed by Jan. 1, 2017, even if they are employed by a physician or group that is contracted to provide services to BlueCross members. Begin the credentialing process by completing the online Provider Enrollment Form.

Reminder: Billing for Medication Wastage from a Single Dose Vile (SDV)*

Effective Jan. 1, 2017, a JW modifier (*Drug amount discarded/not administered to any patient*) will be required to bill any unused drugs or biologicals from SDVs or packages. This requirement is in accordance with the Centers for Medicare & Medicaid Services (CMS) Change Request (CR) 9603 and related Transmittal R3538CP.

BlueCross will continue to follow CMS published guidelines for billing medication wastage from a SDV. The guidelines are found in both the BlueCross BlueShield of Tennessee and the BlueCare Tennessee provider administration manuals and are as follows:

- Documentation of wastage in the medical record is expected.
- **The Provider is responsible for using the most economical packaging of medication to achieve the required dosage with the least amount of medication wastage necessary.**
- Instances of medication wastage from a SDV should be submitted on a single line item with the JW modifier appended to the appropriate HCPCS Level II code.
- The number of units billed for the SDV with specific HCPCS codes with the JW modifier is inclusive of both the administered and discarded amounts.
- The number of units should be reported as one (1) for unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes billed with the JW modifier appended and dosage administered/wastage should be reported as supplemental information.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)[SM] unless stated otherwise

Opioid Prescription Risk Reports Now Available Online for BlueCare Providers

BlueCare Tennessee is promoting opioid prescription safety by showing providers their opioid prescribing patterns through a comprehensive online report.

The Risk Identification and Mitigation (RIM) report is an online tool that will offer BlueCare Tennessee providers a deeper insight into the opioids they prescribe, the levels and frequency at which they provide them and how their prescribing patterns compare to other providers in their specialty across the state, as well as their patients who might be at risk when taking opioids.

BlueCare Tennessee providers who prescribe a minimum of six prescriptions during the previous 90 days can access their personalized report through the secure provider section of our website. The report is available through the **BlueAccess** home page under the heading **RxSafetyTN** by clicking the link **Pain Medication & Care Improvement Program**.

Last Chance to Enroll in TennCare EHR Provider Incentive Program

Program Year 2016 is the final year in which providers and facilities can begin participation in the Medicaid Electronic Health Record (EHR) Incentive Program. The Centers for Medicare & Medicaid Services (CMS) has set a deadline of midnight Dec. 31, 2016, to enroll in this program.

Benefits of program participation include:

- Eligible providers can receive up to $63,750 for full participation in the program.
- Achieve measurable improvements in patient health care delivery and outcomes through the use of Certified EHR Technology.

Check Your Eligibility
To see if you are eligible, check the CMS Eligibility Wizard. If you have other questions about program eligibility, please contact TennCare.EHRIncentive@tn.gov.

Get Started
To register and get started with your 2016 Program Year attestation, please visit https://ehrincentives.cms.gov/hitech/login.action.

Give the Program Another Try
Some providers stopped attesting because they felt meeting Meaningful Use (MU) was too difficult. CMS heard you and MU requirements have changed. Whatever reason caused you to stop attesting, the State would like to help you get back on track. Send an email to TennCare.EHRIncentive@tn.gov.

More Details
For more information about the incentive program, please visit the CMS or Bureau of TennCare websites.

Sick Visits are a Good Opportunity for a TennCare Kids Checkup

Any time a child (patient under age 21 years) with TennCare Kids coverage is in your office, review their medical records to make sure they've had their scheduled checkups. A sick visit may be the only opportunity you or the child will have for a checkup. TennCare Kids services provided should be documented during the office visit as appropriate for age, condition, new patient, established patient, and newborn.

When appropriate and occurring on the same date of service, you can be reimbursed for both a "sick" and well-visit exam. Please see the TennCare Kids Billing Guidelines section of *BlueCare Tennessee Provider Administration Manual* for the correct modifier usage.

Tennessee Health Link and PCMH Programs

The State of Tennessee is continuing its growth of the Tennessee Healthcare Innovation Initiative (THCII) through the development of the Tennessee Health Link (THL) and expansion of the Patient-Centered Medical Home (PCMH) model. The State is working with providers to improve integrated and value-based primary care services for all members and behavioral health services for members with the highest behavioral health needs. The THL will launch statewide Dec. 1, 2016. Expanded PCMH will launch Jan. 1, 2017, for 20-30 primary care provider groups who volunteered to be in the first wave of implementation, with additional opportunities in future years.

Please refer to the State's website for details on the THL and the PCMH programs:
https://www.tn.gov/hcfa/article/patient-centered-medical-homes
https://www.tn.gov/hcfa/article/tennessee-health-link

Provider Bonus Reminder

As of Aug. 1, 2016, BlueCare Tennessee OB/GYN providers are eligible to earn a $10 bonus for specific Category II codes for maternity care.

In order to make the submission process easier we'd like to provide a few tips on this initiative.

When Submitting 0500F remember:

- Include the appropriate Evaluation & Management (E&M) Code (99201-99205 or 99211-99215) confirming pregnancy. **Please submit this claim within 30 days of the visit**. *(Filing the E&M Code will not deter payment.)*
- You must submit at least $10 billed charges to receive the full bonus.
- Submit the Maternity Care Management Notification Form through BlueAccess or fax to (423) 854-6033.

When Submitting 0503F remember:

- Include postpartum code 59430. *(No Additional payment will be made for 59430, this is included in Global OB charges)*
- You must submit at least a $10 billed charge to receive the full bonus.

Reminder: Review Rule Changes for Reporting BlueCare Member Deaths

Providers are required to report all patient deaths if they involve a BlueCare Tennessee member under the age of 21 years or the unexpected death of a member who is **not** receiving home health services. Deaths should be reported as soon as possible using the Death of Member Notification Form.

A member death consistent with the medical diagnosis and prognosis would be considered an expected death. Providers should use the following criteria to determine if the death of the member is unexpected:

- **Accidental**
- **Not anticipated**
- **Suicide**
- **Mistreatment**
- **Homicide**

Reporting the Death of a Member Receiving Home Health Services
These deaths should be reported using the Home Health Critical Incident Form, **even if the member was not receiving care at the time of death**. Complete reporting guidelines and definitions are included in the *BlueCare Tennessee Provider Administration Manual*.

Please submit all forms relating to the death of a BlueCare Tennessee member by email to: BlueCareQOC@bcbst.com. If email is not available, you may fax forms to 1-855-339-3022.

Reminder: Submitting Corrected Bills

When submitting a corrected bill to BlueCare Tennessee, here are a few reminders to help with the process.

- You have 120 days from the date of remittance on the original claim to submit a corrected bill.
- The date used for timely filing purposes remains the remit date of the original claim and not the correction or adjustment remit date.
- Processed claims (received on your Remittance Advice) that were paid incorrectly due to an error or omission should be filed as a "Corrected Bill."
- Only submit a corrected bill if the original claim information was wrong or incomplete (Examples: additional/changed dates of service, procedure and/or diagnosis codes, units, member name, member ID number and/or charges that were not filed on the original claim.)

For all other adjustments and corrections please contact our Provider Service Lines†.

Instructions on submitting corrected bills electronically are available in the *BlueCare Tennessee Provider Administration Manual*.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Help Your Patients Earn MyHealthPath® Rewards

Coding Requirements for Annual Wellness Exams.

In 2016, new and existing BlueAdvantage, BlueChoice and BlueCare Plus members can earn a reward for completing an annual wellness exam (AWE). Existing members must also complete the AWE to qualify for additional rewards for recommended preventive screenings like mammograms and colonoscopies.

IMPORTANT: For your patients to earn those rewards, you must file a claim for an annual wellness visit with one of the following codes: **G0402, G0438, G0439, 99387, 99397, 99342, 99385, 99395, 99386, 99396.**

You can find additional eligibility criteria on the Quality Care Rewards website in the Member Wellness Incentive FAQ.

Note: The Annual Wellness Exam is a calendar year benefit, which means each member is entitled to one AWE in 2016 and one in 2017 regardless of the number of days between each exam. **It is not necessary to wait 365 days between exams.**

New Hearing Aid Benefit for BlueAdvantage and BlueChoice Members*

Beginning in January 2017, BlueCross BlueShield of Tennessee's BlueAdvantage and BlueChoice plans will offer a new hearing aid benefit through TruHearing® that includes access to some of the most advanced hearing aids on the market. Hearing aids can be prohibitively expensive for many people, especially Medicare patients and those on a fixed income. TruHearing can lower a patient's cost from an average of $2,300 per hearing aid to a copay of either $599 or $899 per aid.

If you have BlueAdvantage or BlueChoice patients with hearing loss who ask about hearing aids, please refer them to TruHearing at 1-844-222-3391, (TTY: 1-800-975-2674). TruHearing will find a qualified hearing health care provider who will provide a comprehensive hearing exam and talk with them about treating their hearing loss with hearing aids. TruHearing's Provider Relations team is also available to answer your questions at 1-866-581-9462.

New High-Tech Imaging Authorization Vendor

Starting Jan. 1, 2017, BlueCross will partner with NIA-Magellan for high-tech imaging and cardiac diagnostic authorizations for Medicare Advantage and BlueCare Plus products. Authorization requests can be initiated by phone or online through BlueAccess.

This change does not impact BlueCross Commercial or BlueCare lines of business. They will continue to use eviCore for these services.

More information will be shared in the December issue of *BlueAlert*.

Completed CMS-2728-U03 Required for Dialysis Clinic Claim Reimbursement

Effective Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X will also require submission of a completed CMS-2728-U03 form. Reimbursement will not be considered for dialysis clinic claims if a completed CMS-2728-U03 form is not on file with BlueCross. The initial and subsequent claims will be denied requesting that the provider submit the completed form.

Providers may submit the applicable CMS-2728-U03 form by fax to (423) 535-5498, or by mail at:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37402-0002

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Improving Chronic Obstructive Pulmonary Disease (COPD) Awareness

Many individuals with COPD are not aware of the direct and very severe impact of COPD exacerbations. As defined by the GOLD Initiative for COPD, an exacerbation is "an acute event characterized by a worsening of the patient's respiratory symptoms that is beyond normal day-to-day variations and leads to a change in medication." These exacerbations often cause a negative impact on the quality of life, symptoms, and lung function, accelerate lung function decline, and increase mortality and economic costs.

Evidence shows that most **patients with COPD who have had a recent inpatient hospitalization or emergency room visit can benefit from taking both a systemic corticosteroid and a bronchodilator.**

You can help maintain a high level of quality care by:

- Discussing tips to prevent further COPD flare ups, such as diligent cleaning of all respiratory equipment including oxygen tubing, nebulizers, and inhalers
- Reviewing the importance of filling prescriptions for COPD and identifying/addressing any barriers that prevent your patients from taking their medicines
- Referring your patients to a pulmonary rehab programs or smoking cessation programs
- Updating flu and pneumonia vaccinations

Please contact us if you are treating one of our members with continuing health problems who could benefit from care coordination support.

Reminder: Please Do Not Re-Enter Quality Care Rewards Portal Information

When entering patient information, please allow one monthly refresh for gaps to update in the Quality Care Rewards portal. If you do not see that a gap has updated as it should after one refresh, please contact your BlueCross Quality Outreach Manager or eBusiness at (423) 535-5717.

Please do not re-enter the same information into the portal because this could delay crossover of the gap closure record.

Final Push for Diabetes Screenings

According to the Centers for Disease Control and Prevention (CDC), diabetes affected more than 9.3 percent of the U.S. population in 2013. Tennessee is above the national average with more than 11 percent of Tennesseans living with diabetes in many counties.

You can help your patients control their diabetes by ensuring they complete the following screenings annually:

- Diabetic Nephropathy Screening – **Annual screening** can be done via urine specimen checks for microalbumin, or by documentation of treatment for nephropathy such as a visit to a nephrologist or member being prescribed an ACE inhibitor or ARB therapy.
- Hemoglobin A1c (HbA1c) – Monitoring blood levels helps ensure your patients have a **controlled HbA1c level less than 8 percent.**
- Diabetic Retinal Eye Exam – Help schedule your diabetic patients with an eye care professional for this important **annual exam.**
- Blood pressure control – **The goal is less than 140/80 mm HG.**

Performing these quality care checks is essential to achieve the best health outcomes and quality of life for your patients with diabetes. We may be able to assist your diabetic patients in getting to their optimal control with one of our Case Management or Population Health/Disease Management programs. Encourage your patients to call our "Member Service" number on the back of their member ID card or visit http://www.bcbst.com/ and http://bluecare.bcbst.com/index.html for educational information and assistance.

Talk to your patients today about getting their diabetic screenings.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQHProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386

العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

***Changes will be included in the appropriate 4Q 2016 provider administration manual update.**

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page

†Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or press 1. Then press 1 again if you are a provider and follow the prompts to reach **Network Contracts or Credentialing** to update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
ECF CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail**: eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

of Tennessee

PROVIDER NEWS FLASH

of Tennessee

BlueAlert

December 2016

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Jan. 14, 2017:

- **Digital Breast Tomosynthesis (Revision)**
- **Fractional Laser Treatment of Vulvovaginal Atrophy (New)**
- **Magnetic Resonance Imaging (MRI) of the Breast (Revision)**
- **Proteogenomic Testing for Individuals with Cancer (New)**
- **Tumor-Treatment Fields Therapy for Glioblastoma (Revision)**

The follow medical policies will be archived (i.e., no longer active) 30 days after this *BlueAlert* notification is issued. This policy document is no longer utilized by BlueCross' Commercial and BlueCare Utilization Management departments.

- Ultrafiltration for Decompensated Heart Failure
- Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea and Chronic Pelvic Pain

This medical policy will be archived (i.e., no longer active) 30 days after this *BlueAlert* notification is issued. This procedure is rarely performed and the American Medical Association (AMA) has decided to archive the two unique procedure codes associated with this service.

- Optical Coherence Tomography

Note: These effective dates also apply to BlueCare Tennessee pending State approval.

All Provider-Administered Medications Require NDC Codes

All provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format must include the National Drug Code (NDC) of the drug(s) administered, along with the quantity and unit.

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Providers are encouraged to share NDC billing requirement guidelines with their electronic software vendor to assist in the submission of electronic claims and to help ensure accurate placement of data.
http://www.bcbst.com/docs/providers/Supplemental-EDI-Information.pdf

Please note, submitting claims without the appropriate NDC could delay your reimbursement payments.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Expansion to State Employee Health Plan and Fully Insured

BlueCross will be expanding The State of Tennessee's established Tennessee Health Care Innovation Initiative (THCII) Episodes of Care program to our State Employee Health Plan (SEHP) and Fully Insured members who use Blue Network S^{SM} effective Jan. 1, 2017.

The first effort under this program will focus on episodes of care related to:

- Perinatal
- Total Joint Replacement (hip and knee)
- Screening and Surveillance Colonoscopy
- Outpatient and Non-Acute Inpatient Cholecystectomy
- Acute Percutaneous Coronary Intervention (PCI)
- Non-acute Percutaneous Coronary Intervention (PCI)

The performance period for SEHP will begin Jan. 1, 2017, as preview reports related to performance have been available for review since May of 2014. The performance period for Fully Insured will begin Jan. 1, 2018, with a reporting-only period for calendar year 2017, where Preview reports will be provided for informational purposes only.

More information about this expansion will be available in the coming weeks.

Improving Vaccination Rates Among Children

Children turning 2 years old are often missing several vaccines that are necessary for keeping them healthy. The three most common vaccines missing from most 2-year-olds' immunization records are influenza, rotavirus and hepatitis B.

Influenza – Two shots are needed by the time the child turns 2, the first shot administered after 6 months old. The flu mist is no longer recommended by the Centers for Disease Control and Prevention (CDC).

Rotavirus – Either the two or three dose series, administered beginning 42 days after birth.

Hepatitis B Shot – Three doses are required before the child turns 2, one of which can be the dose given in the hospital after birth.

Source: http://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Flu Prevention Starts with a Shot

You know how important it is to educate all patients or parents of children older than 6 months of age on the importance of getting a yearly flu vaccine. Please refer to flu vaccine benefit information we published in previous issues of the *BlueAlert* Newsletter. Reminder: Because it has concerns regarding the effectiveness of the FluMist Quadrivalent, the Centers for Disease Control and Prevention (CDC) recommends that this vaccine **not** be used during the 2016 – 2017 flu season.

Blood Pressure Monitor Benefit and Treating Hypertension in Federal Employee Program (FEP) Patients: New Information Available

FEP is taking a stand against heart attacks and strokes by helping its members manage high blood pressure. To make it easier for them, FEP initiated a program to provide free blood pressure monitors to its members over age 18 diagnosed with hypertension or those who have high blood pressure without a hypertension diagnosis.

Members can get the monitor by completing the Blue Health Assessment and answering "yes" when asked if they have been diagnosed with high blood pressure.

Information created by the American Medical Association is also available to help you improve health outcomes for your FEP patients. Click on the following links to access these resources:

- Measure Accurately and Promote Self-Measured Blood Pressure Monitoring at Home
- How to Check a Home Blood Pressure Monitor for Accuracy
- Clinical Competency: Self-Measured Blood Pressure at Home

Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

Providers are often the first point of care for alcohol and drug dependence treatment. Follow these suggestions to improve the chances that an individual will engage in and successfully complete treatment:

- Use screening tools to identify alcohol or other drug dependencies (AOD).
- Refer to a behavioral health provider (BHP) to start treatment within 14 days of diagnosis.
- Provide AOD dependence code to the BHP treatment provider.
- If a referral is not elected, see the patient within 14 days to initiate treatment through education on the potential risks and health outcomes.
- Schedule two follow-up visits within 30 days after starting treatment.
- Educate patients on the importance of follow-up care and keeping all appointments for the treatment of this medical condition, even after they start to feel better.
- For help finding a BHP to whom you can refer your patients, call the number listed on the back of the member's ID card.

Importance of Collaboration and Communication Between Medical and Behavioral Health Professionals

High-quality care for your patients needing behavioral health treatment is the result of effective collaboration with behavioral health professionals. By working together, your patients benefit through:

- Integrated interventions
- Patient safety (e.g. potential drug interactions, substance use and interaction with prescriptions, psychosocial support in the home for medical interventions)
- Adjustment in the treatment plan if necessary
- Improved effectiveness such as encouraging compliance with other provider recommendations

Collaboration helps you as the medical professional treating your patients who are also being treated for behavioral health concerns by:

- Increasing awareness of what knowledge and skills you both can offer the patient
- Improving decision-making by understanding the whole person and what might be the most realistic and effective intervention(s)for that individual
- Boosting clinical effectiveness and job satisfaction through learning about other professional's approach to patient care
- Creating and maintaining good relationships with patients and fellow professionals

You can find more information and other resources by visiting www.ncbi.nlm.nih.gov/books/NBK2637/.

Antipsychotic Use Has Potential to Impact Patient Health

As a behavioral health provider, it is recommended that you notify the patient's PCP when an antipsychotic medication is being considered. An assessment of the patient's health is recommended due to the increased risk for weight gain and Type 2 Diabetes associated with the use of antipsychotics. Targeted assessments should include: weight, waist circumference, and/or BMI, blood pressure, heart rate, blood glucose level and lipid profile. Continued assessment of these factors should occur throughout the course of treatment, and collaboration is encouraged between treating providers. The efficacy and safety of antipsychotics should be monitored proactively.

See the American Psychiatric Association's (APA's) Practice Guidelines for more information.

KX Modifier Keeps Professional Claims from Rejecting for Gender Conflict

Background: Regulations implementing Section 1557 of the Affordable Care Act prohibit covered entities from denying professional claims for covered services ordinarily appropriate for individuals of one sex that are provided to transgender, intersex or ambiguous-gender individuals based on their recorded gender.

Situation: Claim systems may reject professional claims for some members due to gender-specific edits and cause inappropriate denials. For example, a claim filed for a pap smear performed on a male patient would typically reject for a gender conflict correctly. However, if the male patient was a transgender male, then a pap smear may be a medically appropriate service. To ensure BlueCross processes professional claims correctly, the KX modifier should be billed on the detail line, when appropriate, with procedure code(s) that are gender-specific.

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KX modifier definition: Requirements specified in the medical policy have been met. The KX modifier is a multipurpose modifier for professional claims and can be used to identify gender-specific services provided to transgender, intersex, or ambiguous-gender individuals. Using it also lets us know you performed a service for a patient for whom gender specific editing may apply, and the service should be allowed to continue with normal processing. All benefit/authorization type requirements still apply.

Please Note: The Federal Employee Program (FEP) claims system will not recognize the KX modifier code and using it will not change how FEP claims are handled.

Seeking Timely Response to Requests for Medical Records

Often medical information and/or records are needed to process member claims, to determine reimbursement levels for certain procedures and for audits/reviews by the Bureau of TennCare. In order to reduce delays in claims processing, it is important that providers respond to these requests as quickly as possible. Please note the following guidelines regarding medical record requests:

- Submit the request letter as the first page of your medical record.
- Fax the requested information to the number listed in the letter.
- Submit only the requested information.
- Copies of the claim are not required. If claim copies are included, please attach behind the medical record.

Correction: Billing for Medication Wastage from a Single Dose Vile (SDV)

Effective Jan. 1, 2017, a JW modifier (*Drug amount discarded/not administered to any patient*) will be required to bill any unused drugs or biologicals from SDVs or packages.

BlueCross will continue to follow the published guidelines found in the Provider Administration Manuals for billing medication wastage from a SDV as follows:

- Documentation of wastage in the medical record is expected.
- **The Provider is responsible for using the most economical packaging of medication to achieve the required dosage with the least amount of medication wastage necessary.**
- Instances of medication wastage from a SDV should be **submitted on a single line item** with the JW modifier appended to the appropriate HCPCS Level II code.
- The number of units billed for the SDV using specific HCPCS codes with the JW modifier is inclusive of both the administered and discarded amounts.
- The number of units should be reported as one (1) for unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes billed with the JW modifier appended and dosage administered/wastage should be reported as supplemental information.

Medical Professional Communication May Increase Clinical Effectiveness

Research indicates that collaboration in health care increases team member awareness of each other's knowledge and skills, leads to integrated interventions for the patient, and improves decision-making. It can be one of the most important factors in clinical effectiveness and job satisfaction. Team members need to share information in a short period of time and structured techniques are available (STCC – Situation Task Intent Concern Calibrate and SBAR – Situation-Background-Assessment-Recommendation). A clinical "champion" who promotes the necessity of team collaboration is an asset. Effective communication is an essential aspect of creating and maintaining good relationships with patients and fellow professionals. Attention to this aspect of practice can pose challenges, but can address patient safety, allows adjustment in the treatment plan and thereby improves effectiveness, and allows for providers to learn in an ongoing manner from one another.

For more information see the National Center for Biotechnology Information website.

Reminder: New Opioid Prescription Policy Effective Jan. 1, 2017; Now Accepting Prior Authorization Requests

BlueCross continues to address the growing national effort toward more appropriate use of opioids. Earlier this year, BlueCross made a policy change requiring your patients who are new to long-acting opioid pain medication therapy and covered by BlueCross commercial plans to have prior authorization (PA) for these drugs. To further promote prescription safety, BlueCross is making other significant changes that will go into effect in January.

Opioid Prescription Policy Changes Effective Jan. 1, 2017
(Applies to your patients with BlueCross commercial, BlueAdvantage (PPO)SM, BlueChoice (HMO)SM and BlueCare Plus (HMO SNP)SM plans)
Prior authorization required for all long-acting opioid prescriptions
Quantity limits for both short-acting and long-acting opioids prescriptions
The combined morphine equivalent dose (MEqD) of all prescriptions cannot exceed 200mg/day
Note – Opioid treatment for members in hospice care or undergoing cancer treatment will receive approval, but still require a prior authorization request.

To view the entire policy on the Use of Opioids in Control of Chronic Pain, please visit our website: **www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm**

Now Accepting Prior Authorization Requests for Jan. 1 Effective Dates
For your patients taking long-acting opioids, and for whom you expect to need the medicines in January, you may request the prior authorization for a Jan. 1 effective date now. The maximum length of a prior authorization for long-acting opioid is six months. **When you make your request, please inform the PA Desk that the request is for prescriptions obtained on or after Jan. 1, 2017.**

How to Obtain Prior Authorization for Your Patients

- For your patients with **BlueCross commercial** plans, please call 1-877-916-2271 or fax your request to 1-800-837-0959.
- For your patients who are covered by **BlueAdvantage, BlueChoice** or **BlueCare Plus** plans, please call 1-844-648-9628 or fax your request to 1-877-328-9799.

Reminder: Improved Prior Authorization Process for Provider-Administered Specialty Medications

Beginning Dec. 1, 2016, BlueCross is partnering with Magellan Rx Management to facilitate the prior authorization process for provider-administered specialty medications under the medical benefit for all lines of business.

Please note that as of Dec. 1, 2016, prior authorization requests for specialty medications are no longer being accepted by fax. Because more detailed information is now being requested through the prior authorization process, and because we want to ensure you get the fastest response possible, authorization requests must be submitted online through BlueAccess℠ or by phone. These direct interactions with clinical pharmacists and board-certified physicians will help ensure we receive all required information to make the most informed and timely determination. For assistance with submitting your authorizations online using BlueAccess, please contact your eBusiness Marketing Consultant.

The Provider-Administered Specialty Drug Lists vary by lines of business and are located online:

BlueCare Tennessee
BlueCare Plus (HMO SNP)℠
Commercial/CoverKids
Medicare Advantage

Reminder: Credentialing Required for Nurse Practitioners and Physician Assistants

BlueCross is requiring all nurse practitioners and physician assistants to complete the credentialing process before providing services to our members. Nurse practitioners and physician assistants must be credentialed by Jan. 1, 2017, even if they are employed by a physician or group that is contracted to provide services to BlueCross members. Begin the credentialing process by completing the online Provider Enrollment Form.

Reminder: Improved Provider Reconsideration and Appeals Process Now in Effect

It is now easier for providers to go through the formal process of asking BlueCross to reconsider claims outcomes or denials, and to file formal appeals when necessary. An overview of the process and the two new forms are located online at http://www.bcbst.com/providers/forms/reconsideration-and-appeals.shtml.

A helpful guide offers more details and guidance about when and how to request claims reconsiderations or appeals. Depending on the line of business, there are some variances in the processes which are outlined in this guide.

Important Note: Beginning Jan. 1, 2017, reconsideration and appeals requests submitted on the ***old*** provider dispute forms may be returned, directing you to resubmit on the appropriate *new* forms. Please use the *new* Provider Reconsideration Form and Providers Appeal Form to prevent delays in processing these requests.

Reminder: Electronic Claims Submission Required

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

BlueCare Tennessee

This information applies to BlueCare, TennCare*Select* and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless stated otherwise

BlueCare Providers Can Now View Opioid Prescription Risk Reports Online

BlueCare Tennessee is working to promote opioid prescription safety by showing providers their opioid prescribing patterns through a comprehensive online report.

The Risk Identification and Mitigation (RIM) report is an online tool that will offer BlueCare Tennessee providers a deeper insight into the opioids they prescribe, the levels and frequency at which they provide them and how their prescribing patterns compare to other providers in their specialty across the state, as well as their patients who might be at risk when taking opioids.

BlueCare Tennessee providers who prescribe a minimum of six prescriptions during the previous 90 days can access their personalized report through the secure provider section of our website. The report is available through the **BlueAccess** home page under the heading **RxSafetyTN** by clicking the link **Pain Medication & Care Improvement Program**.

Tennessee Health Link and PCMH Programs for Behavioral Health Needs

The State of Tennessee is continuing its growth of the Tennessee Healthcare Innovation Initiative (THCII) through the development of the Tennessee Health Link (THL) and expansion of the Patient-Centered Medical Home (PCMH) model. The State is working with providers to improve integrated and value-based primary care services for all members and behavioral health services for members with the highest behavioral health needs. The THL will launch Dec. 1, 2016. Expanded PCMH will launch Jan. 1, 2017, for 20-30 primary care provider groups who volunteered to be in the first wave of implementation, with additional opportunities in future years.

Please refer to the State's website for details on the THL and the PCMH programs:
https://www.tn.gov/hcfa/article/patient-centered-medical-homes
https://www.tn.gov/hcfa/article/tennessee-health-link

TennCare Kids - Healthier by the Dozen

Every child should have 12 TennCare Kids checkups before turning 3 years old. After their third birthday, children should receive TennCare Kids screenings every year until age 21. *Recommendations for Preventive Pediatric Health Care*, including suggested checkups is available on the American Academy of Pediatrics website.

Get Reimbursed for the Administration of Each Vaccine Given in Your Office

Did you know you can receive a $10.25 payment for the administration of vaccines under the Vaccines for Children (VFC) program? To receive this reimbursement, the claim must be filed with the administration and vaccine procedure codes **for each vaccine**. The reimbursement applies to all immunizations under the VFC program. All providers are eligible to receive this reimbursement, even non-VFC providers.

VFC is a federally funded program operated by the State of Tennessee Department of Health. All TennCare enrolled children 18 years of age and under are eligible for the VFC vaccines. These vaccines are available to any provider who serves eligible members.

Information about VFC and the administrative fee reimbursement is available in the Preventive Care Section of the *BlueCare Tennessee Provider Administration Manual*.

Coordinating Patient Care is Key

The coordination of a patient's care is essential for healthy outcomes. If you are a primary doctor/primary care provider (PCP), remember to ask if your patient has been seen by any other providers (specialists, urgent care, emergency room or received durable medical equipment, physical therapy services, etc.) since they were last seen by you. Encourage the discussion of treatment plans they have received elsewhere and request information from the other provider(s).

If you are not the patient's primary doctor/PCP, obtain the name of the patient's primary doctor/PCP and share medical assessments, prescriptions, or treatment provided.

BlueCare Plus (HMO SNP)^{SM} Annual Evaluation Completed and Available

An evaluation of the 2015 **Model of Care (MOC)** and **Quality Improvement (QI) Program** plan has been completed and approved by the BlueCare Plus^{SM} Quality Committee and BlueCare Tennessee Quality and Operational Oversight Committee.

Key accomplishments:

- Member grievance/appeals above goal of 95 percent timeliness
- Utilization Management and Care Coordinator audits above goal of 97 percent
- Provider Satisfaction and Patient Experience Surveys launched
- Increased member engagement with Interdisciplinary Care Teams
- Health risk assessments completed
- Practice pattern analysis established
- Medication review of 29 percent of qualified members
- 53 percent response rate on CAHPS, estimated 5 Stars on member experience with health plan
- Clinical Quality of Care unit developed to review issues

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The trends, barriers and planned actions identified are used to develop the 2016 BlueCare Plus QI plan. To see the 2015 report, with goals and performance results of all QI activities, contact the BlueCare Plus Tennessee Clinical Improvement Department at 1-888-433-8221.

New Event Reporting Requirements for ECF CHOICES in 2017 *

Providers in the Employment and Community First (ECF) CHOICES network will have additional reporting requirements for two types of events starting in January. These new requirements are for actions that do not meet the definition of emotional or psychological abuse.

Disrespectful or inappropriate communication like humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts regarding a person receiving support is strictly prohibited. These actions fall into one of two categories.

- **Tier 2 Reportable Events** – Any disrespectful or inappropriate communication listed above **directed to** or within eyesight or audible range of the person receiving support.
- **Non-Reportable Events** – Any disrespectful or inappropriate communication listed above **about** the person receiving support, but not directed to or within eyesight or audible range of that person.

Regardless of an action's definition as reportable or non-reportable, it must be reported to BlueCare Tennessee's Non-Discrimination Compliance Coordinator starting Jan. 1, 2017. Providers can report events by mailing details of the event on business letterhead or by calling BlueCare Tennessee.

Mail: BlueCare/TennCare*Select* Non-Discrimination Compliance Coordinator
1 Cameron Hill Circle
Chattanooga, Tennessee 37402

Phone: BlueCare: 1-800-468-9736
TennCare*Select*: 1-800-276-1978

How to Report a Member Complaint about a CoverKids Provider

When your patients who are covered by a CoverKids plan express a complaint about a provider's quality of care, please make sure to report it.

The following are examples of quality of care complaints:

- Not satisfied with treatment
- Adverse reaction to medicine
- Pharmacy concerns
- Treatment complications
- Alleged misdiagnosis
- Disagreement with treatment decision

Please report CoverKids member complaints regarding quality of care by calling the provider service line at 1-800-924-7141. Our staff will investigate the complaint to determine if the treating provider followed the standard of care.

Critical Incidents Involving CoverKids Members Must be Reported

Any significant event involving a CoverKids member who is receiving home health services must be reported as a Home Health Critical Incident. **A member death is always considered a critical incident,** regardless of whether the death occurs during the provision of Home Health Services.

The following are all examples of Home Health Critical Incidents:

Critical Incident	Example
Major or severe injury	Broken bones or severe bleeding
Life-threatening medical emergency	Heart attack or unconsciousness
Medication error	Member takes too much medicine at one time.
Safety issues	Member falls due to slippery floor.
Known or suspected physical, mental or sexual abuse	Agency staff hits, inappropriately touches, yells at or intimidates a member.
Neglect (a lack of care that could harm the member)	Member fell because staff member did not help member with walking.
Theft	Worker steals electronic device from member
Financial exploitation - improper use of funds	Agency staff used member's debit card for personal use.

Click here to download a copy of the Home Health Critical Incident Report form.

Email completed forms to: BlueCareQOC@bcbst.com. If email is not available, please fax the form to 1-855-339-3022.

Short Wait Times and Ease of Access Encourages Preventive Care

When your patients can easily make an appointment and only have to wait a few minutes to see you, they see the benefit of visiting their regular provider and will do so more often. These are the foundation of the primary care medical home. They help your patients stay current with preventive care screenings and encourage them to seek care before complications occur.

BlueCare Tennessee has specific standards for routine and urgent care, including physical and behavioral health. Provider compliance with wait times is important to ensure your patients receive care in the appropriate setting and at the appropriate time. These standards are monitored via a member survey on office wait time experience.

For additional information on Access and Availability Standards, please refer to the BlueCare Tennessee Provider Administration Manual.

Reminder: Maternity Authorizations for BlueCare, TennCare*Select* and CoverKids

Prior authorization is not required for an inpatient stay as long as the hospitalization results in the delivery of the newborn, even when the member labors on day one and delivers on day two.

Complications of pregnancy will still require authorization if delivery is not expected during that hospital stay. Medical emergencies do not require prior authorization.

Reminder: Reporting the Death of a CoverKids Member is Required

Providers are required to report all patient deaths if they involve a CoverKids member under the age of 19 or the unexpected death of a member who is **not** receiving home health services. Deaths should be reported as soon as possible using the Death of a Member Notification Form.

A member death consistent with the medical diagnosis and prognosis would be considered an expected death. Providers should use the following criteria to determine if the death of the member is unexpected:

- **Accidental**
- **Not anticipated**
- **Suicide**
- **Mistreatment**
- **Homicide**

Do not use Death of a Member Notification Form if the member was receiving Home Health Services.
The death of a member receiving Home Health Services should be reported using the Home Health Critical Incident Form, even if the member was not receiving care at the time of death. Complete reporting guidelines and definitions are included in the BlueCare Tennessee Provider Administration Manual.

Please submit all forms relating to the death of a BlueCare Tennessee member by email to: BlueCareQOC@bcbst.com. If email is not available, you may fax forms to: 1-855-339-3022.

Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

Annual Wellness Exams and 2017 Member Incentives

An annual wellness exam is an important first step to a healthy 2017. Patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. They may also be eligible to earn a reward for completing the exam. You can help your BlueCross Medicare Advantage patients earn additional rewards for their healthy living by scheduling a check-up early.

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In 2017, members will need to take two steps to be eligible for rewards:

1. BlueCross Medicare Advantage members will need to "opt in" to the rewards program with OnLife Health, our new rewards partner. Each member will receive a welcome kit in January detailing opt-in instructions.
2. An annual wellness claim must be on file for members to receive additional rewards in 2017 for other needed screenings. Annual wellness exams should be filed with 99387, 99397, 99385, 99395, 99386, 99396, 96160, GO402, GO438, GO439, plus appropriate E/M codes.

The *Member Wellness Incentive FAQs* is being revised to reflect the changes to the 2017 program and will be available in January in print or on the Quality Care Rewards website.

High-Tech Imaging Authorization Vendor Changes Effective Jan. 1, 2017

BlueCross BlueShield of Tennessee is partnering with Magellan Healthcare National Imaging Associates (NIA) radiology benefit management program to perform authorization review for non- emergent outpatient advanced imaging and cardiac imaging services for BlueCross' Medicare Advantage and BlueCare Plus members. Emergency room, observation and inpatient imaging procedures do not require prior authorization. If an urgent/emergent clinical situation exists outside of a hospital emergency room, please call 1-888-258-3864.

Procedures requiring prior authorization:

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging
- Muga Scan
- Stress Echocardiogram

You may request prior authorization from Magellan by logging in to BlueAccess at www.bcbst.com or by calling 1-888-258-3864. Magellan does not accept authorization requests via fax.

CMS-2728-U03 Required for Dialysis Clinic Claim Reimbursement*

Initial dialysis clinic claims filed with Type of Bill 072X will require submission of a completed CMS-2728-U03 form annually for each patient effective Jan. 1, 2017. Reimbursement will not be considered for dialysis clinic claims in a given calendar year if a completed CMS-2728-U03 form is not on file with BlueCross. The initial and subsequent claims will be denied requesting that the provider submit the completed form.

You may fax the CMS-2728-U03 form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Cr, Ste 0002
Chattanooga, TN 37402-0002

Guidelines for Oxygen Renewals, Maintenance and Service Repairs, and Replacement Equipment

Oxygen renewals: Most oxygen authorizations will expire at the end of 2016 and providers will need to submit a request to continue service for 2017. Please be sure to include the Certificate of Medical Necessity CMS Form 484. The form must be signed by the ordering physician and include the qualifying diagnosis and oxygen saturation.

Maintenance and service repairs: Oxygen equipment has a cap rental period of 36 months. After the cap is met, you may bill for maintenance and service repairs every six months from months 37 - 60 or until the equipment is replaced. These services should be billed using the appropriate oxygen code with modifier MS. Maintenance and service repairs do not require prior authorization, however they may be reviewed based on current fee schedules if charges exceed the allowed amount. As a reminder, oxygen contents are a lifetime rental item.

Replacement equipment after 60 months: Per *Local Coverage Article A52514 for Oxygen and Oxygen Equipment*, a member may elect to have their oxygen equipment replaced after the reasonable useful lifetime (RUL). The RUL for oxygen equipment is 60 months. If members elect to have equipment replaced at month 61 or after, their cost share for the new equipment will begin again. Therefore, DME companies should not routinely replace equipment once the RUL has been reached. A new prescription and a face-to-face examination with the ordering provider are required unless there is a non-serviceable issue with the patient's current oxygen equipment within six months before the order is required. Replacement equipment will not be eligible for administrative approvals.

Non-Eye Care Professionals Conducting Retinal Eye Screenings in Office Must Bill Appropriate Codes

Clinical guidelines for retinal eye screenings in diabetic patients allows for the screening to be conducted by either dilated or digital format. If you perform digital retinal eye screenings in your office and do not have an eye care professional specialty such as ophthalmology or optometry, make sure claims are billed to BlueCross with the appropriate CPT II codes in addition to procedure and diagnosis codes.

Without a CPT II code, such as 2022F, 2024F, 2026F or 3072F, a gap in care for the *Comprehensive Diabetes Care – Eye* cannot be closed according to NCQA requirements outlined in the HEDIS technical specifications for this measure.

If your office performs these screenings, please let us know by contacting your BlueCross Quality Outreach Consultant.

Submit Chiropractic Request Forms to OrthoNet

All BlueCross Medicare Advantage patients seeking chiropractic services must have a Chiropractic Request Form submitted to OrthoNet. The form must be completed and include supporting clinical documentation.

Supporting clinical documentation may include but not limited to:

- Patient Intake Forms
- Initial or Interim History
- Initial or Interim Exams
- Results of Diagnostic Tests and/or Imaging
- Consultations/Reports
- Daily Progress Notes
- Plan of Treatment
- Informed Consent Forms
- Patient Questionnaires
- Outcomes Assessment Forms
- Other pertinent information to support medical necessity

By rule, Medicare only covers a medically necessary spinal manipulation procedure (e.g., CPT® 98940, 98941, or 98942). Any other chiropractic services, such as evaluations, extremity manipulations and/or therapies/modalities are not payable.

New CPT® Code for Submitting a Provider Assessment Form in 2017

In 2017, you will again be eligible to receive payments for completing and submitting a Provider Assessment Form for your attributed BlueAdvantage℠ and BlueChoice℠ members.

Note: The CPT® code that should be used to file a PAF claim is changing. The new CPT® code, effective Jan. 1, 2017, is **96160**. The current 2016 CPT® code, **99420**, will not be valid in 2017.

BlueAdvantage will continue to reimburse Code 96160, with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2017
- $200 for dates of service between April 1 and June 30, 2017
- $175 for dates of service between July 1 and Sept. 30, 2017
- $150 for dates of service between Oct. 1 and Dec. 31, 2017

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the writable Provider Assessment Form and fax to 1-877-922-2963. The form should also be included in your patient's chart as part of his or her permanent record.

For additional information about the Provider Assessment Form, please visit:
http://www.bcbst.com/providers/quality-initiatives.page

Peer-to-Peer and Re-Evaluation Process Changes*

New guidance from the Centers for Medicare and Medicaid Services (CMS) will change some BlueCross BlueShield of Tennessee provider peer-to-peer and re-evaluation processes. BlueAdvantage and BlueChoice have had long-standing processes in place already. Here are some changes that become effective Jan. 1, 2017:

- When there is **insufficient clinical documentation** to support an organizational determination, and after we made three separate attempts to obtain clinical information from the requesting provider, a BlueCross medical director will contact the physician for the documentation. If we cannot reach the physician, we will follow up with a specific "intent to deny" fax. If we still do not receive the needed clinical information within one business day, we will issue the adverse determination for insufficient clinical documentation. There are no additional peer-to-peer options for the requesting physician. Documents submitted after the organizational determination will be treated as a member appeal (reconsideration) according to CMS regulations.
- When an adverse determination was rendered and there was **sufficient clinical information**, the requesting provider can request a peer-to-peer conversation or submit additional clinical documentation. Either will be treated as a member appeal if services have not yet been rendered. There will not be a re-evaluation process because it is not compliant with CMS guidance.
- When requests are treated as member appeals, only the member and rendering provider have appeal rights. Everyone else needs to have an Appointment of Representative (AOR) form on file before the appeal can be processed. **This includes third-party companies acting on behalf of a facility for adverse determinations appealed while the member is still in the hospital.**
- When **services were already rendered** and there was no additional member financial responsibility, these will be processed as provider appeals. One peer-to-peer conversation and one level of provider appeal are permitted during this process, followed by binding arbitration. This process includes inpatient services with adverse determinations and the member was discharged from the hospital.

This process will be updated in the *BlueCross BlueShield of Tennessee Provider Administration Manual* for Medicare Advantage products.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

Enhanced Quality Care Rewards Tool Shows All Patients and Their Open Gaps in Care

Soon you will have access to a listing of all BlueCross and BlueCare Tennessee members attributed to your practice and their individual open quality measures. This list provides an easy way to identify patients who could benefit from screenings or other preventive care.

If you're participating in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Rating System (PQRS) or a BlueCross Quality Care Rewards program, closing these measures may help boost your quality ratings and payments or reimbursements. You still have a few weeks left in 2016 to get your patients scheduled for the preventive care they need.

To find your listing, go to the Quality Care Rewards tool by visiting bcbst.com then logging in to BlueAccess, then clicking on the tab next to your member roster. If you have questions or want to know more about Quality Care Rewards, visit the Quality Initiative Page for contact information.

Decrease Antibiotic Resistance: Avoid Antibiotics for Respiratory Conditions

We are committed to working with you to decrease antibiotic resistance and to support appropriate testing and antibiotic use. This quality improvement initiative focuses on the avoidance of antibiotic treatment in children and adults with the following respiratory conditions.

- Children (ages three months to 18 years) with upper respiratory infection (URI)
- Children (ages three to 18 years) with pharyngitis (CWP)
- Adults (ages 18 to 64 years) with acute bronchitis (AAB)

Remember to use the appropriate codes to indicate a bacterial infection. If the cause of illness is viral consider suggesting over-the-counter medications to help the symptoms.

Quality Improvement Teams at BlueCross are actively engaged in outreach with our provider community regarding this important initiative.

Educational information is available on following websites:

- Centers for Disease Control and Prevention (CDC)
- HealthCare 21 Business Coalition (HC21)

Together, we can make an impact on antibiotic prescribing in Tennessee.

Your Attention to Quality Care Helps BlueCross Plans Earn High Ratings

Several BlueCross BlueShield of Tennessee plans have earned 4-star ratings due to the quality care you provide daily to your patients/our members. Thanks to your efforts and our important partnerships, our Commercial PPO and BlueCare Tennessee East plans earned 4 out of 5 stars for 2016 by the National Committee on Quality Assurance (NCQA). NCQA ratings are based on a plan's internal quality procedures, customer satisfaction and clinical quality measures of members getting recommended care and their health outcomes.

BlueAdvantage received a 4-star rating (out of 5) from the Centers for Medicare and Medicaid Services (CMS) for a second consecutive year. CMS ratings are based on customer satisfaction, plan operations and quality outcomes.

Several enterprise-wide quality initiatives and programs, including the Medicare Advantage Quality Outcomes program, Quality Care Partnership Initiative (QCPI) and the Clinical Data Exchange, are key components to the improved quality ratings. We appreciate your participation in these important initiatives.

In observance of the holidays,
BlueCross BlueShield of Tennessee
will be closed
Dec. 23 and Dec. 26, 2016

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not to discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select*. For TTY help call 771 and ask for 888-418-0008.

Information about the civil rights laws can be found at http://www.bcbst.com/ or from the Department of Health and Human Services at http://www.hhs.gov/ocr/index.html.

***Changes will be included in the appropriate provider administration manual update.**

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page

†Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or press 1. Then press 1 again if you are a provider and follow the prompts to reach **Network Contracts or Credentialing** to update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
ECF CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail**: eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)