of Tennessee

JANUARY 2017

BlueAlert℠

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 Feb. 12, 2017

- Artificial Intervertebral Disc (Revision)
- Biofeedback and Neurofeedback (Revision)
- Electromyography and Nerve Conduction Studies (Revision)
- Serum Tumor Markers for Gastrointestinal Cancer (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Extended Timelines Announced to Appeal Claims and Request Arbitration*

Based on input we have received from you, we are pleased to announce that extended timelines for claims appeals and arbitration are in effect as of Jan. 1, 2017. After receiving a response on a claim reconsideration, providers now have up to 60 days to request an appeal to a claim. Additionally, after receiving a final decision on a claim appeal, providers now have up to 60 days to request arbitration.

Important Note: When making claim reconsideration and appeal requests, please be sure to use the new forms found on the Reconsideration and Appeals webpage. As of 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.

Please check the Reconsideration and Appeals webpage for updated resources throughout the year.

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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 via:

Fax: 1-866-635-1488
Mail: ArroHealth
Attn: MRR3 Unit – BCBSTN 49 Wireless Blvd,
Ste. 140 Hauppauge, NY 11788

Time to Review Your Commercial Efficiency Practice Pattern Analysis

The Commercial Efficiency Practice Pattern Analysis (PPA) reports, which help provide you with important information about your utilization and quality of care as it compares to your peer group within BlueCross, are updated biannually and are available through BlueAccess℠. The next biannual PPAs will be available soon.

Please note that the 2016 first quarter biannual PPAs were recently updated on BlueAccess to correct an indicator error. Although the indicator error only affected less than one percent of the first quarter PPAs, the first quarter PPAs were recently updated and now available on BlueAccess.

Mental Illness Increases Risks for Other Chronic Conditions

Patients diagnosed with mental illness are more likely than their peers to develop obesity and have an increased risk for being diagnosed with Type 2 Diabetes, heart disease, hypertension, stroke, and premature death. Antipsychotic medications have been associated with an increase in appetite and weight gain. Assessing your patient's psychological state and social situation should be taken into consideration when managing obesity.

Their affect and mood, stressors, social support, and cognitive skills will also influence the treatment plan.

Collaboration between medical and behavioral treatment providers may be especially helpful when developing a treatment plan. Once a plan is in place, both providers can address aspects related to maintaining a healthy diet and exercise with their patient. Patients should be encouraged to believe that in the midst of mental illness, good health is possible. http://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf

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)℠, 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 entire policy on the Use of Opioids in Control of Chronic Pain, please visit our website: http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm

Now Accepting Prior Authorization Requests for Jan. 1 Effective Dates

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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 opioids 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: 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.

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

Reminder: Be Aware of Member Rights and Responsibilities

As a BlueCross network provider, you should know what our members are being told to expect from you and what you have the right to expect from those 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 http://www.bcbst.com and http://bluecare.bcbst.com/.

Reminder: Credentialing Required for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to complete the credentialing process before providing services to our members. As of Jan. 1, 2017, nurse practitioners and physician assistants must be credentialed, 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: 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℠ and TennCareSelect plans, excluding CoverKids℠ and dual-eligible BlueCare Plus unless stated otherwise.

New THCII Programs Begin - Tennessee Health Link and PCMH Expansion

The State of Tennessee is continuing its growth of the Tennessee Healthcare Innovation Initiative (THCII) through the development of the Tennessee Health Link (THL), which launched Dec. 1, 2016, and the expansion of the Patient-Centered Medical Home (PCMH) model for the TennCare population, which will launch Jan. 1, 2017.

The PCMH expansion begins with 29 primary care provider groups selected to be in the first wave of implementation. Approximately 100,000 members are assigned to these providers. Preview reports that feature quality and utilization details were issued in December 2016 and the first payments will be made in January 2017. Large practices with 5,000 or more attributed members are eligible for shared savings based on total cost of care. Smaller practices with fewer than 5,000 members are eligible for payments based on improved efficiency metrics. These shared savings require practices to meet quality metric thresholds.

Both programs represent new opportunities to partner with providers to improve the health and wellbeing of members.

More information can be found on the State's website:
https://www.tn.gov/hcfa/article/patient-centered-medical-homes
https://www.tn.gov/hcfa/article/tennessee-health-link

BlueCare Tennessee Authorized to Handle Personal Health Information

It is sometimes necessary for BlueCare Tennessee employees to contact providers with questions about a patient's clinical or demographic information. On occasion, provider offices will cite HIPAA as the reason for not releasing the requested information. Please make sure your staff is aware that we are authorized to handle the Protected Health Information (PHI) of your patients and they should provide the information when BlueCare Tennessee makes a request.

This information is critical, especially for our Population Health Case Management staff when they work with your patients who have complicated care needs, chronic illnesses and catastrophic illnesses or injuries.

For more information about the provider requirements for the release of personal health information (PHI), please see the BlueCare Tennessee Provider Administration Manual.

Enrollment Extended for TennCare EHR Provider Incentive Program

The Centers for Medicare & Medicaid Services (CMS) has extended the EHR Incentive Program enrollment deadline beyond the original Dec. 31, 2016, date. Providers now have until March 31, 2017, (11:59 PM CT) to enroll and submit their Program Year 2016 attestation to TennCare. Click here for more information about the Medicaid Electronic Health Record (EHR) Incentive Program.

By participating in the program, 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 the program 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 at TennCare.EHRIncentive@tn.gov.

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

Hysterectomy Form Reminder

Please ensure each field in the TennCare published Hysterectomy Form is completed accurately. The form was revised for clarity to ensure providers complete only one section of the form. All Abortion, Sterilization, and Hysterectomy (ASH) forms, along with instructions for completion, are accessible online in the ASH section of the BlueCare Tennessee Provider Administration Manual.

Reminder: TennCare Kids Medical Record Documentation Requirements for Comprehensive Physicals

In accordance with their periodicity guidelines, the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care requires evidence of a comprehensive unclothed/suitably draped physical examination in a TennCare-eligible child's medical record.

All required components of the physical exam should be performed and documented in the medical record with the date of the exam. If the child is uncooperative or the examination was deferred/refused, be sure to include this information in the medical record.

Please refer to the American Academy of Pediatrics at tnaap.org/coding for the required components of the TennCare Kids exam as well as required medical record documentation criteria.

Medicare Advantage

This information applies to BlueAdvantage and BlueChoice plans. BlueCare Plus is excluded unless stated otherwise.

Annual Wellness Exams and 2017 Member Incentives

An annual wellness exam (AWE) 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. These members 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 in the year.

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. AWEs should be filed with CPT 96160, 99385, 99386, 99387, 99395, 99396, 99397, G0402, G0438, G0439, plus appropriate E/M codes.

The Member Wellness Incentive FAQs document is being revised to reflect the changes to the 2017 program and is available on the Quality Care Rewards website.

Note: The AWE is a calendar year benefit, which means each member is entitled to one AWE in 2016, one in 2017, etc. regardless of the number of days between each exam. It is not necessary to wait 365 days between exams.

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 annual submission of a completed CMS-2728-U03 form for each patient. 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. Initial and subsequent claims will be denied, and you will be asked to submit the completed form.

You may fax the applicable CMS-2728-U03 form to (423) 535-5498, or mail it to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefits plan that permits Medicare Advantage to conditionally pay the health care provider when a third party causes the member's condition. Medicare Advantage follows Medicare policy whereby law, 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)/ Section and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

The federal law found at 42 U.S.C. 1395y(b)(2(B)(ii) and 1862(b)(2)(B)(ii) and federal regulations found at 42 C.F.R. 411.24(e) & (g), state that the Centers for Medicare and Medicaid Services (CMS) may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. A Medicare Advantage plan sponsor may recover in the same manner as CMS.

Similar to Medicare, if responsibility for the medical expense incurred is in dispute and other insurance will not pay promptly, the provider may bill the Medicare Advantage plan as the primary payer. If the item or service is reimbursable under Medicare Advantage and Medicare rules, Medicare Advantage may pay conditionally on a case-by-case basis, subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. In situations such as this, the member may choose to hire an attorney to help recover damages.

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 changed Jan.1, 2017, to 96160. The 2016 CPT® code, 99420, is invalid in 2017.

BlueAdvantage will continue to reimburse the service as E/M 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 submit via 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.

It is not necessary to wait 365 days between PAF submissions. For additional information about the Provider Assessment Form, please visit: http://www.bcbst.com/providers/quality-initiatives.page

Updated Occupational Therapy and Physical Therapy CPT® Codes for 2017

Effective Jan. 1, 2017, there are eight new CPT® codes for occupational therapy and physical therapy services. These new codes replace four codes currently being used. See below for changes:

- 97001 is replaced by 97161, 97162, 97163
- 97002 is replaced by 97164
- 97003 is replaced by 97165, 97166, 97167
- 97004 is replaced by 97168

Quality Care Rewards

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

THCII: Performance Period for ADHD Episode Delayed by Year

The Tennessee Healthcare Innovation Initiative (THCII) Episodes of Care program is delaying the first performance period for the ADHD episode. The performance period will begin Jan. 1, 2018. Additional time allows changes to be made to the episode design, such as adding additional quality measures and excluding episodes where the member experienced homelessness.

Primary care and behavioral health providers who are accountable for this episode will continue to receive quarterly preview reports throughout 2017 and will have additional time to prepare for the performance period.

These changes are a result of additional feedback received from stakeholders in Tennessee. The original design was based on input from a Technical Advisory Group (TAG) of expert Tennessee clinicians. The THCII met again with the same TAG members in November 2016 and asked for additional design recommendations. Preview reports released in May 2017 and after will reflect the updated design and new recommendations.

Regular Screenings Help Detect Cervical Cancer

According to the Centers for Disease Control and Prevention (CDC), cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up. Two screening tests, the pap test/smear and HPV test, can help prevent cervical cancer or find it early.

Starting at age 21 your female patients should begin receiving cervical cancer screenings at least every three years. Once women turn age 30, they have options for cervical cancer screening: to get cervical cytology tests at least every three years, or get a co-testing of cervical cytology and HPV testing every five years. However, you, as their health care provider, can make the best decision for your patient.

This recommendation from the U.S. Preventive Services Task Force applies to women who have a cervix, regardless of sexual history. It does not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised – such as those who are HIV positive.

A pap test may be performed annually for women ages 21 to 65. Please note that annual screenings are a covered benefit for BlueCare Tennessee and CoverKids members. Commercial member coverage is subject to verification of benefits.

Tips to Help Patients Quit Tobacco Use

As a BlueCross BlueShield of Tennessee provider, you have the opportunity to encourage our members to improve their health by quitting smoking. You can provide vital support by discussing tobacco cessation with members and directing members to support resources.

Follow these tips to help patients kick the nicotine habit:

- Engage patients in a conversation about quitting.
- Discuss over-the-counter cessation aids and determine if medications may be beneficial.
- DO NOT promote the use of e-cigarettes as smoking-cessation aids.
- Direct patients to the Tennessee Tobacco Quitline at 1-800-Quit-Now or http://www.tnquitline.com/ for cessation support or counseling resources.

Fall Prevention Key to High Quality of Life for Seniors

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

- Removing loose rugs from the floor
- Adding non-skid surfaces on the shower floor
- Removing clutter, especially in hallways
- Moving electrical cords that are running across the floor
- Maintaining good lighting, especially in stairwells and halls
- Installing handrails near the toilet, tub and stairways
- Moving items from higher shelves to lower, more reachable ones
- Wearing shoes with rubber soles in the house instead of slippers, socks or bare feet

of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

CAQH Solutions | PROVIEW™

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

† 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 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
***Select*Community**	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
Email:	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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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 March 9, 2017

- Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer (Revision)
- Osteochondral Autografting (OCG) (Revision)
- Positron Emission Tomography (PET) for Cardiac Applications (New)
- Positron Emission Tomography (PET) for Miscellaneous Applications (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

2017 Medical Record Requests to Begin

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.

Medical record requests are sent to providers who show they treated the member or were assigned as the member's primary care provider. We will be contacting you soon for medical records related to prevention and screening, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well child visits.

You may be asked to provide records related to a certain condition. Even if you did not specifically treat the member for that condition, you may be able to

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provide valuable information on the member's health – such as blood pressure or medications. Please provide as much of the requested information as possible.

We will work with you to arrange the most appropriate method for obtaining medical record information, which may include scheduling onsite collection 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.

Emergency Preparedness Requirements Set by CMS

The Centers for Medicare & Medicaid Services (CMS) established regulations requiring national emergency preparedness for Medicare and Medicaid participating providers and suppliers to adequately plan for both natural and man-made disasters, and coordinate with federal, state, tribal, regional and local emergency preparedness systems. These requirements were mandated Nov. 15, 2016, and must be implemented by Nov. 15, 2017. Click here to view the Federal Register Rules and Regulations related to this requirement.

The regulation addresses three key essentials that are necessary for maintaining access to health care services during emergencies, safeguarding human resources, maintaining business continuity, and protecting physical resources. The three key elements are:

1. Risk Assessment and Emergency Planning – See the Federal Emergency Management Agency (FEMA) National Preparedness System website for more information.
2. Policies and Procedures – Develop and implement documents that support the successful execution of the emergency plan and risks identified during the risk assessment process.
3. Communication Plan – Develop and implement a system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to help ensure continuation of patient care functions throughout the facilities and to ensure that these functions are carried out in a safe and effective manner.

Additionally, facilities must:

- Develop and maintain an emergency preparedness training program.
- Offer annual training to their staff.
- Conduct drills and exercises to test the emergency plan.

Reminder: Verify Member Benefits and Eligibility Online

Member benefits often change at the turn of the new year, just like the calendar. The new year may bring new ID numbers for our subscribers and their families. Be sure to log into BlueAccess℠ to obtain current eligibility and benefit details for your patients. These benefit details include information about copays, deductibles, coinsurance and benefit limitations. Most member ID cards are listed in the subscriber's name. Looking up the member ID number in BlueAccess will list all members covered by the subscriber. Please contact your eBusiness Marketing Consultant for more information.

Reminder: New Opioid Prescription Policy Began January 1

BlueCross continues to address the growing national effort toward more appropriate use of opioids. Beginning Jan. 1, 2017, all members covered by BlueCross plans must have prior authorization (PA) for long-acting opioid drugs. Additionally, new quantity limits for all opioids are now in place.

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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, visit our website at http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm and select Administrative Services.

To Obtain Prior Authorization

- For your patients with BlueCross commercial plans, call 1-877-916-2271 or fax your request to 1-877-328-9799.
- For your patients who are covered by BlueAdvantage, BlueChoice or BlueCare Plus plans, call 1-844-648-9628 or fax your request to 1-877-328-9799.

Please remember, ALL patients must have a PA for their long-acting opioids.

Reminder: Understanding Member Rights and Responsibilities

We periodically remind members of the rights and responsibilities they have when they carry a BlueCross BlueShield of Tennessee or BlueCare Tennessee member ID card. These reminders are intended to make it easier for members to access quality medical care and to attain services. They also help members understand what they should expect from you, and what you expect of them.

Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and BlueCare Tennessee provider administration manuals, which are available online at https://www.bcbst.com/providers/manuals.page.

Reminder: Credentialing Required for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to complete the credentialing and contracting process before providing services to our members. Beginning Jan. 1, 2017, nurse practitioners and physician assistants must be credentialed and contracted, either individually or as part of an existing physician group providing services to BlueCross members. Begin the credentialing process by completing the online Provider Enrollment Form.

Reminder: Obstetric Anesthesia Must Be Billed on Single Claim Form

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a C-Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code. In those cases with obstetrical anesthesia for the planned vaginal delivery beginning on one day and the actual caesarean delivery on the following day, dates of service for both codes should have the same "from and through" date, i.e. from beginning of anesthesia through to the completion.

Obstetric anesthesia services involving more than one provider (e.g. two physicians or two CRNA's) for the same episode are to be submitted on a single claim, under one NPI, with the date of delivery as the date of service. Separate claims for multiple providers will result in denial for the add-on code.

BlueCare Tennessee

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

Latest TennCare℠ PDL Includes Changes for Anti-Migraine Drugs and Ophthalmic Agents

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 Anti-Migraine: 5-HT1 Receptor Agonists, Hereditary Tyrosinemia Agents and Ophthalmic Immunomodulators.

In addition, some agents were removed from the list of branded agents classified as generics.

Click here for the most current PDL.

Click here for the notice of PDL changes effective Jan. 1, 2017.

Document Any Refusal to Vaccinate

Each parent or patient has the right to refuse recommended vaccines. If the parent or patient decides not to get recommended immunizations, their decision must be documented in the patient's medical record. Resources for documenting the refusal are available on the American Academy of Pediatrics website. Additionally, the Centers for Disease Control and Prevention website has conversation tools to help talk with parents and patients about the importance of immunizations and the importance of preventive care.

BEHIP II Training Now Available

BlueCare Tennessee is proud to sponsor Behaviorally Effective Healthcare in Pediatrics (BEHIP) training along with the Tennessee Chapter of the American Academy of Pediatrics and Vanderbilt University School of Medicine. Providers can take advantage of free training modules online, and earn 2.5 AMA PRA Category Credits™ per completed module. Most courses take as little as an hour to complete.

Topics this training session includes:

- Trauma and early brain development
- Trauma competent care principals in a primary care setting
- Psychopharmacology
- Motivational interviewing
- Working with children and families in the child welfare system

This is the second part of training for an ongoing program that equips providers to improve diagnoses and care for patients with behavioral health conditions. To date, hundreds of providers across the state have already used this free resource.

To learn more about BEHIP II training, please contact TNAAP Training Coordinator Heather Smith at heather.smith@tnaap.org.

Your Timely Response Is Needed for Medical Records Requests

Often medical information or records are needed to process member claims, to determine reimbursement levels for certain procedures and for audits/reviews by the Bureau of TennCare. 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.

Population Health Is Available for Eligible CoverKids℠ Patients

We can partner with you to help eligible CoverKids patients with certain conditions that need special care, including programs for tobacco cessation, weight management and transplant management. To refer a patient to the program, please complete a CoverKids Population Health Form and submit by email to DMScreeners_GM2@bcbst.com or by fax to 1-800-421-2885.

New Process for Submitting Population Health IEPs for CoverKids Members

Eligible CoverKids patients now have access to Population Health Individual Education Plan (IEP) services. To submit a request for your patient, please fax the IEP along with the Parental Authorization Release Form to 1-800-851-2491.

Reminder: Seven Required Components of a TennCare Kids Checkup

According to evidence-based guidance from the American Academy of Pediatrics, all seven components of a TennCare Kids physical exam must be performed and documented in the patient's medical record. The date of the exam and documentation of the nutritional assessment and physical activity portion of the exam must be included. If the child is uncooperative or the examination was deferred or refused, be sure to include this information in the medical record.

1. Comprehensive Health (Physical and Mental) and Developmental History
   - Initial and Interval History
   - Developmental/Behavioral Assessment
2. Comprehensive Unclothed Physical Exam
3. Vision Screening
4. Hearing Screening
5. Laboratory Tests
6. Immunizations
7. Health Education/Anticipatory Guidance

Helpful services and required medical record documentation criteria for the TennCare Kids exam are available on the Tennessee Chapter of the American Academy of Pediatrics website.

Medicare Advantage

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

Code Changes for Drugs Requiring Prior Authorization

As of Jan. 1, 2017, code changes are effective for specialty drugs requiring prior authorization for Medicare Advantage patients. The 2017 Medicare Advantage Specialty Pharmacy List is available online.

BlueCross has partnered with Magellan Rx Management℠ to facilitate the prior authorization process for provider-administered specialty medications.

Because more detailed information is being requested through the prior authorization process, and because we want to help ensure you get the fastest response possible, authorization requests must be submitted online through BlueAccess or by calling 1-800-841-7434. Prior authorization requests for specialty medications are no longer being accepted by fax.

New CPT® Code for Submitting a Provider Assessment Form in 2017

In 2017, physicians are again eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage℠ and BlueChoice℠ members.

Note: The CPT® code that should be used to file a PAF claim is changing. The new code, as of Jan. 1, 2017, is 96160. CPT® code 99420 is no longer valid.

BlueAdvantage will continue to reimburse the service as E/M 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 submit via 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.

Annual Wellness Exam Must Be Documented for Members to Earn 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 are also 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.

In 2017, members will need to take the following steps to be eligible for rewards:

1. "Opt in" to the rewards program with OnLife Health, our new rewards partner. Each member received a welcome kit in January detailing opt-in instructions.
2. Get an annual wellness exam. Claims must be on file for members to receive additional rewards* in 2017 for other needed screenings. Annual wellness exams should be filed with 96160, 99385, 99386, 99387, 99395, 99396, 99397, G0402, G0438, G0439, plus appropriate E/M codes.

Members earn 15 wellness points for completing their exam in 2017; however, they can also earn 10 bonus points if completed prior to Oct. 1, 2017.

*Additional information about specific screenings eligible for rewards will be available soon. This program aligns with the annual STAR rating and quality bonus for providers.

High-Tech Imaging Authorization Vendor Changes Effective Jan. 1, 2017

BlueCross BlueShield of Tennessee has partnered 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.

Medicare Part D Prescriber Enrollment Requirement

The Centers for Medicare & Medicaid Services (CMS) will implement a multifaceted/phased approach to help ensure enforcement of the Part D Prescriber Enrollment requirement on Jan. 1, 2019, unless the health care provider formally "opts out". This requirement impacts most providers (e.g., dentists, physicians, psychiatrists, residents, nurse practitioners and physician assistants), including Medicare Advantage providers, who prescribe medications for patients with Part D plans.

Prescribers must be enrolled in an active status for their written prescriptions to be covered under the Medicare Part D benefit plan. CMS previously announced that enforcement of the prescriber enrollment requirement would begin Feb. 1, 2017, but has delayed the implementation requirement to minimize the impact on the beneficiary population and to help ensure beneficiaries have access to the care they need.

Note: CMS must also be notified by Jan. 1, 2019, if you choose to opt out of the program. By opting out you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

To help your Medicare patients, please enroll in Medicare to bill and prescribe Part D benefits. There are no fees to complete the process. Enroll online or by mail.

- Fast-track the enrollment process online via the Medicare Provider Enrollment, Chain and Ownership System (PECOS).
- Enroll offline by completing the CMS-855O (paper) Enrollment Application and submitting to the appropriate Medicare Administrative Contractor (MAC).

For more information see the CMS How to Enroll page.

Coding Information for Compounded Bevacizumab (Avastin)

In November 2016, the Medicare Administrative Contractor (MAC) for the State of Tennessee retired its Local Coverage Determination (LCD) for intravitreal Avastin.

Beginning Feb. 1, 2017, compounded bevacizumab (Avastin) for the treatment of retinal diseases of the eye should be coded in the following manner: CPT® 67028, and HCPCS J7999, with a primary diagnosis supporting the retinal eye condition. Claims for compounded bevacizumab (Avastin) for intrivitreal administration coded with J9035 will be denied.

The National Drug Code (NDC) for Avastin, when billed as compounded bevacizumab, does not require prior authorization. Avastin for other clinical conditions does require authorization through Magellan Rx.

Other intravitreal medications for the treatment of retinal diseases also require prior authorization.

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member's condition. The MA plan follows Medicare policy where by law, 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)/Section and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

According to 42 U.S.C. 1395y(b)(2(B)(ii)/Section 1862(b)(2)(B)(ii) of the Act and 42 C.F.R. 411.24(e) & (g), the Centers for Medicare & Medicaid Services (CMS) may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

Similar to Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

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

The Centers for Medicare & Medicaid Services (CMS) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey every year which contains several questions directly related to the member's experience with their doctor. The specific questions include:

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?
- 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 an appointment with specialist?

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

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

Reminder: Peer-to-Peer and Re-evaluation Process Changes

New guidance from the Centers for Medicare & Medicaid Services (CMS) will change some BlueCross provider peer-to-peer and re-evaluation processes. The following are changes that became effective Jan. 1, 2017:

- When insufficient clinical documentation exists to support an organizational determination, and after BlueCross has made three separate attempts to obtain clinical information from the requesting provider, a BlueCross medical director will contact the provider for the documentation. If the provider cannot be reached, we will follow up with a specific "intent to deny" fax. If the needed clinical information is not received within one business day, an adverse determination will be issued for insufficient clinical documentation. No additional peer-to-peer options will be available to the requesting provider. 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 ask for 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 per 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.
- Services rendered with no additional member financial responsibility 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.

Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. 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 the provider to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Quality Care Rewards

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

Help Your Patients Take Control of Their Heart Health

Encouraging your patients to manage their blood pressure by checking it at home and keeping a journal may lead to better heart health. At-home monitoring can help your patients maintain their blood pressure within the following ranges:

- 18-59 Years of Age: <140/90
- 60-85 Years of Age: Diabetic: <140/90
- 60-85 Years of Age: 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, and to help prevent sudden cardiac death. For patients that have recently experienced a heart attack, it is important to encourage them to take the prescribed beta-blocker medication for at least six months after their heart attack.

SilverSneakers® Benefit for BlueAdvantage and BlueChoice Members

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 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 like high cholesterol or hypertension, may help boost your quality scores and earn fee schedule bonuses from BlueCross.

Pharmacotherapy Management of COPD

Early diagnosis and aggressive treatment of Chronic Obstructive Pulmonary Disease (COPD) may improve a patient's 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 the 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.

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.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

CAQH Solutions | PROVIEW™

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

† 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 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
***Select*Community**	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
Email:	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

MARCH 2017

BlueAlert℠

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/medical-policy-manual/index.page under the "Upcoming Medical Policies" link.

Effective Feb. 22, 2017

- Varicose Vein Treatments for the Lower Extremities (Revision)

Effective April 13, 2017

- Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Individuals with Non-Small Cell Lung Cancer (NSCLC) (Revision)
- Hematopoietic Stem Cell Transplantation for Miscellaneous Solid Tumors in Adults (Revision)
- Positron Emission Tomography (PET) for Oncologic Applications (Revision)

Implantable Ventricular Assist Devices and Total Artificial Hearts

BlueCross will continue to address total artificial hearts within its current medical policy; however, the implantable ventricular assist devices portion of this medical policy will be archived (i.e., no longer active) as the company transitions to MCG- Formerly Milliman Care Guidelines to address ventricular assist devices. This action will take place in April/May of 2017. Link to policy

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

All Blue Workshops

The dates for the 2017 All Blue provider workshops are April 5 in Chattanooga, April 18 in Johnson City and April 19 in Knoxville. We will announce more details and dates for Memphis, Jackson and Nashville on our website soon!

INSIDE THIS ISSUE

New Process Aims to Increase Payment Accuracy, Reduce Administrative Burden on Providers

BlueCross will begin a new process that will help reduce the administrative burden put on providers when we recover overpayments on your patients' claims. Beginning in April, our claims payment process for all lines of business, including BlueCare Tennessee and BlueAdvantage (PPO)℠, will more carefully analyze claims with the goal of delivering payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability.

This process will not reduce provider reimbursement rates, your patients' benefits or the speed at which we pay your claims. In fact, this addition to our system will increase efficiency and compliance with standards set by the Centers for Medicare & Medicaid Services and other governing organizations.

While this system will not completely eliminate overpayments or the need for recovery, our efforts in 2017 help ensure a more accurate and efficient payment process to our providers.

New Requirements in Effect for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This requirement went into effect Jan. 1, 2017, and applies even if nurse practitioners and physician assistants are employed by a physician or group already contracted with BlueCross.

Important Notes:

- Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form.
- Once this process is complete, nurse practitioners and physician assistants must submit bills under those/their specific specialties.
- Nurse practitioners and physician assistants are not permitted to bill as a delegated service and claims will be denied beginning May 1, 2017.
- Claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants will be considered out of network beginning May 1, 2017.

Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, visit http://www.bcbst.com/providers/mycontact/ to locate your BlueCross contact.

Changes to Moderate Conscious Sedation Codes

In keeping with current coding standards BlueCross is making changes to payment rates for codes related to Moderate Conscious Sedation. Please review this important information for each line of business.

BlueCross' changes are in response to the Centers for Medicare & Medicaid Services (CMS) modification of procedure codes and corresponding payment rates for the Medicare Physician Fee Schedule, based on the American Medical Association's (AMA's) CPT® coding changes for Moderate Conscious Sedation services.

- The AMA deleted procedure codes 99143-99145 and 99148-99150 effective Dec. 31, 2016, and adopted seven new Moderate Conscious Sedation procedure codes effective Jan. 1, 2017.
- CMS reduced the Relative Value Units (RVUs) for procedure codes listed in the Appendix G Summary of CPT® Codes that include Moderate Conscious Sedation last published in the 2016 AMA CPT® Manual.
- CMS changed the RVUs for certain codes included in Appendix G that now correspond with the seven new Moderate Conscious Sedation procedure codes, for which payment may be made.

For more information see our website at www.bcbst.com/sedationcode.

Reminder: Billing Assistant-at-Surgery Services for Commercial Plans

Assistant-at-surgery services provided by a physician assistant (PA) or nurse practitioner (NP) should include the Level II HCPCS AS modifier. Eligible assistant-at-surgery services provided by a PA or NP credentialed as an assistant-at-surgery will be based on the lesser of total covered charges or 13.6 percent (i.e. 85 percent of 16 percent) of the maximum allowable fee schedule amount. The maximum allowable for assistant-at-surgery services provided by a physician assistant who is not credentialed as an assistant at surgery will be $0.00.

Assistant-at-surgery services by a PA or NP must be billed using the unique provider number and/or NPI. Refer to the Billing and Reimbursement section of the BlueCross BlueShield of Tennessee Provider Administration Manual for more information.

Note: Assistant-at-surgery charges will only be reimbursed if filed with the appropriate taxonomy code.

Reminder: All-Inclusive Reimbursement for MRI/MRA/CT Scans

Reimbursement for MRI/MRA/CT scans is an all-inclusive rate that includes pharmacy, anesthesia, and/or supplies used in conjunction with these radiology services for Commercial and Medicare Advantage plans. Supplies incidental to radiology (RC 0621) and supplies incidental to other diagnostic services (RC 0622) should be filed accordingly with the appropriate HCPCS/CPT® code(s), but will not be reimbursed in addition to the MRI/MRA/CT scan payment.

For more information see the Billing and Reimbursement section of the BlueCross BlueShield of Tennessee Provider Administration Manual.

BlueCare Tennessee

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

Encourage Mothers to Get Postpartum Care

The American Congress of Obstetricians and Gynecologists (ACOG) recommend that all women undergo a comprehensive postpartum visit within the first six weeks (42 days) after giving birth.

For some new moms, self-care is not a priority. If postpartum care during maternity visits isn't part of your normal discussion, please let your patients know it's an important part of their health care. This visit should include a complete assessment of the mother's physical and emotional health, a plan for continued well-woman care, as well as a discussion regarding contraception.

Note: The CoverKids program wants to encourage providers to schedule the mother's postpartum visit within 21-56 days of delivery. This service is part of the CMS Quality Core measures for CHIP.

Immunizations Save Lives

Children turning 2 years old often miss several vaccines needed to keep them healthy. The three most common vaccines missing from most 2-year-olds' immunization records are influenza, rotavirus and hepatitis B.

Influenza – A child needs two shots before age 2, the first of which is recommended after the child is 6 months old. Note: Flu mist is no longer recommended by the Centers for Disease Control and Prevention (CDC).

Rotavirus – Administer the two- or three-dose series beginning 42 days after birth.

Hepatitis B Shot – Three doses are required before the child turns two, one of which can be the dose given in the hospital after birth.

Reimbursement for Vaccines Given in Your Office

You can receive a payment for the administration of vaccines under the federal 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. 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 you last saw them. 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.

Tips for Coding Preventive Care for TennCare Kids

The Tennessee Chapter of The American Academy of Pediatrics offers free training and resources to help providers with coding preventive care services for TennCare Kids. Proper coding of all preventive care is not only practical when caring for your patients, but also helps ensure you are paid for the care you provide. Solid records maintenance also makes the process of external reviews and medical audits much easier and more effective.

For more information, tips and guidelines on coding, please visit the Tennessee Chapter of the American Academy of Pediatrics website.

Model of Care Training

BlueCare Plus℠ offers Model of Care (MOC) training for all PCPs. The training is required annually by CMS and describes the framework for BlueCare Plus, our dual eligible special needs plan. PCPs completing the MOC training between Jan. 1 to March 31, 2017, will receive a 1 percent bonus to their base rate of reimbursement.

CHOICES Incident Examples: Proper Reporting to Adult Protective Services and BlueCare Tennessee

The reporting of incidents to Adult Protective Services (APS) is an important part of your role as a BlueCare Tennessee CHOICES provider. Any unexpected member death reported to APS should also be reported to BlueCare Tennessee as a critical incident. APS requires reporting of all incidents specifically related to abuse, neglect or exploitation.

The following are examples of incidents that ALWAYS require you to file a CHOICES critical incident report, but would NOT require a report to APS unless they involved allegations of abuse, neglect or exploitation:

- A member falls and breaks a bone while your staff is providing services.
- A member reports theft of personal items or household goods.
- A member reports $5 in change is missing from the kitchen table.

The following are examples of incidents that ALWAYS require you to file a CHOICES critical incident report, and WOULD also require a report to APS:

- A member breaks a bone as the result of an HCBS worker transferring the member improperly.
- An HCBS worker arrives for shift and discovers the member did not receive any care from family since the last shift.
- A member reports unauthorized use of a debit card by an HCBS worker.

Submit APS reports to by phone or fax:

- Phone: 1-888-277-8366
- Fax: 1-866-294-3961

Submit CHOICES reports by email or fax:

- Email: CHOICESQuality@bcbst.com
- Fax: 1-855-292-3715

Reminder: Billing Requirements for Behavioral Health Providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering the service to BlueCare Tennessee, BlueCare Plus or CoverKids members is different than the billing provider. In the case of an agency billing for services not provided by a licensed clinician, the medical director or other supervising professional may be entered on the claim as the rendering provider.

Failure to provide this information could result in a denial or reduction in reimbursement.

Medicare Advantage

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

New Colorectal Screenings Fulfill CMS Criteria

Having regular screenings for colorectal cancer is a critical part of a healthy lifestyle for patients 50 years of age or older. Now you have more options for fulfilling the CMS requirement for providing this potentially life-saving screening for your Medicare Advantage patients.

In 2017, both a CT Colonography and a FIT-DNA test, in addition to the services traditionally accepted by CMS, will satisfy the clinical requirement if a member is eligible for a colorectal screening. The CT Colonography satisfies the screening requirement for five years, and the FIT-DNA test for three.

Please remember you must document in your patient's chart the specific test you perform in order to get credit for the clinical service that satisfies the quality measure.

Reminder: Per HEDIS® definitions, digital rectal exams and fecal occult blood tests (FOBT) performed in the office or performed on a sample collected from a digital rectal exam, cannot be used to close the colorectal cancer gap in care.

Updated Authorization Codes for Spinal Surgery, Occupational and Physical Therapy

Several codes related to spinal surgery, occupational therapy and physical therapy have been added or removed from the authorization list for OrthoNet, our musculoskeletal vendor. The codes removed include:

- 62310
- 62311
- 62318
- 62319

Please visit the BlueCross website for a complete list of codes, including any added to the prior authorization list.

You may submit authorization requests via fax to OrthoNet at 1-866-747-0587 or online via BlueAccess℠ at https://www.bcbst.com/secure/public/login.asp.

Reminder: Last Month to Get Maximum Provider Assessment Form Bonus for 2017

In 2017, physicians are again eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage℠ and BlueChoice℠ members.

Note: The CPT® code that should be used to file a PAF claim has changed. The new code, as of Jan. 1, 2017, is 96160. CPT® code 99420 is no longer valid.

CONTINUED FROM PAGE 5

BlueAdvantage and BlueChoice will continue to reimburse the service as E/M 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 and submit the form 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 per guidelines set by CMS.

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

CMS conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey every year which contains several questions directly related to the member's experience with their doctor. 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?
- 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 a specialist?

The responses CMS receives from our Medicare Advantage members become part of BlueCross' network contracted physician's annual STAR quality rating score. This year, the member experience measures account for 50 percent of the total score, making these survey results very important.

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

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member's condition. The MA plan follows Medicare policy. According to 42 U.S.C. §1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

According to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.24(e) and (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

As with Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

Reminder: Peer-to-Peer and Re-Evaluation Process Changes

Beginning Jan. 1, 2017, BlueCross has made changes to the provider peer-to-peer and re-evaluation processes for our Medicare Advantage products per guidance received from CMS.

These processes have been updated in the Medicare Advantage section of the BlueCross BlueShield of Tennessee Provider Administration Manual.

Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. 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 you to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee

Attn: BlueAdvantage Revenue Reconciliation

1 Cameron Hill Circle, Suite 0002

Chattanooga, TN 37402-0002

Reminder: High-Tech Imaging Authorization Vendor Changes Effective Jan. 1, 2017

BlueCross has partnered 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 http://www.bcbst.com and clicking "Submission" by the section for Medicare Advantage or BlueCare Plus, or by calling 1-888-258-3864. Magellan does not accept authorization requests via fax.

Reminder: 2017 Member Incentive Information Now Available Online

An annual wellness exam is an important first step to a healthy 2017, and it can qualify your patients for wellness rewards from BlueCross. It is also a good time for you to complete a Provider Assessment Form and get extra reimbursement. You can help your BlueCross Medicare Advantage patients earn rewards for their healthy living by scheduling a check-up early in the year.

In 2017, BlueCross Medicare Advantage members will need to take two steps to be eligible for rewards:

1. Opt in to the rewards program with OnLife Health, our new rewards partner. Each member received a welcome kit in January detailing opt-in instructions.
2. File an annual wellness claim so members can receive any additional rewards in 2017 for other needed screenings. File annual wellness exams with CPT® 96160, 99385, 99386, 99387, 99395, 99396, 99397, or HCPCS G0402, G0438, G0439, plus appropriate E/M codes for the visit.

The Member Wellness Incentive FAQ is now available on the Quality Care Rewards website with more information about the member program.

Note: The annual wellness exam is a calendar-year benefit, which means each member is entitled to one in 2016, one in 2017, etc. regardless of the number of days between each exam. It is not necessary to wait 365 days between exams.

Quality Care Rewards

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

Deadline for Commercial Pay for Gaps Claim Submission

The 2016 Commercial Pay for Gaps program is coming to a close. The deadline has passed for completing attestations, but claims can be submitted and processed by March 31, 2017, to document the clinical service that satisfies the quality measure.

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.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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CAQH Solutions | PROVIEW™

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

† 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 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
***Select*Community**	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
Email:	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

APRIL 2017

BlueAlert℠

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 May 13, 2017

- Breast Cancer Gene Expression Assays (Revision)
- Small Bowel/Small Bowel-Liver/Multivisceral Intestinal Transplantation (Revision)
- Spinal Cord Stimulation/Peripheral Subcutaneous Field Stimulation for the Treatment of Pain (Revision)

Effective June 21, 2017

- Osteochondral Allografting (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Intracavitary Balloon Catheter Brachytherapy for Malignant Gliomas or Metastases to the Brain – This medical policy is no longer used by BlueCross Utilization Management. It will be archived and no longer active 30 days after this notification.

You're Invited! Annual All Blue Workshops

Please join us at one of our free annual All Blue provider workshops. Our knowledgeable representatives and subject matter experts will be available to answer questions and address your concerns. Register online today!

- Chattanooga – April 5, 2017
- Johnson City – April 18, 2017
- Knoxville – April 19, 2017
- Nashville – May 4, 2017
- Memphis – June 6, 2017
- Jackson – June 7, 2017

INSIDE THIS ISSUE

Prior Authorization Required for Lartruvo

Lartruvo will be added to the Provider-Administered Specialty Drug Lists requiring prior authorization, for all lines of business, effective April 1, 2017. Periodically, new specialty drugs are added to the lists which vary by lines of business. You can find information on all provider-administered specialty medications requiring prior authorization on the web pages below.

- BlueCare Tennessee
- Commercial/CoverKids
- BlueCare Plus (HMO SNP)SM
- Medicare Advantage

See the CDC's Recommended Immunization Schedules for 2017

The Centers for Disease Control and Prevention (CDC) has released its 2017 immunization schedules. As is the case each year, there are a number of changes to the vaccine recommendations. Among them were three vaccines that showed low member compliance in 2016: Human papillomavirus (HPV), influenza and meningococcal.

For the new recommendations regarding HPV, flu and meningococcal, as well as the complete 2017 schedule of immunizations for kids 18 years and younger, see the CDC website.

Claim and Remittance Explanation Codes Updated Online; Remapped Quarterly

The Centers for Medicare & Medicaid Services (CMS) maintains and publishes codes used by providers when filing claims and by payers when issuing payments. These codes are updated frequently and can be found on the BlueCross website.

Several times a year, BlueCross reviews and updates code mapping in order to remain compliant with CAQH CORE EFT & ERA Operating Rules. These updates may impact your internal processes. Please remember to check our website regularly to remain informed of these code changes. The changes will be highlighted and can be found here.

Code changes are also published by the Washington Publishing Company. See Claim Adjustment Reason Codes (CARC) and Remittance Advice Remarks Codes (RARC) on the Washington Publishing company website.

Dental Credentialing/ Recredentialing Is Required

As of March 1, 2017, BlueCross requires all dental providers to be credentialed. This will apply to dental providers who have not been credentialed and/or recredentialed in the past three years. You should receive a letter soon providing additional information about the credentialing process.

Reminder: New Process Aims to Increase Payment Accuracy, Reduce Administrative Burden on Providers

Beginning in April BlueCross has a new process that will help reduce the administrative burden put on providers when we recover overpayments on your patients' claims. Our claims payment process for all lines of business, including BlueCare Tennessee and BlueAdvantage (PPO)SM, will more carefully analyze claims with the goal of delivering payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability.

This process will not reduce provider reimbursement rates, your patients' benefits or the speed at which we pay your claims. In fact, this addition to our system will increase efficiency and compliance with standards set by CMS and other governing organizations.

While this system will not completely eliminate overpayments or the need for recovery, our efforts in 2017 help ensure a more accurate and efficient payment process to our providers.

Reminder: All Provider-Administered Medications Require NDC Codes

Medical claims for all provider-administered drugs must include the National Drug Code (NDC) of the drug(s) administered, along with the quantity and unit.

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: Claims submitted for provider-administered drugs without the appropriate NDC may be rejected.

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 Moderate Conscious Sedation Codes

In keeping with current coding standards, BlueCross made changes to payment rates for codes related to Moderate Conscious Sedation. Please review this important information for each line of business.

BlueCross' changes are in response to CMS modification of procedure codes and corresponding payment rates for the Medicare Physician Fee Schedule, based on the AMA's CPT® coding changes for Moderate Conscious Sedation services.

- The AMA deleted procedure codes 99143-99145 and 99148-99150 effective Dec. 31, 2016, and adopted seven new Moderate Conscious Sedation procedure codes effective Jan. 1, 2017.
- CMS reduced the Relative Value Units (RVUs) for procedure codes listed in the Appendix G Summary of CPT® Codes that include Moderate Conscious Sedation last published in the 2016 AMA CPT® Manual.
- CMS changed the RVUs for certain codes included in Appendix G that now correspond with the seven new Moderate Conscious Sedation procedure codes, for which payment may be made.

For more information, see our website at http://www.bcbst.com/sedationcode.

Reminder: CT and MRI Associated With Joint Arthrogram

CT and MRI testing for Commercial 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, by phone at 1-866-747-0586 or by fax to 1-866-747-0587. (When submitted online, the musculoskeletal code must be the primary code.)

Reminder: New Requirements in Effect for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This requirement went into effect Jan. 1, 2017, and applies even if nurse practitioners and physician assistants are employed by a physician or group already contracted with BlueCross.

Important Notes:

- Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form.
- Once this process is complete, nurse practitioners and physician assistants must submit bills under those/their specific specialties.

CONTINUED FROM PAGE 3

- Nurse practitioners and physician assistants are not permitted to bill as a delegated service and claims will be denied beginning May 1, 2017.
- Claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants will be considered out of network beginning May 1, 2017.

Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, visit http://www.bcbst.com/providers/mycontact/ to locate your BlueCross contact.

BlueCare Tennessee

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

Copays are the Only Acceptable Payment Allowed from TennCare Patients

The Bureau of TennCare has identified a large number of prescriptions written for members with TennCare coverage that don't correspond with provider claims. If your office sees patients with BlueCare Tennessee benefits, the only payments you can accept from them are copayments for authorized services. Providers who violate this part of their contract can be removed from participating in TennCare provider networks.

Bright Futures Online Resource for Kids' Well-Care Schedule

The American Academy of Pediatrics (AAP) recommends a schedule of comprehensive, age-specific, preventive health care screenings, assessments, physical examinations and procedures used as the standard of care for your young patients. These recommendations have recently been updated in the Bright Futures/AAP Periodicity Schedule.

In addition to covering scheduled periodic checkups, BlueCare Tennessee also covers other inter-periodic screens for kids. Children should have 12 TennCare Kids checkups between birth and age 30 months and a checkup every year from age 3 to age 20.

Helping You Coordinate Care for Your BlueCare Tennessee Patients

Ideally, BlueCare Tennessee members who are assigned to you as their primary care provider (PCP) would visit you for all of their care. Seeing you for check-ups, as well as when they're sick, would allow you to best coordinate their care. Since that doesn't always happen, our claims data is a great resource when you need to know more about your patients' complete health histories.

BlueCare Member Information Available to Assigned PCPs is available to you and includes:

- Patient demographics
- Well-care visits including Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Sick visits
- Hospitalization
- Medication history
- Age specific screenings
- Immunizations
- Lab results
- Allergies

To request the health history of a BlueCare Tennessee member, please call Provider Service.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978

If you need to request information regarding a SelectKids member, please e-mail your request including the member name, member ID number and date of birth to SelectKids_GM@bcbst.com.

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

Abortion, Sterilization and Hysterectomy (ASH) Form Reminder

Please ensure each field in the TennCare published ASH forms are completed accurately. The Hysterectomy form has been revised for clarity to help ensure providers complete only one section of the form. All ASH forms, along with instructions for completion, are accessible online in the ASH section of the BlueCare Tennessee Provider Administration Manual.

Note: This information is applicable to your patients with BlueCare Tennessee and CoverKids health plans.

Reminder: TennCare Behavioral Health Guidelines Update

As a part of the Tennessee Health Care Innovation Initiative, Level 2 Mental Health Case Management is no longer a reimbursable service. Instead, members can be referred for Care Coordination Services that are delivered by Bureau-approved Tennessee Health Link providers. For more information, please visit https://www.tn.gov/hcfa/article/tennessee-health-link.

Medicare Advantage

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

Behavioral Health Launches Partnership with AbleTo for Medicare Advantage Members

Approximately one in five seniors is likely to struggle with behavioral health issues, and this can worsen other chronic health problems. Additionally, the senior population typically manages multiple medical conditions on a daily basis, which puts them at greater risk for behavioral health issues such as depression and anxiety. This can negatively impact medication compliance and other efforts to follow your prescribed treatment plan.

Starting June 1, BlueCross will partner with AbleTo to provide a telephonic counseling and outreach program to a small group of Medicare Advantage members with adjustment and mood disorders. AbleTo will provide 16 telephonic sessions with a licensed therapist and a behavioral health coach over the course of eight weeks. Once enrolled in the program, members can access these services 24 hours a day, seven days a week at no additional cost.

Initially, this service will be limited to 250 Medicare Advantage members with adjustment and mood disorders and other chronic health conditions. Members may be asked to participate via letter, or you can refer a BlueCross Medicare Advantage patient by calling 1-866-287-1802. This program does not limit any other behavioral health services through the patient's Medicare Advantage plan.

Integrated Denial Notice Revised by CMS

CMS revised the Notice of Denial of Medical Coverage (Integrated Denial Notice [IDN]) template that all Medicare Advantage plans must use by April 10, 2017. CMS issues the IDN to inform enrollees of their appeal rights as applicable for payment or service denials and for discontinuation or reduction of a previously authorized course of treatment.

Please note the following changes to the IDN:

- A suggestion for the enrollee to share a copy of the decision with his or her doctor so it can be discussed. The notice also explains that a copy of the decision was sent to the doctor if the he or she made the request on the enrollee's behalf.
- Information on how enrollees can request the notice in an alternative format
- Language related to the doctor's supporting statement for an appeal
- A new statement: "We recommend keeping a copy of everything you send us for your records."
- The Standard Appeal formatted documentation for mailing address, phone and fax number, in-person delivery address, and TTY user call number
- The Fast Appeal formatted documentation was updated to include a TTY user call number.

New Home Health Billing Guidelines for Medicare Advantage*

Beginning June 1, 2017, Medicare Advantage will require HCPCS codes for all outpatient physical, occupational and speech therapy services. Skilled nursing, medical social services and home health aide services also require the appropriate HCPCS codes that correspond with the Revenue Code being billed.

Please be sure the billing units for home health services are filed as 1 unit for each 15-minute increment. Refer to the BlueCross BlueShield of Tennessee Provider Administration Manual for additional home health billing information

Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Physical Therapy	421	G0151	1 unit per 15 minutes
		G0157	
		G0159	
Home Health Occupational Therapy	431	G0152	
		G0158	
		G0160	
Home Health Speech Therapy	441	G0153	
		G0161	
Home Health Agency Skilled Nursing (RN or LPN)	551	G0493	
		G0494	
		G0495	
		G0496	
Home Health Agency Medical Social Services	561	G0155	
Home Health Agency Home Health Aide	571	G0156	

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BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Reminder: No Prior Authorization Required for Home-Based Polysomnography Sleep Studies

Home-based polysomnography sleep studies do not require a prior authorization. Facility-based sleep studies (polysomnogram or PSG), CPAP titration and split-night sleep studies all require prior authorization.

Reminder: Medicare Risk Adjustment Medical Records

CMS requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross has partnered with ArroHealth to obtain medical records on our behalf to meet this requirement.

ArroHealth will formally request medical records beginning in late April and early May. 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 instructions provided with your letter how to return the requested medical records to ArroHealth.

You have three convenient ways to submit medical records to ArroHealth:

- Fax:1-866-790-4192
  1-646-883-9921
- Mail: (please mark envelope as "Confidential")
  ArroHealth
  Attn: MRR3 Unit – BlueCross BlueShield of Tennessee
  49 Wireless Blvd Suite 140
  Hauppauge, NY 11788
- Secure Email: auditing@arrohealth.com

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

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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.

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- Update your provider profile on the CAQH ProView™ website.

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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
***Select*Community**	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
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of Tennessee

MAY 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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Medical Policy Updates/Changes

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Effective June 10, 2017

Homocysteine Testing in the Screening, Diagnosis, and Management of Dyslipidemia and Cardiovascular Disease and Venous Thromboembolic Disease (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee Health Care Practice Recommendations have been revised to include the **2017 Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease (GOLD Report) and American Diabetes Association: Standards of Medical Care in Diabetes**. These and other updates can be viewed in their entirety online at bcbst.com/providers/hcpr. Paper copies of the guidelines are available upon request by calling 1-800-924-7141, ext. 6705.

INSIDE THIS ISSUE

Coming Soon: New Provider Portal Offers Enhanced Online Tools

BlueCross is making enhancements to our online tools to keep pace with advancements in technology and to provide you with the resources you need. We have partnered with Availity, a leading provider of electronic health care transactions, to offer you a wider range of web-based products and services. Availity offers a multi-payer portal solution allowing you to use a single sign-on to work with BlueCross and other participating health care plans online.

Initially, the new portal will be used for reviewing remittance advices, claims status, eligibility and benefits with more features phased in throughout the year. As changes emerge, you will see eBusiness and other BlueCross resources leading efforts on education, provider engagement and training. We will continue to keep you updated about our transition to Availity through BlueAlert, online messages and updates through BlueAccess℠. Availity will eventually replace BlueAccess for providers.

New Claims Editing System to Be in Effect Later this Year

BlueCross plans to implement a more robust editing system for Commercial professional and facility claims in the latter part of 2017. The editing system adheres to industry rules and standards, as well as federal regulations and policies governing health care claims.

You may see some slight differences in how claims are processed as a result of this change. Look for more information in upcoming issues of BlueAlert.

New and Improved Online Provider Enrollment Form

The Provider Enrollment Form has recently been updated and can now be completed and submitted online. The new online form will help reduce processing time and prevent some of the return phone calls to providers to verify or obtain required information for processing the form.

When the new Provider Enrollment Form is submitted online, you will receive a reference number (DCN) that you will need to use when contacting (by phone or email) Provider Network Services for status.

We will continue to accept paper copies of the old Provider Enrollment Forms (PDF version) by email, fax or mail until June 30, 2017. Beginning July 1, 2017, we will no longer accept printed versions the Provider Enrollment Form. The Provider Enrollment Form must be completed and submitted online.

Prior Authorization Required for CPT® Code 81545

Effective July 8, 2017, a prior authorization is required for CPT® Code 81545 (Molecular Markers in Fine Needle Aspirates of the Thyroid) for Commercial lines of business. For a list of services that require prior authorization see the BlueCross website.

Prior Authorization Required for Spinraza and Sustol

Effective March 30, 2017, Spinraza and Sustol requires prior authorization for all lines of business. These drugs have been added to the Provider-administered Specialty Drug Lists.

The Provider-administered Specialty Drug Lists vary by lines of business. For the most current provider-administered specialty medications requiring prior authorization, visit our website(s).

- BlueCare Tennessee
- BlueCare Plus (HMO SNP)℠
- Commercial/CoverKids
- Medicare Advantage

Alternative Provider-administered Specialty Medications Not Requiring Prior Authorization (PA)

Many provider-administered specialty medications require prior authorization, often due to safety, handling and/or storage concerns. However, there are some provider-administered specialty medications that do not require prior authorization, and if appropriate for the patient, could possibly save office staff time and patient out-of-pocket expense.

The following are some examples of alternative provider-administered specialty medications that do not require prior authorization:

Provider-Administered Specialty Medications REQUIRING Prior Authorization	Provider-Administered Alternative Specialty Medications NOT Requiring Prior Authorization
Lucentis, Macugen, Eylea	Compounded Avastin for ophthalmic use
Neulasta	Granix, Neupogen, or TPO-filgrastim
Fusilev	Leucovorin
Aloxi	Ondansetron
Abraxane	Taxol

Patient Safety: Medication Errors

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm. Medication errors occur in all settings and may or may not cause an adverse drug event.

Here are some ways to help prevent medication errors:

- Workers who are not certified or licensed should never administer medication to patients in the home.
- Encourage patients to keep their medications in a lock box.
- Educate your patients on the following:
  - What is the medicine used for?
  - How long is the medicine to be taken?
  - How is the medicine administered?
  - What should they do if they experience side effects?
  - Is the medicine safe to take with other medications or with certain foods?
  - Can the patient continue normal activities while taking the medication?

Following these steps can help keep patients safe.

Long-acting Opioid Prior Authorization Requirements

(Applies to your patients with BlueCross Commercial, BlueAdvantage (PPO)℠, BlueChoice (HMO)℠ and BlueCare Plus (HMO SNP)℠ plans)

Earlier this year, BlueCross announced a policy change requiring your patients who take long-acting opioid pain medication therapy covered by BlueCross Commercial and Medicare plans to have a prior authorization for these medications effective Jan. 1, 2017. Following is the documentation required to process prior authorization for a long-acting opioid:

- Documentation containing the patient's diagnosis, evaluation and medical assessment for the requested medication which clearly indicates ALL of the following:
  - Nature and intensity of pain
  - Past and current treatments of pain (e.g., receiving opioids previously in treatment of acute pain)
  - Underlying or concomitant disorders and conditions
  - Effect of the pain on physical and psychological functioning
  - Review of history, physical examination and laboratory findings
- Pain management agreement signed by the patient and the provider in the past six months
- Aberrant behavior risk assessment tool
  - SOAPP (Screener and Opioid Assessment for Patients with Pain) for a new opioid user
  - COMM (Current Opioid Misuse Measure) for a current opioid user
  - ORT (Opioid Risk Tool)

CONTINUED FROM PAGE 3

- Documentation confirming the state controlled substance database has been reviewed in the past 90 days
- Treatment plan signed by patient and provider that includes goals, monitoring and periodic drug testing agreement
- Documentation with patient's results from a chronic opioid therapy assessment, using either the 5A's assessment or a pain assessment tool, e.g., Pain, Enjoyment and General Activity (PEG) scale

Note – Opioid treatment for patients in hospice care or undergoing cancer treatment will receive approval but still requires a prior authorization request.

Please note that there may be other components required for completion of the prior authorization. To view the entire policy on the Use of Opioids in Control of Chronic Pain, visit our website at bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm and select Administrative Services.

The 2017 Long Acting Opioids Criteria for the Commercial/Essential plans is available in the Pharmacy section of our website.

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.

BlueCross Morphine Equivalent Dose (MEqD) Criteria Effective 1/1/2017

(Applies to your patients with BlueCross Commercial, BlueAdvantage, BlueChoice and BlueCare Plus plans)

A component of the opioid policy change that was effective Jan. 1, 2017, was setting MEqD criteria. The policy change set a MEqD limit of 200mg per day across all opioids, both short-acting and long-acting, covered by BlueCross Commercial, BlueAdvantage, BlueChoice and BlueCare Plus plans.

Currently, approval of requests over the 200mg MEqD are limited to a maximum MEqD of 600mg with a six- month approval timeframe. If your patient is still receiving a cumulative MEqD greater than 200mg at the end of the six-month approval, a renewal request will need to be submitted. Following are helpful hints to aid in the MEqD prior authorization renewal process.

In order to process your patient's prior authorization for a MEqD renewal, we require the following information:

- Patient's cumulative MEqD for their opioid regimen at the time of the initial request
- Patient's current cumulative MEqD for their opioid regimen at the time of the renewal request
- Documentation of a taper plan to less than 200mg MEqD in the next six months

MEqD Resources:

agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Note – Opioid treatment for members with a terminal illness or undergoing cancer treatment will receive approval in six month increments and will not be limited to a MEqD of 600mg. However, these requests will still require prior authorization.

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.

Recommended Blood Glucose Testing for Overweight, Obese Patients

The US Preventive Services Task Force (USPSTF) has endorsed blood glucose testing as part of cardiovascular risk assessment in adults, 40 to 70, who are overweight or obese. Patients with abnormal blood glucose results should be referred for behavioral counseling to promote a healthy diet and physical activity. These interventions can help lower blood pressure, glucose and lipid levels and weight, all of which can reduce a patient's risk for type II diabetes.

The Centers for Disease Control and Prevention's (CDC's) National Diabetes Prevention Program website lists nationally recognized programs that have agreed to use a CDC-approved curriculum that meets established duration, intensity and reporting requirements.

Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

Providers are often the first point of care for alcohol and drug dependence treatment. Incorporate these suggestions to improve the chances that an individual will engage in and successfully complete treatment:

- Use screening tools to identify alcohol and other drug dependencies (AOD).
- Educate the patient on the new alcohol and other drug dependence diagnosis.
- Ensure the initial treatment is scheduled within 14 days of the diagnosis.
- Schedule two additional follow-up appointments within 29 days of starting treatment.
- Educate the patient's support system on the patient's diagnosis after obtaining an appropriate release of information to involve the patient's support system.
- For help finding a behavioral health provider to refer your patients, call the number listed on the back of their Member ID card.

Correction: Billing Assistant-at-Surgery Services for Commercial Plans

The March BlueAlert incorrectly stated that nurse practitioners (NPs) are eligible for reimbursement when providing assistant-at-surgery services. Assistant-at-surgery services provided by an NP or clinical nurse specialist (CNS) is considered ancillary support, is included in reimbursement to the licensed supervising physician or to the facility and should be compensated directly to the NP or CNS by the supervising physician or facility. The maximum allowable for reimbursement of assistant-at-surgery services provided by an NP or CNS is $0.00.

We apologize for any inconvenience this error may have caused.

Reminder: New Requirements in Effect for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect on Jan. 1, 2017.

BlueCross had previously indicated that claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants would deny beginning May 1, 2017; however, to allow more time to comply with this requirement, BlueCross will not begin denying claims on May 1. A revised date will be published in an upcoming BlueAlert.

Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, please visit bcbst.com/providers/mycontact to locate your BlueCross contact.

Reminder: Credentialing Requirements

Professional providers are reminded to update and maintain current information with CAQH®. With the following required information completed and kept up to date, the credentialing process should be seamless:

- Attest to the accuracy of your information with CAQH every 120 days.
- Current Certificate of Insurance (BlueCross cannot accept a Declarations Page)
- BlueCross requires call coverage – please complete this section on CAQH.
- If the practitioner does not admit to a hospital, BlueCross requires the name of the person authorized to admit for the practitioner.
- Complete work history with any gaps in work history explained
- Nurse Practitioners/Physician Assistants: Please upload professional certifications to CAQH.

Reminder: Durable Medical Equipment (DME) and Prosthetics and Orthotics Requirements

Providers billing for DME should have a Home Medical Equipment license. The only exceptions are providers billing for non-motorized equipment (e.g. walkers, canes, crutches). DME and medical supplies should only be billed by a DME provider when the services are purchased in a DME retail store or delivered to the member at their private residence. DME or medical supplies provided in a facility setting or during ambulance transport should not be billed by the DME provider. DME and supply services in these settings are incidental to the services provided by the facility or ambulance provider. Services billed improperly by DME or medical supply providers for items provided during a facility stay or ambulance transport are subject to recovery.

Providers billing for prosthetics or orthotics should have proper certification or accreditation. The provider is responsible for ensuring all codes billed are valid for the date of service. Information about certification and licensing requirements, as well as billing guidelines, is available in the provider administration manuals located on the company website at bcbst.com/providers/manuals.page.

Reminder: Requesting an MRI with Arthrogram for Commercial Members

CT and MRI testing for Commercial members associated with joint arthrogram procedure codes 23350, 27093, 27095, 27370, G0259, and G0260 can be authorized through the Musculoskeletal Program administered by OrthoNet.

- Member benefits should always be verified prior to submitting.
- If the member has musculoskeletal benefits and the procedure is on the Musculoskeletal Code List, the requested arthrogram should be submitted to OrthoNet including the MRI. You can request an authorization from OrthoNet through BlueAccess or by fax to 1-866-747-0587.
- If the member does NOT have musculoskeletal benefits but has high-tech imaging benefits, the MRI authorization request can be submitted to eviCore through BlueAccess as well. You may also call eviCore at 1-888-693-3211 or fax the request to 1-888-693-3210.
- In cases where the member has musculoskeletal benefits, when requesting authorization through BlueAccess, be sure the initial code listed is for the injection (for example 23350) then list the MRI code. This will help ensure the entire case is routed appropriately to OrthoNet.

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℠ and TennCareSelect plans, excluding CoverKids℠ and dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.

Tennessee Health Link, Patient-Centered Medical Home Preview Reports

Preview reports for Tennessee Health Link (THL) and Patient-Centered Medical Home (PCMH) – two newer programs of the Tennessee Health Care Innovation Initiative (THCII) – will be posted during the month of May.

To review your reports, login to BlueAccess at bcbst.com. If you need help accessing the reports, contact our eBusiness team at (423) 535-5717, Option 2 or at ebusiness_service@bcbst.com.

Children with Special Needs Require Annual TennCare Kids Checkups 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 checkup, children with special needs should also have TennCare Kids well-child checkups every year. You can find Recommendations for Preventive Pediatric Health Care 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.

TennCare Registration Required for Secondary Providers on Certain Claims

Beginning with claims on or after June 1, 2017, the following secondary providers submitting professional and/or institutional claims for BlueCare Tennessee and CoverKids members must be registered with the Bureau of TennCare as well as with BlueCare Tennessee for all dates of service on the claim.

Institutional Claims

- Attending Provider
- Operating Provider
- Other Operating Provider
- Rendering Provider
- Service Facility Location

Professional Claims

- Service Facility Location
- Purchased Service Provider

Claims submitted on or after June 1, 2017, with an unregistered secondary provider will be returned to the provider unprocessed.

To learn more about registering with TennCare please visit the TennCare website.

To register with BlueCare Tennessee, please call the Provider Service lines.

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

CDC Revises Vaccine Program for Dually Enrolled Children*

The CDC has updated guidance issued in 2017 for the Vaccines for Children (VFC) Program regarding children dually enrolled in Medicaid and private insurance. **Until further notice, BlueCare Tennessee will follow the guidelines in the 2016 VFC Operations Guide**.

Insured and Medicaid as Secondary Insurance:

Situations occur where children may have private health insurance and Medicaid as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid. The parent is not required to participate in the VFC program. The following are options for the parent and provider:

- **Option 1:** A provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee.
- **Option 2:** A provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee.

If you have questions, please contact Provider Service.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978

First Step for VFC Immunization Reimbursement is to Register with TennIIS

Your practice can receive payments for the administration of vaccines under the federal VFC program by registering with the Tennessee Immunization Information System (TennIIS). TennIIS is a statewide system managed by the Tennessee Department of Health to help ensure Tennesseans of all ages are properly immunized. The program allows health care providers, pharmacists, schools and childcare organizations to access and update vaccination records.

To learn more about TennIIS and VFC programs, please visit the TennIIS website.

If you are interested in enrolling in the VFC Program for the first time or would like to request a Starter Kit, please contact the VFC Enrollment team directly at VFC.Enrollment@tn.gov.

New Athletic Training Evaluation Codes Not Covered by BlueCare Tennessee and CoverKids

BlueCare Tennessee and CoverKids cover a complete, preventive checkup each year, so when your office is seeing patients for the purpose of a sports physical, these visits will serve as a great opportunity to perform a well-care visit.

Also, because these annual physicals meet or exceed the criteria required of a physical evaluation for playing sports, BlueCare Tennessee and CoverKids will not cover the four new athletic training evaluations codes released by the Centers for Medicare & Medicaid Services (CMS) (97169, 97170, 97171 and 97172) at the start of 2017.

BlueCare Plus Reimbursements for Patient Readmissions

In conjunction with the CMS Hospital Readmissions Reduction Program, BlueCare Plus will reimburse for readmissions to acute care hospitals that occur within 31 days from the index admission discharge as follows:

Facilities are not eligible for two DRG inpatient payments if a same or similar diagnosis readmission occurs within three to 31 days from a complication of the original hospital stay or admission – and it's due to a modifiable cause related to the facility's discharge diagnosis. This applies to readmission to the same facility or any other facility that is operating under the same contract.

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The facility will be reimbursed for a single inpatient DRG (the higher weighted of the two admissions) only. All other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for medical necessity.

A same or similar diagnosis readmission that occurs within 48 hours of an acute care hospital discharge from the same or similar facility, or facility operating under the same contract, will not be reimbursed regardless of the length of stay. CMS considers a short term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the member not being clinically stable at the time of the original discharge.

BlueCare Plus readmission guidelines are less stringent than the Readmission Reduction Program guidelines for original Medicare by not penalizing a facility for all diagnoses that could lead to a readmission or adjusting all Medicare payments. BlueCare Plus applies the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the individual member that is readmitted.

The goal of this program is to engage providers and facilities in addressing transition of care options. CMS considers 31 day readmissions to be an indicator of quality of care.

Notes:

- Members cannot be held liable for denied charges associated with a readmission within 31 days of a previous admission as indicated above.
- Standard facility appeal remedies are applicable.

NCCI Guidelines for 2017 Codes Available on CMS Website

No one is more aware of how complicated the coding process is for medical claims than providers and their support staff. The CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding methods nationwide.

The **NCCI Coding Policy Manual for Medicare Services** is updated each year and includes explanations for NCCI edits. The 2017 version is available at the CMS website and serves as a great reference tool for proper claims billing and the correct use of modifiers when billing specific services.

Implementing Patient Goals for Home Health

Home health care is often seen as a long-term or even perpetual service for patients. However, its intended role is to stabilize patients in a home environment to the point where they no longer need medical care. The demand for home health care is on the rise and stretching beyond capacity. To help ensure your patients continue to get the care they need, BlueCare Tennessee will implement new guidelines to help track progress as the health of patients improves. Specifically this will require providers who order private duty nursing (billed under code T1000) to set long-term and short-term goals, as well as evaluate their patients' progress toward those goals. Further details will be available in future editions of BlueAlert.

Guidelines for Expedited Medical Service Appeal

If you have a patient who is at risk of serious health problems or might die if he or she does not get health care, you can file an expedited appeal on their behalf. Expedited appeals for medical service must be approved or denied within three business days by the Bureau of TennCare.

To request an expedited appeal from the Bureau of TennCare, you may submit the Treating Provider's Certificate: Expedited TennCare Appeal Form located on TennCare website. See the TennCare website for details on how to file a medical appeal.

If you need to verify your patient's TennCare Eligibility, please visit TennCare's Verify Eligibility page.

Reminder: Coordinating Therapy for Your School-Age Patients

If you have a patient who is 20 or younger and needs physical, occupational and/or speech therapy while at school, BlueCare Tennessee can coordinate those services for our members. Before your patient begins therapy, in order to receive payment, the school must submit the patient's Individual Education Plan (IEP) to BlueCare Tennessee, along with a consent form signed by the patient's parent.

Please note that BlueCare Tennessee only pays for covered, medically necessary services performed by a licensed therapist.

For more information about the requirements for therapy, please see 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.

Provider Star Ratings Now Available in BlueAccess

The Medicare Advantage Quality Care Rewards Program offers providers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2016 measurement period of Jan. 1 – Dec 31, 2016. Providers may now visit BlueAccess to view their current Star rating based on the clinical data received from their practice for the previous measurement year.

After logging in to BlueAccess through bcbst.com/providers and accessing the Quality Rewards tool, providers may click on their Medicare Advantage scorecard and view their star rating at the top of the scorecard.

Star ratings, as calculated by the previous year's performance, may have impacted each provider's current reimbursement rates, effective April 1, 2017.

Providers should refer to their contract amendments for information about their base rate, the quality escalator and total earning potential. A complete listing of all providers who achieved 4-Star or above performance is available on our website.

BlueCross Medicare Advantage Members Have Free Gym Membership

Physical activity is an important part of living a healthy and fulfilling life as a person ages. SilverSneakers® is a value-added benefit that allows all BlueCross Medicare Advantage members access to hundreds of fitness facilities and classes throughout Tennessee. To find out more about this benefit and what it can do for your patients' activity levels, sign up for a free 30-minute webinar.

You'll learn that 86 percent of active SilverSneakers participants answer "yes" to the important quality survey question "Have you discussed physical activity with your provider?" and 62 percent of SilverSneakers participants report their health as either "very good" or "excellent."

Sign up to find out how SilverSneakers can help your patients.

Reminder: Behavioral Health Launches Partnership with AbleTo for Medicare Advantage Members

Beginning Aug 1, 2017, BlueCross will partner with AbleTo to provide a telephonic counseling and outreach program to a small group of Medicare Advantage members with adjustment and mood disorders. AbleTo will provide 16 telephonic sessions with a licensed therapist and a behavioral health coach over the course of eight weeks. Once enrolled in the program, members can access these services 24 hours a day, seven days a week at no additional cost.

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Initially, this service will be limited to 250 Medicare Advantage members with adjustment and mood disorders and other chronic health conditions. Members may be asked to participate via letter, or you can refer a BlueCross Medicare Advantage patient by calling 1-866-287-1802. This program does not limit any other behavioral health services patients have through their Medicare Advantage plan.

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member's condition. The MA plan follows Medicare policy. According to 42 U.S.C. § 1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

According to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.24(e) and (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

As with Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

Reminder: Medicare Risk Adjustment Medical Records

CMS requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross has partnered with ArroHealth to obtain medical records on our behalf to meet this requirement.

ArroHealth will formally request medical records beginning in late April and early May. 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 instructions provided with your letter how to return the requested medical records to ArroHealth.

You have three convenient ways to submit medical records to ArroHealth:

- Fax: 1-866-790-4192
  (646) 883-9921
- Mail: (please mark envelope as "Confidential")
  ArroHealth
  Attn: MRR3 Unit – BlueCross BlueShield of Tennessee
  49 Wireless Blvd Suite 140
  Hauppauge, NY 11788
- Secure Email: auditing@arrohealth.com

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

Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. 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 you to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Reminder: Medicare Advantage Home Health Billing Guidelines

Beginning June 1, 2017, Medicare Advantage will require HCPCS codes for all outpatient physical, occupational and speech therapy services. Skilled nursing, medical social services and home health aide services also require the appropriate HCPCS codes that correspond with the Revenue Code being billed.

Please be sure the billing units for home health services are filed as 1 unit for each 15-minute increment. Refer to the BlueCross BlueShield of Tennessee Provider Administration Manual for additional home health billing information.

Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Physical Therapy	421	G0151 G0157 G0159	1 unit per 15 minutes
Home Health Occupational Therapy	431	G0152 G0158 G0160	
Home Health Speech Therapy	441	G0153 G0161	
Home Health Agency Skilled Nursing (RN or LPN)	551	G0493 G0494 G0495 G0496	
Home Health Agency Medical Social Services	561	G0155	
Home Health Agency Home Health Aide	571	G0156	

Note: These coding changes will not affect current reimbursement.

Quality Care Rewards

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

THCII Episodes of Care Annual Feedback Session is May 16

The Tennessee Division of Healthcare and Finance will hold its annual feedback session on May 16, 2017. This is an opportunity for the public to comment on what is working well with each episode's clinical design and offer suggestions on changes for next year.

Twenty episodes of care (waves 1 – 4) will be open for discussion. Sessions will be offered simultaneously by video conference in six locations across the state. Episodes are grouped in four broader categories:

- Gastrointestinal Episodes, 8 – 9:30 a.m., CT
- Orthopedic and Cardiac Episodes, 9:45 – 11:15 a.m., CT
- Respiratory and Primary Care Episodes, 12:15 – 1:45 p.m., CT
- Behavioral Health Episodes, 2 – 3:30 p.m., CT

Click here to register for a session and select your meeting location.

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.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

CAQH Solutions | PROVIDER

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

† 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 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
***Select*Community**	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
Email:	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

JUNE 2017

BlueAlert℠

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 is being updated to reflect the following revised policies. The full text of these policies can be found online by clicking Upcoming Medical Policies.

Effective July 8, 2017

- Bio-Engineered Skin and Soft Tissue Substitutes (Revision)
- Diagnosis and Treatment of Facet Joint Pain (Revision)
- Molecular Markers in Fine Needle Aspirates of the Thyroid (Revision)
- Treatment of Tinnitus (Revision)

Effective Aug. 23, 2017

- Home Apnea Monitoring / Home Cardiorespiratory Monitoring (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Availity - New Provider Portal Coming Soon

BlueCross is making enhancements to our online tools to keep pace with advancements in technology and to provide you with the resources you need. We have partnered with Availity, a leading provider of electronic health care transactions, to offer you a wider range of web-based products and services. Availity offers a multi-payer portal solution allowing you to use a single sign-on to work with BlueCross and other participating health care plans online.

Initially, the new portal will be used for reviewing remittance advices, claims status, eligibility and benefits. More features will be phased in throughout the year. As changes emerge, you will see eBusiness and other BlueCross resources leading efforts on education, provider engagement and training. We will continue to keep you updated about our transition to Availity through BlueAlert, online messages and updates through BlueAccess℠. Availity will eventually replace BlueAccess for providers.

INSIDE THIS ISSUE

Upgrade to Web Authorizations Improves MCG Selection and Documentation

BlueCross has enhanced its online authorization tool. The upgraded tool improves the MCG guideline selection and documentation process for your web authorization requests.

What are the changes?

- New easy to use format
- Most authorizations submitted online have MCG criteria applied.
- Sticky note icons are now included at the end of the guidelines. Additional clinical information can be included by clicking the sticky note icon (250 character limit per note).
- Guidelines that include "…" allow additional criteria to be presented.

Please remember to always load the primary diagnosis first.

When did the changes go into effect?

The changes were implemented on May 1, 2017. If you're not currently using online authorization submission or are using the tool but would like additional training and support, please contact the eBusiness Technical Support or the eBusiness Marketing team.

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 in 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 professionals' approach to patient care
- Creating and maintaining good relationships with patients and fellow professionals

You can find more information and other resources by visiting the National Center for Biotechnology Information (NCBI) website.

Antipsychotic Use Has Potential to Impact Patient Health

We recommend that behavioral health providers notify their patient's PCP when antipsychotic medications are being considered. The American Psychiatric Association (APA) recommends an assessment of the patient's health 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 APA Practice Guidelines for more information.

Prior Authorization Required for Bavencio and Ocrevus

As of April 28, 2017, Bavencio and Ocrevus were added to the Provider-Administered Specialty Pharmacy Lists and require prior authorization for all lines of business.

You can find information on all provider-administered specialty medications requiring prior authorization on our website(s).

BlueCare Tennessee
BlueCare Plus (HMO SNP)SM
Commercial/CoverKids
Medicare Advantage

Updated THCII Preview and Performance Reports Now Available

The Tennessee Health Care Innovation Initiative (THCII) preview and performance reports are now available on Blue Access for your review. You can use them to identify specific opportunities to further improve quality and reduce the cost of care.

- View your reports by logging in to BlueAccess at bcbst.com/providers.
- Scroll down to Tennessee Healthcare Innovation Initiative to locate your reports. Note: Reporting is segmented by Tax ID."

Applies only to BlueCare Tennessee, CoverKidsSM, State Employee Health Plan and Fully Insured.

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Beginning immediately, CPT® code 27279 requires prior authorization through the Musculoskeletal Program administered by OrthoNet.

Before submitting prior authorization requests, please verify member benefits/eligibility through BlueAccess or by calling the Provider Service Line.

Prior authorization requests can be submitted through BlueAccess or by fax to 1-800-747-0587. When submitting requests online, the musculoskeletal code must be the primary procedure code.

Reminder: Prior Authorization Required for CPT® Code 81545

Effective July 8, 2017, a prior authorization is required for CPT® Code 81545 (Molecular Markers in Fine Needle Aspirates of the Thyroid) for Commercial lines of business. For a list of services that require prior authorization, see the BlueCross website.

Reminder: New Requirements in Effect for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect on Jan. 1, 2017.

BlueCross had previously indicated that claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants would be considered out of network and would be denied beginning May 1, 2017. In order to allow more time to comply with this requirement, BlueCross will not process these claims as out of network or deny them for dates of service beginning May 1, 2017. A revised date will be published in an upcoming BlueAlert.

Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, please visit our website to locate your BlueCross contact.

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 any barriers that prevent you from filing electronic claims.

BlueCare Tennessee

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

Reminder: Document Any Refusal to Vaccinate

Each parent/guardian or patient has the right to refuse recommended vaccines. Refusal to get recommended immunizations must be documented in the patient's medical record. Resources for documenting the refusal are available on the American Academy of Pediatrics website.

Additionally, the Centers for Disease Control and Prevention has conversation tools to help talk with parents/guardians and patients about the importance of immunizations and the importance of preventive care.

Reminder: Sick Visit Could be Your Only Chance to Conduct a TennCare Kids Checkup

Thousands of kids from low-income homes in Tennessee miss their annual well-care checkups, and the number who miss increases every year. Any time a child (patient under age 21) with TennCare Kids coverage is in your office is a great time to make sure your patient's checkups are up to date.

While your patient's visit might be for an illness, shots or a prescription refill, statistics show it could be years before you get another chance to conduct a checkup, especially if your patient is a teenager. TennCare Kids Screening Guidelines permit reimbursement for both a "sick" and "well" visit on the same day, so you don't have to schedule another appointment.

For the correct coding and modifier usage for billing both types of care on the same day, please see the TennCare Kids Screening Guidelines section of the BlueCare Tennessee Provider Administration Manual.

Reminder: Prior Authorization Required for DPP-4 and SGLT-2 Inhibitors for Diabetes

Diabetes medications such as DPP-4 and SGLT-2 inhibitors and their combinations require prior authorization (PA).

For questions or prior authorization requests for your BlueCare Tennessee patients, please contact Magellan Health Services Clinic Call Center at 1-866-434-5524 or fax your request to 1-866-434-5523.

Drugs requiring prior authorization for BlueCare Tennessee members are identified by (PA) on the TennCare's Preferred Drug List (PDL).

Reminder: TennCare Registration Required for Secondary Providers on Certain Claims

Beginning with claims on or after June 1, 2017, the following secondary providers submitting professional and/or institutional claims for BlueCare Tennessee and CoverKids members must be registered with the Bureau of TennCare as well as with BlueCare Tennessee for all dates of service on the claim.

Institutional Claims

- Attending Provider
- Operating Provider
- Other Operating Provider
- Rendering Provider
- Service Facility Location

Professional Claims

- Service Facility Location
- Purchased Service Provider

Claims submitted on or after June 1, 2017, with an unregistered secondary provider will be returned to the provider unprocessed.

To learn more about registering with TennCare please visit the TennCare website.

To register with BlueCare Tennessee, please call the Provider Service lines.

BlueCare	1-800-468-9736
TennCareSelect	1-800-276-1978
CoverKids	1-800-924-7141

Medicare Advantage

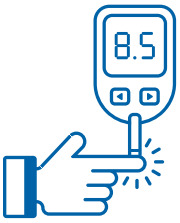
This information applies to BlueAdvantage (PPO)℠ and BlueChoice (HMO)℠ plans. BlueCare Plus (HMO SNP)℠ is excluded unless stated otherwise.

Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. 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, and you will be asked to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002



Reminder: 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 your Medicare Advantage patients tools and rewards to encourage them to follow your plan of care and maintain a healthy lifestyle.

For details about the rewards your patients can receive for completing recommended diabetes screenings, see the comprehensive list of wellness incentives on our Quality Care Rewards webpage.

If you have diabetic patients who have trouble making it to your office, we can help schedule in-home visits so your patients can complete the tests they need. Just call us at 1-800-841-7434 and 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

You will receive all copies of test results. And if you participate in our provider quality program, you will receive credit for these gaps in care getting completed.

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member's condition. The MA plan follows Medicare policy. According to 42 U.S.C. § 1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

According to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.24(e) and (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

As with Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly; the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

Quality Care Rewards

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

Delay of Breast Cancer Medical Oncology, Mastectomy Episodes of Care

The Breast Cancer Medical Oncology and Mastectomy episodes in Wave 5 will not be included in the Tennessee Health Care Innovation Initiative (THCII) May 2017 preview reports, because the Cancer Registry data has not yet been incorporated. The performance period for these two episodes will begin with calendar year 2019, instead of calendar year 2018.

The Breast Biopsy episode will not be delayed, and will be included in the May 2017 reports. The first performance period for this episode will be in calendar year 2018.

Filing an Encounter Claim for Comprehensive Diabetes Care

An encounter claim may be filed for patients who have a retinal or dilated eye exam by an eye care provider in 2017. For patients who had a negative dilated retinal eye exam in 2016, you can file an encounter claim and refer them to an eye care professional for a comprehensive eye exam in 2017.

The CPT® Category II code for a negative retinal screen in the prior year is 3072F. You can find sample codes for diabetic retinal exams and more information on our website.

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

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

CAQH Solutions | PROVIDER

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

† 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 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
***Select*Community**	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
Email:	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

JULY 2017

BlueAlert℠

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 policy listed below can be found at bcbst.com/providers/medical-policy-manual/index.page under the "Upcoming Medical Policies" link.

Effective Aug. 1, 2017

- Corneal Collagen Cross-Linking (Revision)
- Genetic (Human Leukocyte Antigen) Testing for Celiac Disease (Revision)
- Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy (Revisio)

Effective Aug. 23, 2017

- Autologous Chondrocyte Implantation (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Utilization Management (UM) Guideline Updates/Changes

The BlueCross website has been updated to reflect upcoming changes to select UM Guidelines. Click here to review the pending modifications.

Effective Aug. 23, 2017

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

- Hyperemesis Gravidarum

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

INSIDE THIS ISSUE

Coming Soon: Availity

BlueCross has partnered with Availity to help ensure your online experience is equal to or better than your experience with BlueAccess℠. Initially, Availity will be used to review remittance advices, claims status, eligibility and benefits with more features added throughout the year. For example, these BlueCross-specific features will be available at or shortly after the upcoming launch:

- **Unified Member Search** – This custom member search will closely match our capabilities in BlueAccess and will include search options by SSN, name and DOB.
- **BlueCard®** – Searches for your out-of-state patients will be available in the same interface, which means you will no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- **Claims Management Tool** – BlueCross will be among the first payers to implement Availity's upgraded Claim Management Tool for managing claim follow-up tasks. A customized search for BlueCross will include rejected claims, as well as adjudicated claims, allowing you to retrieve a full picture of your claim lifecycle all in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications and updates.

As we get closer to transitioning our online provider tools to the Availity web portal, you will receive more information about the next steps you'll need to take. To prepare for the transition, identify the person in your office who would create and manage accounts for other users.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.

Online Claims Submission Exception

BlueCross requires providers to submit claims online, but we know that sometimes things happen that are out of your control. If you have a technical and/or temporary issue or extenuating circumstances that prevent you from submitting claims online, please call our eBusiness Department at (423) 535-5717 (select option 2) or email us at eBusiness_TechSupport@bcbst.com.

For complete information and requirements to submit paper claims when there are extenuating circumstances that prevent electronic filing, please see the Billing and Reimbursement section of our BlueCross BlueShield of Tennessee Provider Administration Manual.

Post-Hospitalization Mental Illness Follow-up

Appropriate follow-up care after 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. Completing a follow-up appointment within seven days of discharge decreases the possibility of medication interruption, offers support at a vulnerable time and decreases the likelihood of readmission by almost 50 percent.

Sample diagnoses for follow-up visits include:

- Dementia
- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Other mental illnesses

What can you do to help increase patient follow-up visits after discharge?

1. Schedule follow-up visits with patients within seven days.
2. Share information about established patients with hospital staff to make sure their discharge needs are met.
3. Make sure your patient understands the discharge plan and importance of keeping follow-up appointments.
4. Advise office staff/schedulers about the importance of follow-up visits within seven days.
5. Follow up with a patient who misses an appointment and attempt to reschedule.

Prior Authorization Required for Imfinzi

Periodically, new Specialty Pharmacy drugs are added to our Provider-Administered Specialty Drug List requiring prior authorization. Imfinzi was added to the Provider-Administered Specialty Drug Lists requiring prior authorization for all lines of business effective June 1, 2017.

You can find information on all provider-administered specialty medications requiring prior authorization on our website(s).

FREE Quality Training for Network Providers

BlueCross is offering a two-day class Aug. 23 to 24, 2017, to promote health care quality. The training class will be held in the BlueCross BlueShield of Tennessee Community Room, 1 Cameron Hill Circle in Chattanooga. The class is designed to help those planning to take the Certified Professional in Healthcare Quality® (CPHQ) examination and offers intermediate quality improvement content that can benefit anyone working in the health care quality field. Get more information on our website.

Although the training costs $399, BlueCross is offering the class to our network providers at no charge. 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 network provider

Registration for network providers is limited to two participants per group/facility for the 2017 class. To register, email tawanda_malone@bcbst.com.

Reminder: Prior Authorization Submissions for Provider-Administered Specialty Medications

Please note we are not able to accept prior authorization requests for specialty medications by fax. Because more detailed information is requested through the prior authorization process, and because we want to help ensure you get faster responses from us, we require online or phone prior authorization submissions. These direct interactions with clinical pharmacists and board-certified physicians will help ensure we get all the information required to make informed and timely decisions. For help submitting your authorizations online using BlueAccess, please contact your eBusiness Marketing Consultant.

Reminder: 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 claim 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.

Paper claims will only be accepted when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support to discuss any barriers that may prevent you from filing electronic claims.

Reminder: New Claims Editing System to Take Effect Later this Year

BlueCross will implement a more robust editing system for Commercial professional and facility claims in the latter part of 2017. The editing system adheres to industry rules and standards, as well as federal regulations and policies governing health care claims.

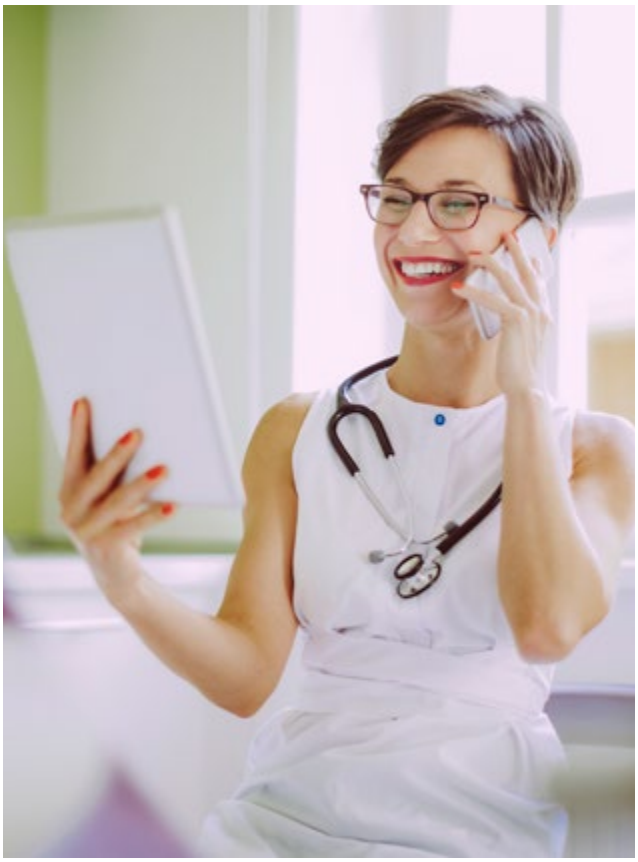
You may see some slight differences in how claims are processed as a result of this change. Look for more information in upcoming issues of BlueAlert.

Reminder: New Requirements for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect Jan. 1, 2017.

BlueCross had previously indicated that claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants would be considered out of network and would be denied beginning May 1, 2017. To allow more time to comply with this requirement, BlueCross will not process these claims as out of network at this time. A revised date will be published in an upcoming BlueAlert.

You can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local Provider Network Manager if you have any questions. If you don't know who your Network Manager is, please visit our website to locate your BlueCross contact.



Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise

Post-Operation Billing for Unrelated Procedures

We want to make sure your claims process efficiently and without any issues. So when the same issues trigger denials on a regular basis, we want you to know.

More claims are being denied when incorrect modifiers are used during a global billing period.

Modifiers 24 (unrelated post-op evaluation and management) and 79 (unrelated post-op procedure) are available to help simplify the post-op billing process, but the use of these modifiers is very strict. These two modifiers are only for care that has no relation to the surgery. Please include documents that substantiate any care unrelated to the surgery to help speed the payment of your claims.

For more information, refer to the "Medicare Claims Processing Manual," Chapter 12, Section 40.2, on the CMS website.

Radiopharmaceutical Allowance Updated for Code A9500

Starting Aug. 1, 2017, we will no longer require supplemental information when filing claims with HCPCS Code A9500. This change is the result of our in-depth analysis of code A9500 (Technetium Tc-99m sestamibi, diagnostic, per study dose) to address provider concerns about the reimbursement process. In this analysis, data from paid claims were reviewed along with invoice documents supplied by providers to establish a reasonable allowable.

Reminder: Prior Authorization Required for CPT® Code 81545

Effective July 8, 2017, prior authorization is required for CPT® Code 81545 (Molecular Markers in Fine Needle Aspirates of the Thyroid) for Commercial lines of business. For a list of services that require prior authorization, see the BlueCross website.

Reminder: Billing Guidelines for Non-Eye Care Professionals Conducting In-Office Retinal Eye Screenings for Medicare Advantage Members

If you perform in-office digital retinal eye screenings and send the results to eye care professionals to review and interpret, please verify your claims have the appropriate CPT® II, procedure and diagnosis codes.

Without the correct CPT® II code (e.g., 2026F or 3072F), a gap in care for the Comprehensive Diabetes Care Eye measure cannot be closed per NCQA requirements in the 2017 HEDIS® technical specifications for this measure.

- Code 2026F documents that you reviewed the results and confirm the patient had retinal imaging.
- Code 3072F documents that you reviewed evidence the patient had a negative retinal eye exam during the prior year and therefore did not need a retinal eye exam during the current measurement year.

Please use the date of retinal imaging as the date of service.

If you have any questions about in-office retinal eye exams, please contact your BlueCross Quality Outreach Consultant.

BlueCare Tennessee

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

Latest Changes to TennCare PDL Become Effective July 1

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 anti-infectives, gastrointestinal agents, endocrine and metabolic agents, as well as vitamins and electrolytes.

Click here to view the notice of PDL changes effective July 1, 2017.

Provider Satisfaction Survey Coming Soon

Your satisfaction is important to BlueCare Tennessee. Your responses to our annual BlueCare, BlueCare Plus, TennCare*Select* and CoverKids Provider Satisfaction Surveys will help us continue to improve the services and support you need. The surveys are conducted by random sampling. If selected, you will receive the survey at the email address we have on file for you between July 5 and Sept. 29, 2017.

Durable Medical Equipment Review Process Update

As of Aug. 1, 2017, BlueCare Tennessee will begin using MCG Care Guidelines for durable medical equipment reviews. When MCG Care Guidelines are not available, Medicare Local Coverage Determination (LCD)/National Coverage Determination (NCD) Coding Guidelines will continue to be used.

Providers Cannot Accept Cash Payments from TennCare Enrollees that Exceed Copayments

The Bureau of TennCare has identified a large number of prescriptions written for members with TennCare coverage that don't correspond with a provider claim. If your office sees patients with BlueCare Tennessee benefits, you cannot accept cash payments that exceed the amount of their authorized copayments. Providers who violate this part of their contract can be removed from participating in TennCare provider networks.

Reminder: Tips to Help More Children Get TennCare Kids Screening

Thousands of kids (ages 20 and younger) from low-income homes in Tennessee miss their annual well-care checkups and that number increases every year. Statewide, about three of every 10 kids enrolled in BlueCare Tennessee do not get the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings they need. We're working to reverse that trend and are asking for your help.

Combining a Well-Care Visit with Other Types of Visits

Any time a child is in your office is a great time to make sure their checkups are up to date. While the visit might be for an illness, shots, sports physical or a prescription refill, statistics show it could be years before you get another chance to conduct a checkup – especially if the patient is a teenager. TennCare Kids Screening Guidelines allow reimbursement for both a "sick" and "well" visit on the same day, so you don't have to schedule another appointment for a checkup.

Reminder: Document Any Refusal to Vaccinate

Each parent/guardian or patient has the right to refuse recommended vaccines. If the parent/guardian or patient decides not to get recommended immunizations, their decision must be documented in the patient's medical record. Resources for documenting the refusal are available on the American Academy of Pediatrics website. Additionally, the CDC website has conversation tools to help talk with parents/guardians and patients about the importance of immunizations and the importance of preventive care.

Medicare Advantage

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

Medicare Advantage End Stage Renal Disease (ESRD) Prescription Drugs Part D Versus Part B

The CMS final rule (79 FR 66149) identified four ESRD drug categories included in the ESRD base reimbursement rate, which are not separately payable:

Access Management	Drugs that remove clots from grafts to ensure access will reverse anticoagulation if too much medication is given.
Anemia Management	Drugs used to stimulate red blood cell production and/or treat or prevent anemia. This category includes Erythropoietin Stimulating Agents (ESAs) as well as iron.
Bone and Mineral Metabolism	Drugs used to prevent/treat bone disease secondary to dialysis. This category includes phosphate binders and calcimimetics.
Cellular Management	Drugs used for deficiencies of naturally occurring substances needed for cellular management. This category includes levocamitine.

BlueCross reviews prescription drug claims for ESRD patients processed through their Medicare Part D benefit. If we find BlueCross paid for a prescription for renal dialysis-related drug that was under the ESRD Prospective Payment System, we will recoup that amount from the Part B renal facility claim on file.

Reminder: BlueCross Medicare Advantage Case Management Program

BlueCross' Medicare Advantage Case Management program helps our most complex or sickest patients, and those suffering from chronic conditions, effectively manage their illnesses to help ensure they live the highest quality of life possible.

Our programs are designed to assist members who have catastrophic health care needs and limited knowledge or understanding of chronic conditions. Services include nutritional counseling and general assistance with medications, transportation and other barriers to care.

Our members are eligible for case management at no additional cost, and our programs support your plan of care. It is an opt-out program, meaning your patient can choose to leave at any time. However, we encourage our members to participate to help them get the support they need to live happy and healthy lives. You can help your patients by also encouraging them to participate.

Refer your patients to case management by calling 1-800-611-3489 or faxing 1-800-727-0841.

Reminder: Behavioral Health Launches Partnership with AbleTo for Medicare Advantage Members

Beginning Aug. 1, 2017, BlueCross will partner with AbleTo to provide a telephonic counseling and outreach program to a small group of Medicare Advantage members with adjustment and mood disorders. AbleTo will provide 16 telephonic sessions with a licensed therapist and a behavioral health coach over the course of eight weeks. Once enrolled in the program, members can access these services 24 hours a day, seven days a week at no additional cost.

Initially, this service will be limited to 250 Medicare Advantage members with adjustment and mood disorders and other chronic health conditions. BlueCross will be sending letters to identified members that would be eligible for and benefit from the AbleTo program or you can refer a BlueCross Medicare Advantage patient by calling 1-866-287-1802. This program does not limit any other behavioral health services patients have through their Medicare Advantage plan.

Reminder: In-Home Test Kits Available for Homebound Medicare Advantage Members

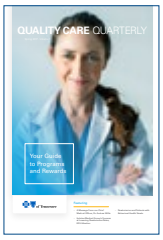
We know that getting to the doctor's office can sometimes be a challenge for some of your patients. That's why we offer in-home test kits for three of the most common annual screenings Medicare Advantage members should receive.

With a simple phone call, our partner Home Access, can mail your patient an in-home test kit for a:

- Fecal immunochemical (iFOBT of FIT) blood screening for colorectal cancer
- Kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

The member then follows the instructions to mail the kit back to the vendor for lab testing and the written results are 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.

For more information on how to order an-in home test kit for your patients, contact your BlueCross Quality Outreach Consultant.



Quality Care Rewards

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

New Quality Newsletter Available Online

BlueCross has developed a quarterly newsletter devoted to information on our quality programs. The spring 2017 Quality Care Quarterly provides insights on our quality initiative, and includes informative articles on quality measures, helpful tips and success stories from your peers.

Each edition of the newsletter will be sent to you by your BlueCross contact and will be posted online. If you didn't receive the link to the spring 2017 Quality Care Quarterly, you can view it here.

REMINDER: Updated THCII Preview and Performance Reports Now Available

The Tennessee Health Care Innovation Initiative (THCII) preview and performance reports are now available on Blue Access for your review. You can use them to identify specific opportunities to further improve quality and reduce the cost of care.

- View your reports by logging in to BlueAccess.
- Scroll to Tennessee Healthcare Innovation Initiative to locate your reports.

Note: Reporting is segmented by Tax ID.

For more information, or if you need help understanding your Episode of Care reports, see our webpages:

- BlueCare Tennessee Episode of Care Program
- Commercial Episode of Care Program

Reminder: Preventing Falls

One of every five falls causes a serious injury like a broken bone or blow to the head. The risk of falling is higher for someone who is weak or confused because of a previous injury, surgery, medical condition or medicine. Falls become even more dangerous if the person is taking certain medicines (like blood thinners).

Here are some tips you can share with your at-risk patients that may help reduce the risk of falls in their homes:

- Remove clutter and items that could cause a trip like small furniture, rugs and electrical cords.
- Make sure railings are installed on both sides of stairs.
- Use non-skid adhesive strips on stairs.
- Install grab bars in showers, bathtubs and near toilets.
- Place non-skid mats in the bath and shower.
- Make sure any dark areas are well lit and add nightlights in areas such as the kitchen, bathrooms and hallways.
- Use walkers or canes.
- Wear proper shoes

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*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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CAQH Solutions | PROVIDER

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

† 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 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
***Select*Community**	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
Email:	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 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, please click here.

Effective Sept. 1, 2017

- Keratoprosthesis (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Clarification: Technical Component for Professional Services Performed in a Facility*

Commercial DRG and outpatient case rates paid to a facility must include any technical component for professional services provided while a patient is in a facility setting. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist or other provider. Payment is not made under the physician fee schedule for technical component services furnished to patients in institutional settings.

This article is for clarification only and is not a change to our current policy or practice. This information will be included in the next available update to the BlueCross BlueShield of Tennessee Provider Administration Manual.

If you are providing this service and have reimbursement questions, please contact the facility or your BlueCross Network Manager.

INSIDE THIS ISSUE

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Beginning Sept. 1, 2017, the CPT® codes listed below will require prior authorization through the Musculoskeletal Program administered by OrthoNet.

0213T	22867	27198	62370
22853	22868	27702	64999
22854	22869	27703	
22859	22870	62380	

Before submitting prior authorization requests, please verify member benefits and eligibility through BlueAccess℠ or by calling the Provider Service Line.

Prior authorization requests can be sent through BlueAccess or by fax to 1-866-747-0587. When submitting requests online, the musculoskeletal code must be the primary code.

Further Updates to Claims Editing Process Aim to Increase Payment Accuracy

Earlier this year, BlueCross began updating the claims payment process for all lines of business, including BlueCare Tennessee and Medicare Advantage. The latest updates will include a more careful analysis during the pre-payment phase of claims editing, with the goal of delivering payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability.

Because the system performs a closer review of claims, some unintended or incomplete items that have passed through for payment in the past may process differently in the future. However, this update will not reduce provider reimbursement rates, your patients' benefits or the speed at which we pay your claims.

While these updates will not completely eliminate overpayments or the need for recovery, our efforts in 2017 help ensure a more accurate and efficient payment process to our providers.

Reminder: Availity Coming Soon

We're excited to announce that we have partnered with Availity – an advanced account management system scheduled to replace BlueAccess. Initially, Availity will be used to review remittance advices, claims status, eligibility and benefits with more features added throughout the transition. For example, these BlueCross-specific features will be available at or shortly after launch:

- Unified Member Search – This custom member search will closely match our capabilities in BlueAccess and will include search options by SSN, name and DOB.
- BlueCard® – Searches for your out-of-state patients will be available in the same interface, which means you will no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- Claims Management Tool – This upgraded tool features a customized search function so you can find rejected and adjudicated claims. You'll also be able to see your full claim lifecycle in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications and updates.

As we get closer to transitioning our online provider tools to the Availity web portal, we'll send more information about next steps. In the meantime, you may want to begin sharing information with the person who will create and manage accounts for other users.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.

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. Please keep in mind that genetic testing not performed by a network provider requires prior authorization, and other out-of-network services may require review.

Reminder: New Requirements in Effect for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect on Jan. 1, 2017.

Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local Provider network manager with any questions. Or visit our website to find your BlueCross contact.

Reminder: Split Billing

BlueCross does not accept split billing unless requested. A split bill is appropriate only when requested by BlueCross to reflect covered charges allocated for approved and denied days. Split bills that have not been requested by BlueCross are subject to denial or recovery. All services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise

Submitting Evaluation and Management with Injection Services

We want to help you make sure that your claims process efficiently and without any issues, so we want to let you know when items that trigger a denial start appearing on a regular basis. If you're performing evaluation and management services and injections, infusions, immunizations or chemotherapy during the same date of service, National Correct Coding Initiative (NCCI) editing will bundle these together.

If you would like detailed information, please see the NCCI Policy Manual for Medicare Services. Chapter XI of the manual details the process of using modifiers for reporting evaluation and management services in addition to therapeutic or diagnostic infusion/injection and immunization services.

BlueCare Tennessee

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

See the New BlueCare Tennessee Website

Check out the provider page of our new BlueCare Tennessee website. We've redesigned all of our pages to make it easier than ever to get what you need from us online for BlueCare Tennessee plans including CoverKids. And everything is optimized to work on tablets too. The new site is live now at bluecare.bcbst.com/Providers/index.html.

CMS Makes Changes to Therapy Codes

As of Jan. 1, 2017, the Centers for Medicare and Medicaid Services (CMS) replaced CPT® code 97002 with 97164 and 97004 with 97168. These codes will be included in the TennCare Budget Reduction memo under attachment I. Reimbursement for these services will the lesser of 1) the MCOs current reimbursement amount for therapy codes or 2) the current published CMS Medicare reimbursement amount.

Community Outreach Events Bridge Gaps in Patient Care

Across the state, only about 70 percent of kids enrolled in BlueCare Tennessee get their annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) checkups, also known as TennCare Kids well-child checkups. We need your help to push that rate above 80 percent.

That's why we'd like to cohost a Provider Community Outreach Event with you.
These events offer a relaxed and enjoyable way for your patients to get the preventive care and screenings they need. Not only do these events serve your patients, they help build stronger communities.

You're important to the BlueCare Tennessee members in your care. They trust you, and we know you're dedicated to helping them improve their health.

If you're ready to partner with us for an event or if you'd like more information, please call us at 1-800-771-0217.

Reminder: Provider Satisfaction Survey Coming Soon

Your satisfaction with the service we provide is important to BlueCare Tennessee. Your responses to our annual BlueCare, BlueCare Plus, TennCare*Select* and CoverKids Provider Satisfaction Survey will help us continue to improve the services and support you need. The surveys are conducted by random sampling. If selected, you will receive the survey at the email address we have on file for you between July 5 and Sept. 29, 2017.

Reminder: Coordinating Therapy for Your School-Age Patients

If you have a patient who is 20 or younger and needs physical, occupational or speech therapy while at school, BlueCare Tennessee can coordinate these services for our members. Before your patient begins therapy, in order to receive payment, the school must submit the patient's Individual Education Plan (IEP) to BlueCare Tennessee along with a consent form signed by the parent or guardian.

Please note that BlueCare Tennessee only pays for covered, medically-necessary services performed by an in-network, licensed therapist.

For more information about the requirements for therapy, please see the BlueCare Tennessee Provider Administration Manual.

Reminder: Filing an Appeal on Behalf of Your Patient

Your patients have the right to appeal decisions about their health care. If coverage for services is denied or reduced, an appeal can be requested within 30 days of notification of the decision. You can submit an appeal on your patient's behalf to the Bureau of TennCare by mailing or faxing the TennCare Medical Appeal form to:

TennCare Solutions Medical Appeals

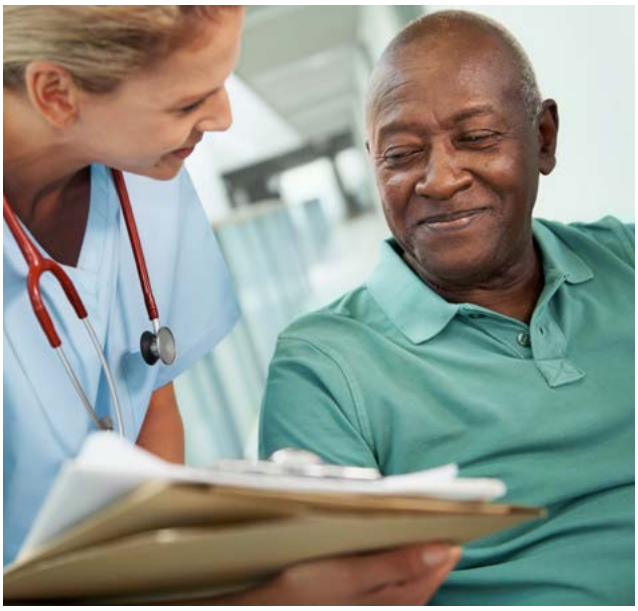
P.O. Box 593
Nashville, TN 37202-0593

Fax (toll-free) 1-888-345-5575

Please include all pertinent medical records related to the appealed service. For a timely response, please do not file a member appeal on a provider appeal form.

You can find more information about how to file a medical appeal on the State of Tennessee website.

Note: Beginning Jan. 1, 2018, an appeal must be filed within 60 days from the date of the notice of adverse benefit determination. You will still be able to file an appeal on the patient's behalf, but must first have written consent from the patient. You will not able to file a request for Continuation of Benefits.



Medicare Advantage

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

In-Home Bone Density Screenings Available for BlueAdvantage℠ and BlueChoice℠ Members

Usually, the first symptom of osteoporosis in an older patient is a broken bone. Seniors – especially women – are susceptible to osteoporosis, so it's important to schedule a bone density test for any patients who have suffered a recent fracture.

We understand it's not always easy for our BlueAdvantage patients to see their physicians for an in-office screening, so we work with our independent health partner, MedXM, to provide in-home bone density screenings. Our members who cannot travel can now receive this important test in the privacy of their own homes.

BlueCross identifies members for in-home bone density screenings using a variety of factors, such as a pattern of non-compliance with the screening in previous years or barriers to care that might prevent members from visiting their physician's office.

This service is available at no additional cost to members, and results are given to members and their primary care physician.

To order an in-home bone density screening, members can contact MedXM at 1-866-435-4372, Monday through Friday, 7 a.m. to 8 p.m., (ET). TTY users can call 711.

Earn Bonus by Sending Your Provider Assessment Forms

In 2017, you are eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueChoice℠ members.

BlueAdvantage will reimburse the service as E/M Code 96160, with an allowable charge through the end of the year as follows:

- $175 for dates of service between July 1 and Sept. 30, 2017
- $150 for dates of service between Oct. 1 and Dec. 31, 2017

You can receive your reimbursement by completing and submitting the Provider Assessment Form electronically via BlueAccess. You may also complete the fillable form and fax it to 1-877-922-2963. The form should be included in your patient's chart as part of their permanent record.

Note: It's not necessary to wait 365 days between PAF submissions. For additional information about the PAF, please see the Quality Care Rewards section of our website.

Hospice Prescription Drugs Review

Members who are in hospice care generally experience common symptoms, including pain, nausea, constipation and anxiety during end-of-life care. CMS identified four common prescription categories typically used to treat these symptoms: Analgesics, anti-nauseants, laxatives and anti-anxiety drugs.

CMS requires Medicare Advantage plans to review claims paid within the hospice election period for prescription drugs in these four categories. It also plans to conduct outreach to the hospice provider or prescriber.

Hospice facilities may receive written requests from the Medicare Advantage plan to retrospectively determine payment responsibility for the four categories of drugs used in the hospice setting. You can find more information on the CMS website.

Reminder: Hospice Modifier GV & GW

When Medicare beneficiaries select hospice coverage, they may designate an attending physician (or nurse practitioner) that is not employed by the hospice provider in addition to a hospice-employed physician. Services provided to a hospice patient by an attending physician/nurse practitioner that isn't associated with the hospice in any way (employed, contracted or volunteering), should be billed to the Medicare Administrative Contractor (MAC) with one of the following modifiers:

- GV – This modifier is used when billing for a service **that is** related to the diagnosis for which a patient has been enrolled in hospice.
- GW – This modifier is used when billing for a service **that is not** related to the diagnosis for which a patient has been enrolled into hospice.

You can find these guidelines on the CMS website.

Medicare Advantage Members Electing Hospice Services

MACs retain payment responsibility for all hospice- and non-hospice-related claims, excluding supplemental benefits, beginning on the day hospice care was selected.

Medicare Advantage members who select hospice care may revoke this option at any time. However, claims will continue to be paid by the appropriate A/B MACs as if the beneficiary was covered under original Medicare until the first day of the month following the month in which hospice was revoked. Please note that certain medications not related to the admitting hospice diagnosis may be covered under the Medicare Advantage Part D benefit.

You can find these guidelines on the CMS website.

Please Comply with ArroHealth Documentation Requests

Every year, CMS requires Medicare Advantage organizations to document the existing medical conditions within their membership. This process is referred to as risk adjustment.

To comply with this requirement, BlueCross partners with ArroHealth to acquire medical records on select individuals to support this documentation. In May, you may have received information from ArroHealth with detailed instructions on which records were requested and how to submit them.

If you haven't already responded to this request, please submit documentation as soon as possible. There are many ways to send your information to ArroHealth, including onsite assistance if you need it. If you have questions, please call ArroHealth customer service at 1-855-651-1885.

New Medicare Advantage PCP Change Request Form

A new PCP Change Request Form is available to update your patient attribution information. After your patient signs it, please mail or fax the completed form to:

BlueCross BlueShield of Tennessee
BlueAdvantage Operations
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37402-0005
Fax: (423) 535-5498

The patient's PCP attribution information will update in the next data refresh of the Quality Care Rewards tool in BlueAccess.

Home Health Administrative Approvals Updates

Effective Oct. 1, 2017, Medicare Advantage will update the number of days spanned for administrative approval on initial home health care requests from 30 days to 14 days.

Initial requests for Home Health authorization will receive administrative approval of up to seven visits over a timeframe of up to 14 days. The number of visits and timeframe given is sufficient to cover an initial evaluation and up to three visits per week for two weeks. No clinical information is necessary for administrative approvals other than a diagnosis. Any additional requests for services beyond the initial timeframe will require supporting clinical documentation for a medical necessity review.

Quality Care Rewards

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

THCII Episodes of Care: Final Performance, Interim Performance and Preview Reports

Episodes of Care Final Performance, Interim Performance and Preview Reports for Commercial and Medicaid lines of business will be available later this month. If you have episodes in Waves 1 or 2, you will have a Final Performance Report available for the Medicaid lines of business. Both Interim Performance Reports and Preview Reports will be available based on respective Waves for all lines of business.

Please login to BlueAccess to view your reports. Reports are aggregated to the Contract ID + Tax ID level. For more information related to Episodes of Care, please visit our BlueCare Tennessee and Commercial websites.

If you believe you should have reports, but cannot access them, please call eBusiness at (423)-535-5717.

Correct LOIN Codes for Closing Hemoglobin A1c Gap in Care Measure

Physicians and their patients with diabetes rely on regular hemoglobin A1c testing to understand patients' level of blood sugar control. To close a gap in care for this important quality measure, your patients should:

- Have at least one HbA1c test in the measurement year AND
- The most recent result should be less than eight percent.

BlueCross has found that many providers are using a LOIN code that will not close this gap in care. Please note:

- LOINC 17856-6 (Hemoglobin A1c/Hemoglobin.total in blood by HPCL) will close this measure gap in care.
- LOINC 17855-8 (Hemoglobin A1c/Hemoglobin.total in blood by calculation) will not close this measure gap in care.

Reminder: Audit Procedures for PCMH and QCPI Practices

Please know that we are required to audit commercial claims, so we can verify all information is correct, follows established coding guidelines and provider contract requirements. To help us with this required process, please furnish electronic or hard copies of medical records and encounter data requested.

Here are additional details:

- Claim payments related to records that have not been received will be subject to immediate recovery as unsubstantiated by documentation.
- Based on audit findings, we may make a decision to expand the scope of the audit (for example, if we don't receive a requested medical record).
- HIPAA requires that all Electronic Health Records contain a system-generated, permanent date and time record.

Thank you for your help with this process.

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† 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 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
***Select*Community**	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
Email:	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

SEPTEMBER 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, please click here.

Effective Oct. 1, 2017

- Analysis of MGMT (O6-methylguanine-DNA methyltransferase) Promoter Methylation in Malignant Gliomas (Revision)
- Daily Hemodialysis in the Home (Revision)
- Circulating Tumor DNA (Liquid Biopsy) and Circulating Tumor Cells (Revision)
- Genetic Testing for Mitochondrial Disorders (Revision)

The following medical policies will be archived and no longer active 30 days after this notification:

- Suprachoroidal Delivery of Pharmacologic Agents
- Chromoendoscopy as an Adjunct to Colonoscopy
- Cervical Cancer Screening Technologies

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

We've updated our BlueCross BlueShield of Tennessee Health Care Practice Recommendations for July 2017 to include the American Academy of Pediatrics (AAP) re-publication of their Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain. Additionally, the AAP has new content and a new web address for Bright Futures. These and other updates can be viewed online at http://www.bcbst.com/providers/hcpr. You can also request paper copies of any clinical practice guideline by calling (423) 535-6705.

INSIDE THIS ISSUE

Current Data Verification Forms Necessary to Improve Provider Directory Quality

BlueCross members often use our Find a Doctor Tool on our websites to find in-network doctors by name, location, specialty or medical procedure. We make every effort to make sure the provider information in our provider directory is current and accurate, but we need your help.

When you receive a Data Verification Form, please:

1. Verify your demographic information is up-to-date for each provider at the group/location.
   - Confirm network participation.
   - Indicate if they are accepting new patients.
   - Verify location/facility hours.
   - Specify provider's status at each location, e.g., sees patients or doesn't see patients.

Note: We only list provider locations where members can call and make an appointment.

2. If changes are needed, please mark through the incorrect information and print the correct details in the space beside that field.
3. Please sign and return all of the forms for each provider, even if the information is correct.
4. Send completed forms by fax to (423) 535-3066 or email to PNS_GM@bcbst.com.

It's also very important that your office staff members who make appointments for our members, are aware of the specific demographic information for each location.

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

Prior Authorization Required for Brineura, Radicava and Renflexis

New specialty pharmacy drugs are periodically added to the Provider-Administered Specialty Drug Lists. The following specialty drugs have been added and require prior authorization:

Specialty Drug	Effective Date	Line of Business
Brineura	July 28, 2017	Commercial and BlueCare℠
Radicava	July 28, 2017	All
Renflexis	July 29, 2017	All

You can find information on all provider-administered specialty medications requiring prior authorization on our websites.

Non-Compliance Denial Reminder

Please note that non-compliance denials aren't subject to reconsideration. However, you have 60 days to submit an appeal related to a non-compliance denial. Please complete and submit the Provider Appeal Form located on our provider webpage under the forms section. If you send the Reconsideration Form, it will delay your appeal, so be sure to use the correct form. If you need help or have questions, please call the Provider Service Line.

UPDATE: Technical Component for Professional Services Performed in a Facility*

Commercial and BlueCare Tennessee DRG and outpatient case rates paid to a facility include any technical component for professional services provided for facility patients. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist or other provider. Payment is not made under the physician fee schedule for technical component services provided for facility patients. The member cannot be held liable in these cases, as reimbursement for technical component services is part of the all-inclusive global payment made to facilities. Should a facility choose to partner with a provider for the technical component associated with the facility services, the facility will be responsible for payment of the provider.

These guidelines do not apply to Medicare Advantage plans. Medicare Advantage claims should continue to be billed consistent with CMS billing guidelines.

Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

Primary care providers are often the first point of care for alcohol and drug dependence treatment. Thank you for helping our members get the care and resources they need to adhere to treatment, improve their health and achieve a sense of well-being.

We're here to support you as you help our members:

- Stay engaged in their behavioral health treatment plans.
- Transition successfully across treatment settings.
- Understand why, when and how to take their medications.
- Receive other care coordination and case management services that promote resilience and recovery.

To learn more how you can help patients manage their dependence on alcohol and other drugs, click this Treatment Training link. You'll be connected to a WebEx on the Initiation and Engagement for Alcohol and other Drug Dependence Treatment (IET).

Reminder: Further Updates to Claims Editing Process Aim to Increase Payment Accuracy

Earlier this year, BlueCross began updating the claims payment process for all lines of business, including BlueCare Tennessee and Medicare Advantage. The latest updates will include a more careful analysis during the pre-payment phase of claims editing. The goal is delivering payments to providers with more accuracy and reducing the need to recover payments that exceed claims liability.

Because of this closer review of claims, some unintended or incomplete items that have passed through for payment in the past may process differently in the future. However, this update won't reduce provider reimbursement rates, your patients' benefits or the speed at which we pay your claims.

While these updates won't completely eliminate overpayments or the need for recovery, our efforts will help ensure a more accurate and efficient payment process.

Reminder: Requirements for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect on Jan. 1, 2017.

Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local provider network manager with any questions. Or visit our website to find your BlueCross contact.

Reminder: Availity Coming Soon

We're excited to announce that we have partnered with Availity– to provide a free advanced account management system scheduled to replace BlueAccess℠. Initially, Availity will be used to review remittance advices, claims status, eligibility and benefits – though more features will be added throughout the transition. For example, these BlueCross-specific features will be available at or shortly after launch:

- Unified Member Search – This custom member search will closely match our capabilities in BlueAccess and will include search options by SSN, name and DOB.
- BlueCard® – Searches for your out-of-state patients will be available in the same interface, which means you will no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- Claims Management Tool – This upgraded tool features a customized search function so you can find rejected and adjudicated claims. You'll also be able to see your full claim lifecycle in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications and updates.

As we get closer to transitioning our online provider tools to the Availity web portal, we'll send complete information once we're ready to launch. In the meantime, you may want to begin sharing information with the person who will create and manage accounts for other users.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.

Tips for Coding Professionals

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

Key Points to Remember for Diagnosis Coding

We want to help make sure your claims process efficiently and without any issues that will delay your reimbursement. Below are coding items that are triggering denials and appearing on a regular basis.

- When diagnosis codes include an age range, make sure the patient's age matches with the diagnosis code.
- The sequence of how encounter codes are listed is important. This situation happens often with chemotherapy treatments. If a patient admission/ encounter is only for administering chemotherapy, immunotherapy or radiation therapy, please assign the appropriate encounter code as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.
- Please follow the ICD-10 guidelines for the sequence of external codes not used for a primary diagnosis.

Reminder: Appropriate Billing of CPT® Code 95165

BlueCross professional reimbursement is based on CMS - RBRVS methodology, as defined in our provider administration manuals. CMS publishes fees that are used as the basis for BlueCross contracting and referenced in the provider contract. In order to facilitate correct payment, providers should bill non-venom antigens as outlined by CMS in their Claims Processing Manual.

This isn't a policy change, only a reminder due to findings that some providers are billing this code with an inappropriate number of units resulting in incorrect reimbursement. Please refer to your contract for correct reimbursement procedures.

BlueCare Tennessee

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

Let Us Help Coordinate Care for Your Patients with Chronic or Complicated Health Conditions

Our Population Health Management programs for BlueCare, TennCare*Select*, BlueCare Plus and CoverKids members can help coordinate care for your patients with complicated care needs, chronic illnesses, and catastrophic illnesses or injuries. Our clinical teams can help educate your patients about their conditions, as well as provide tools and resources that will assist them and their families when making health care decisions. These include behavioral and physical health activities, as well as CHOICES care coordination processes when appropriate. (CHOICES services aren't available to CoverKids members.)

We identify members for specific programs using claims data, health risk assessments and provider referrals. If you have patients with conditions who could benefit from our Population Health Management programs, please call 1-888-416-3025.

Billing Changes for Long-Acting Contraceptives*

Beginning Oct. 1, 2017, BlueCare Tennessee and CoverKids will begin reimbursing providers for long-acting reversible contraceptives (LARC) as separate items. Charges for LARC devices implanted during the labor and delivery inpatient stay must be billed as part of the inpatient claim. The following is a list of current HCPCS codes that will be affected:

J7297	J7300	J7307
J7298	J7301	Q9984

This change doesn't affect claims billed by physicians who perform implants in the hospital. These services can still be billed using the CPT® code associated with the procedure.

Member Complaints Process Changing Name to Grievance Rights*

BlueCare Tennessee is building a new process to address member complaints and it will include a name change. Based on a contract amendment with the Division of TennCare, Complaint Rights will now be called Grievance Rights

Provider Satisfaction Survey Responses Are Due September 29

BlueCare Tennessee recently sent out satisfaction surveys to a number of BlueCare, BlueCare Plus, TennCare*Select* and CoverKids providers. If you've received a survey, please be sure to return it as soon as possible. We won't be able to review your responses after September 29.

Your opinions are important to us, because they help us determine how we can improve service to our providers. Thank you for your participation.

TennCare Eliminates Pre-Pay Submission of IEP for School Therapy

Effective immediately, TennCare has ended the requirement for schools to submit an Individual Education Plan (IEP) prior to receiving payment for covered, medically-necessary services delivered in a school setting.

Please note, the following BlueCare Tennessee guidelines still apply:

- Services billed must meet IEP therapy standards.
- Services must be performed by a participating provider.
- BlueCare will conduct post payment audits on a sample of IEPs for members who receive school-based therapy.
- If requested, the school must send a copy of the IEP and the parental consent in support of the services.

Review of 2016 ASH Claims Begins in October

During the fourth quarter of 2017, we will begin a review of all BlueCare, TennCare*Select* and CoverKids claims submitted in 2016 that include an absolute or possible abortion, sterilization or hysterectomy (ASH). If your practice submitted an ASH claim for a procedure conducted last year, we may contact you to request records if they weren't submitted with the claim.

Online-Only Provider Enrollment Process Starting Oct. 1

Earlier this year, we launched a new online Provider Enrollment Form to simplify the enrollment process. This step has greatly improved efficiency by reducing omissions, the need for follow-up phone calls and duplicate applications. Due to the success of this online process, we have decided to accept online-only submissions starting Oct.1, 2017. We'll accept paper copies of the provider enrollment form (PDF version) by email, fax or mail up to that point, ending Sept. 30, 2017.

Reminder: Scheduling Non-Emergency Transportation

Transportation is a vital element of patient care. BlueCare Tennessee is reminding network facilities about the guidelines for any non-emergency trip requested by a hospital, facility or other provider.

The mode of non-emergency transportation is a decision the facility will make based on the patient's condition and care needs. When you have BlueCare or TennCare*Select* members who need non-emergency transportation, please contact Southeastrans♦.

If the patient must travel on a stretcher, but doesn't need medical care during the trip, Southeastrans will provide a stretcher van, along with a driver and attendant to transport the patient. To ensure Southeastrans provides the proper service and vehicle, please have the following information available when scheduling non-emergency transportation:

- Patient's name and BlueCare Tennessee member ID number
- Addresses for patient's pick-up and destination (including room numbers if necessary)
- Date of transportation and appointment time (if applicable)
- Special medical needs of the patient
- Any escorts that will travel with the patient

To schedule non-emergency transportation, please call Southeastrans in your area of the state:

- BlueCare East – 1-866-473-7563
- BlueCare Middle – 1-866-570-9445
- BlueCare West – 1-866-473-7564
- TennCare*Select* – 1-866-473-7565

If you have questions about non-emergency transportation, please call 1-800-468-9698 for BlueCare members or 1-800-263-5479 for TennCare*Select* members.

♦ Southeastrans isn't equipped to provide emergency transportation.

Converting a Sports Physical to TennCare Kids Checkup

Across the state, only about 70 percent of kids enrolled in BlueCare Tennessee get their annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) checkups. There are many ways you can help us push that rate above 80 percent. One effective way is to convert a sports physical to a well-care visit.

As a reminder, stand-alone sports physicals and their corresponding codes aren't covered services. However, by converting that appointment into a complete well-care visit, you can meet all requirements of the sports physical and receive reimbursement for a covered service.

Medicare Advantage

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

Prior Authorization Required for Medicare Advantage

Beginning Oct. 1, 2017, the specialty medications listed below will require prior authorization for Medicare Advantage.

Specialty Medications Requiring Prior Authorization (effective Oct. 1, 2017)		
Abraxane	Firmagon	Ozurdex
Acthar HP	Fusilev	Perjeta
Adcetris	Gazyva	Proleukin
Aloxi	Glassia	Provenge
Aralast/Prolastin/Prolastin C/Zemaira	Halaven	Retisert
Arzerra	Ilaris	Signifor_LAR
Beleodaq	Iluvien	Soliris
Benlysta	inflectra	SOMATULINE DEPOT
Berinert	Istodax	Synribo
Cerezyme	Jetrea	Thyrogen
Cimzia	Jevtana	Trelstar Depot
Cinryze	Kadcyla	Tyvaso
Cyramza	Kalbitor	Vantas
Elelyso	Kyprolis	Vimizim
Eligard/Lupron Depot	Lupron Depot	Xiaflex
Empliciti	Marqibo	Zaltrap
Epoprostenol (Flolan/Veltri)	NAGLAZYME	Zoladex
Fabrazyme	Onivyde	

You can find information on all provider-administered specialty medications requiring prior authorization on our websites.

Reminder: Home Health Administrative Approvals Updates

Effective Oct. 1, 2017, Medicare Advantage will update the number of days spanned for administrative approval on initial home health skilled nursing care requests from 30 days to 14 days.

Initial requests for home health skilled nursing authorization will receive administrative approval of up to seven visits over a timeframe of up to 14 days. The number of visits and timeframe given is sufficient to cover an initial evaluation and up to three visits per week for two weeks. No clinical information is necessary for administrative approvals other than a diagnosis. Any additional requests for services beyond the initial timeframe will require supporting clinical documentation for a medical necessity review.

Reminder: Hospice Prescription Drugs Review

Members who are in hospice care generally experience common symptoms, including pain, nausea, constipation and anxiety during end-of-life care. CMS identified four common prescription categories typically used to treat these symptoms: Analgesics, anti-nauseants, laxatives and anti-anxiety drugs.

CMS requires Medicare Advantage plans to review claims paid within the hospice election period for prescription drugs in these four categories. It also plans to conduct outreach to the hospice provider or prescriber.

Hospice facilities may receive written requests from the Medicare Advantage plan to retrospectively determine payment responsibility for the four categories of drugs used in the hospice setting. You can find more information on the CMS website.

Reminder: Don't Forget to Submit Your Provider Assessment Forms (PAF)

In 2017, you're eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service as E/M Code 96160, with an allowable charge through the end of the year as follows:

- $175 for dates of service between July 1 and Sept. 30, 2017
- $150 for dates of service between Oct. 1 and Dec. 31, 2017

You can receive your reimbursement by completing and submitting the Provider Assessment Form electronically via BlueAccess. You may also complete the fillable form and fax it to 1-877-922-2963. The form should be included in your patient's chart as part of their permanent record.

Note: It's not necessary to wait 365 days between PAF submissions. For additional information about the PAF, please see the Quality Care Rewards section of our website.

Reminder: Medicare Advantage End Stage Renal Disease (ESRD) Prescription Drugs Part D Versus Part B

The CMS final rule (79 FR 66149) identified four ESRD drug categories included in the ESRD base reimbursement rate, which are not separately payable:

Access Management	Drugs that remove clots from grafts to ensure access will reverse anticoagulation if too much medication is given.
Anemia Management	Drugs used to stimulate red blood cell production and/or treat or prevent anemia. This category includes Erythropoietin Stimulating Agents (ESAs) as well as iron.
Bone and Mineral Metabolism	Drugs used to prevent/treat bone disease secondary to dialysis. This category includes phosphate binders and calcimimetics.
Cellular Management	Drugs used for deficiencies of naturally occurring substances needed for cellular management. This category includes levocamitine.

BlueCross reviews prescription drug claims for ESRD patients processed through their Medicare Part D benefit. If we find BlueCross paid for a prescription for a renal dialysis-related drug that was under the ESRD Prospective Payment System, we will recoup that amount from the Part B renal facility claim on file.

Quality Care Rewards

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

THCII Episodes of Care Reports Now Available

Episodes of Care Final Performance, Interim Performance and Preview Reports for Commercial and Medicaid lines of business are available. If you have episodes in Waves 1 or 2, you have a Final Performance Report available for the Medicaid lines of business. Both Interim Performance Reports and Preview Reports are available based on respective Waves for all lines of business. Gain- or risk-share payments will be initiated in November of this year.

Please login to BlueAccess to view your reports. Reports are aggregated to the Contract ID + Tax ID level. You can find more information related to Episodes of Care on our BlueCare Tennessee and Commercial websites, or visit the state's website for additional program detail.

If you believe you should have reports, but cannot access them, please call eBusiness at (423) 535-5717.

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.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

CAQH Solutions | PROVIEW™

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

† 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 and follow the prompts to reach Network Contracts or Credentialing to update your information; and
- Update your provider profile on the CAQH ProView™ website.

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Monday-Friday, 8 a.m. to 6 p.m. (ET)	
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Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
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BlueCare Plus℠	1-800-299-1407
BlueChoice℠	1-866-781-3489
***Select*Community**	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
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of Tennessee

OCTOBER 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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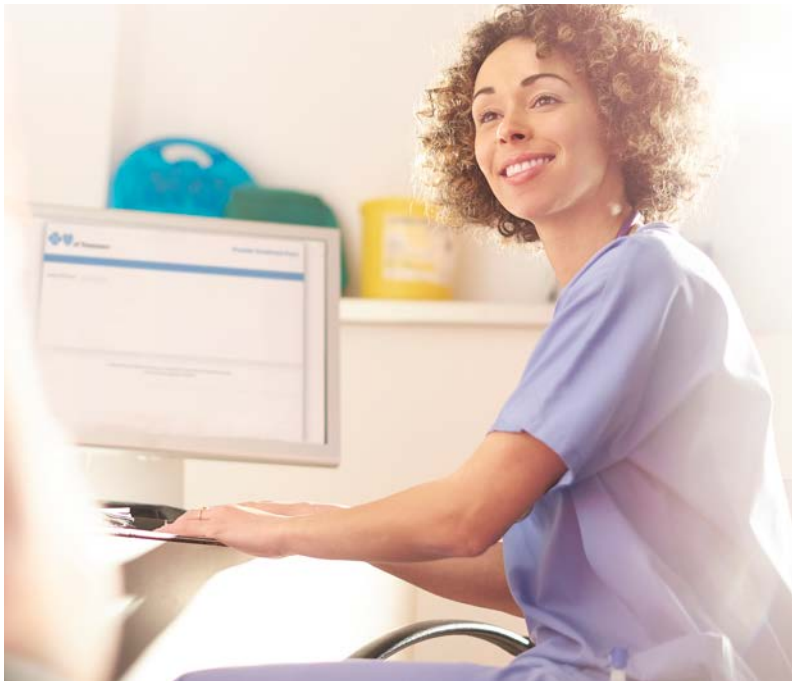
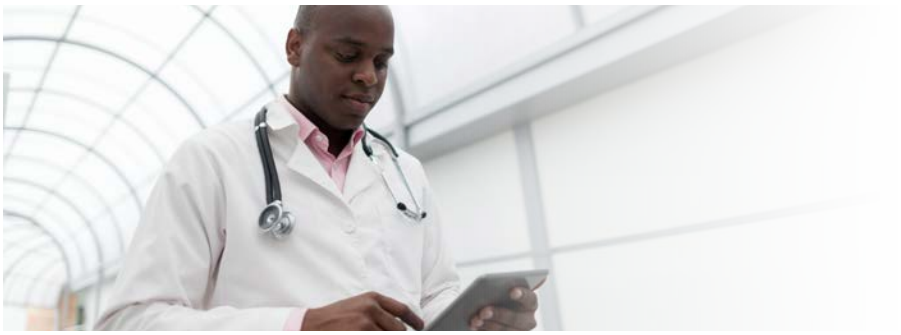


Online-Only Provider Enrollment Process Starting Oct. 1

Earlier this year, we launched a new online Provider Enrollment Form to simplify the enrollment process. The new form has reduced omissions, the need for follow-up, phone calls and duplicate applications to the point that we have decided to move to an online-only submission process starting Oct.1, 2017. This will affect enrollment for professional providers for every line of business.

Please look for further enhancements as we continue to reduce enrollment processing time and improve our service to you.

INSIDE THIS ISSUE



Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, please click here.

Effective Nov. 1, 2017

- Ablation Procedures for Peripheral Neuromas (Revision)
- Human Amniotic Membrane Grafts and Amniotic Fluid Injections (Revision)
- Magnetic Resonance Imaging (MRI) of the Breast (Revision)
- Whole Exome and Genome Sequencing (Revision)

The following medical policies will be archived and no longer active 30 days
after this BlueAlert notification.

- **Modified Condylotomy for the Treatment of TMJ Disorders♦** – An MCG Care Guideline contains similar clinical indication criteria and will be used as needed.
- **Mechanical Embolectomy for the Treatment of Acute Stroke♦** – This procedure is now accepted by health care professionals as standard/conventional practice.
- **Beta Amyloid Imaging with Positron Emission Tomography (PET) for Alzheimer's Disease** – The use of PET for Alzheimer's Disease is addressed as investigational within another BlueCross medical policy titled Positron Emission Tomography for Miscellaneous Applications; thus, the investigational policy position reflected by this policy is redundant.
- **Nerve Fiber Density Testing♦**

♦ There is no longer a need to maintain this medical policy for use by our Commercial and BlueCare Tennessee Utilization Management departments.

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

2018 Formulary Changes

Each year BlueCross Formularies are reviewed to determine changes based on a drug's effectiveness, safety and affordability. While many changes to the BlueCross Formularies occur at the beginning of the year, formulary changes may occur at any time because of market changes such as:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links to view the 2018 Formulary Changes for each of the formularies listed below:

- 2018 Preferred Formulary Changes
- 2018 CoverKids Formulary Changes
- 2018 Essential Formulary Changes

In November, we'll begin sending letters to our members whose medications are changing to non-formulary status Jan. 1, 2018. We aren't sending letters about every change to their formulary, so please remind your patients to check for changes at bcbst.com.

Managing Weight Gain in Children Taking Antipsychotics

In a review of regularly prescribed antipsychotic medications, weight gain is listed as one of the most common side effects. Children on these medications are also at risk for weight gain and other metabolic effects, such as increased total cholesterol and triglycerides.

You can help monitor weight gain by first taking a baseline measurement of:

- Weight (or body mass index)
- Waist circumference
- Blood pressure
- Fasting plasma glucose
- Fasting lipid profile

After the baseline, providers are encouraged to check the child's weight every three months and other measures at least once a year. If you notice significant increases, you should consider more frequent visits.

Use of antipsychotic medications should only be considered after a thorough assessment of the child's health, family history and alternative medications and therapeutic interventions.

Prior Authorization Required for Imlygic

Beginning Nov. 1, 2017, Imlygic will be added to the Provider-Administered Specialty Drug Lists and require prior authorization for all lines of business. Imlygic is currently listed on the Commercial, CoverKids, and BlueCare Tennessee Provider-Administered Specialty Drug Lists. Imlygic will also be added to the Medicare Advantage and BlueCare Plus (HMO SNP)SM drug lists requiring a prior authorization beginning Nov. 1, 2017.

You can find information on all provider-administered specialty medications requiring prior authorization on our websites.

BlueCare Tennessee
BlueCare PlusSM
Commercial
CoverKids
Medicare Advantage

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are going into effect Jan. 1, 2018 for air ambulance providers (rotary or fixed-wing):

- NPI and the appropriate taxonomy codes are required to distinguish between ground charges and air charges when filing claims.
- You must include pick-up and drop-off ZIP codes, mileage, etc.

Member cost share can be significant for this type of service, so please try to work with in-network providers.

You can find updated billing guidelines for Commercial plans in your BlueCross BlueShield of Tennessee Provider Administration Manual.

Non-Emergent Air Ambulance Transportation Requires Prior Authorization for Commercial plans*

Starting Jan. 1, 2018, prior authorization is required for non-emergent air ambulance transportation. Prior authorization won't be required for emergency transport (e.g., from the scene of an accident when ground isn't appropriate or would pose a threat).

To arrange non-emergent air ambulance transport for a patient with BlueCross Commercial benefits, please request prior authorization by calling BlueCross at 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. ET.

This prior authorization requirement may affect your patients if an out-of-network air ambulance is used for non-emergent transportation.

Be Prepared for the 2017–2018 Flu Season

It's important that you help set preventive care measures to protect your patients during this time of year. Please educate all patients and 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 a greater risk for serious complications from the flu, they have the option to receive a higher-dose vaccine or the standard-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 for a flu shot as early as possible this flu season. To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations.

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. Please 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 people 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 isn't available under VFC.

  For more information, please call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

Medicare Advantage

- Intradermal vaccines
  Covered benefit

CoverKids

- Vaccine and administration
  The influenza vaccine, including intradermal is a covered benefit.

Note:

- Code 90756 will become effective on Jan. 1, 2018, for Flucelvax Quadrivalent – antibiotic-free vials (2017-2018 NDCs 70461-0301-10 and 70461-0301-12). Prior to the implementation/effective date, codes 90749 or Q2039 may be billed for this product.
- Code 90674 became effective on Sept. 1, 2016, for BlueCare and Jan. 1, 2017, for all other lines of business for Flucelvax Quadrivalent – preservative and antibiotic-free syringes (2017-2018 NDCs 70461-0201-01 and 70461-0201-11).

Help Bust Flu Shot Myths

You play an important role in making sure our members have accurate information about flu shots. Here are some common misconceptions and answers you can share with your patients:

It might give me the flu.

The flu shot can't cause the 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 the flu. 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.

Social Problems from Bullying

Bullying is aggressive and intentional behavior that causes another person discomfort. It can take the form of physical contact, words or more subtle actions. **Cyberbullying** includes sending hurtful or threatening messages, spreading rumors, or posting embarrassing photos of others on e-mail, instant messaging or social media.

In recent years, cyberbullying has increased dramatically among preteens and teens. A recent survey♦ indicates fewer students feel upset or afraid when bullied online than in person. However, victims of cyberbullying are more likely to show social problems or even harass peers online, themselves.

Surprisingly, a little more than half of the youth surveyed spoke up about the harassment they were experiencing. As a health care provider, you may learn about bullying – or suspect bullying – during a routine office visit. It's an ideal time to engage parents, discuss social concerns and ways to help their child.

♦ Second Youth Internet Safety Survey published by the American Academy of Pediatrics

Non-Compliance Denials

Please note that non-compliance denials aren't subject to reconsideration. However, you have 60 days to submit an appeal related to a non-compliance denial. Please complete and submit the Provider Appeal Form located on our provider webpage under the forms section. If you send the Reconsideration Form, it will delay your appeal, so be sure to use the correct form. If you need help or have questions, please call the Provider Service Line.

Claims Editing Process Update Is Now Complete and Applies to Facilities

An important claims editing process update was completed the last week of August. This update moved our Commercial member claims process, which includes facility claims, to an automated system. There are also additional claims editing capabilities that allow us to process claims more efficiently. We already use this system to process claims for our BlueCare Tennessee and Medicare Advantage lines of business.

With this upgrade, our system can identify and apply pre-payment edits to claims that weren't possible in the past. Because the system performs a closer review of claims, some unintended or incomplete items that have passed through for payment in the past may process differently in the future. However, this update won't reduce contracted provider reimbursement rates, your patients' benefits or the speed at which we pay your claims.

The editing system meets industry rules and federal regulations for health care claims including modifier usage, diagnosis coding and MUEs for facilities. Additional information can be found in the NCCI Manual, BlueCross Provider Administration Manual, the Code Editing page on our website and previous editions of the BlueAlert newsletter.

Cologuard®: In-Home Colon Cancer Screening Test for Commercial Plans

Colon cancer is the second leading cause for cancer deaths in America. It is also one of the most preventable. If you have a patient (50 years or older) who declines colonoscopy, you can now offer Cologuard, annual fecal immunochemical testing (FIT), as an in-home colon cancer screening test. Cologuard, a DNA fecal test administered by Exact Sciences Laboratory, is part of the preventive services and considered an eligible service. However at this time, Exact Sciences does not participate in the BlueCross BlueShield of Tennessee provider networks. We are currently talking with Exact Sciences and hope to bring them into our networks in the near future. In the meantime, a claim from Exact Sciences Laboratory will process as an out-of-network provider and the member will be responsible for any disallowed amounts that are over the maximum allowable.

Availity Coming Soon

We're excited to announce that we've partnered with Availity to provide a free advanced account management system scheduled to replace BlueAccess℠. Initially, Availity will be used to review remittance advices, claims status, eligibility and benefits – though more features will be added throughout the transition. For example, these BlueCross-specific features will be available at or shortly after launch:

- **Unified Member Search** – This custom member search will closely match our capabilities in BlueAccess and will include search options by SSN, name and DOB.
- **BlueCard®** – Searches for your out-of-state patients will be available in the same interface, which means you'll no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- **Claims Management Tool** – This upgraded tool features a customized search function, so you can find rejected and adjudicated claims. You'll also be able to see your full claim lifecycle in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications and updates.

As we get closer to transitioning our online provider tools to the Availity web portal, we'll send you complete information. In the meantime, you may want to begin sharing information with the person who will create and manage accounts for other users.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.

New Member ID cards, ID numbers, and Prefixes for NECA and IBEW Anthem Plan Members Effective in January

As of Jan. 1, 2018, member ID cards will be reissued for NECA and IBEW Anthem plan members. These ID cards will have new Member ID numbers and prefixes. Below is a quick reference guide with prefixes that are terminating on Dec. 31, 2017, and the new prefixes replacing them as of Jan. 1, 2018.

Please be sure to use the updated information on the new member ID card for these groups when filing claims for services beginning Jan. 1. Direct any questions to the appropriate Provider Inquiry Customer Service phone number listed below.

Current Prefix	New Prefix as of Jan. 1, 2018	State	Plan Name	Provider Inquiry – Customer Service
FJJ	Group# 004009986 (Members) – KFM	all, except GA	BlueCard	1-844-594-0393
FFX	Group# 004009986 (Members) – QFM (GA AltNet)	GA	GA Alt Net	1-844-594-0393
FJJ	Group # 004009987 (Employees) – VFE	all, except GA	BlueCard	1-844-594-0393
FFX	Group # 004009987 (Employees) – ZFE (GA AltNet)	GA	GA Alt Net	1-844-594-0393

BlueCare Tennessee

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

New Reporting Form for HCBS CHOICES Critical Incidents

The new HCBS CHOICES Critical Incident Reporting Form is now available online. The new form is now consistent among all TennCare℠ managed care organizations (MCOs), including BlueCare Tennessee, to help make critical incident reporting easier for providers. Here are a few of the changes you'll notice on the form:

- Checkboxes for providers to indicate the correct MCO for the member.
- Free-form fields – replacing drop down boxes – for easier documentation.
- Reorganized sections to help streamline the reporting process.
- New headings to help gather information for the investigation.

Please use the new form to report all HCBS CHOICES critical incidents. If you have any questions about critical incident reporting, please email us at CHOICESQuallity@bcbst.com.

TennCare Issues Budget Memo for 2018 Fiscal Year

Each year, TennCare updates its fiscal year budget to provide guidance based on the current budget appropriations for the State of Tennessee fiscal year. You can view the TennCare Budget Memo at the BlueCare Tennessee website.

In addition to the budget reductions and/or buyback as described in the memo, all other previous reductions and limits remain in effect.

BlueCare Tennessee Members Exceeding Monthly Benefit Limit for Antidepressants

If you have BlueCare Tennessee members in your care that have been prescribed five or more antidepressants in a month, you may be able to help them get additional medications with an attestation request. While this exceeds our monthly prescription benefit limit, we understand you may have patients who could suffer adverse health consequences without these medications. This includes members who could be hospitalized, institutionalized or at risk of death within 90 days.

Here are the steps:

1) **Determine if the medicine is on the TennCare Attestation List**. If so, we may be able to approve the medicine for high-risk members who are at their monthly prescription benefit limit (more than five prescriptions or two brand medications). For the complete list, visit https://tenncare.magellanhealth.com.

2) **Call Magellan Health Services** at 1-866-434-5524 to make an attestation request.

3) **Fax a completed Attestation Fax Form** to Magellan Health Services at 1-866-434-5523. You can find the form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_RxLimit_Override_Attestation_Fax_Form.pdf.

If you have questions or need to request prior authorization for BlueCare℠ or TennCare*Select* members for any of these medications, please contact Magellan Health Services at 1-866-434-5524 or fax your request to 1-866-434-5523.

TennCare Implements 200 Morphine Milligram Equivalent Daily Limit

TennCare began a new policy for prescription narcotics on Sept. 5, 2017. Patient claims for any short-acting or long-acting narcotic or combination of the two that exceed 200 Morphine Milligram Equivalent (MME) per day will be denied. Prior authorization is required for patient prescriptions that exceed the daily MME limit.

In addition, the following products (brand and generic) have new daily quantity limits:

- Hydrocodone/APAP: 6/day
- Hydrocodone/ibuprofen: 6/day
- Oxycodone IR 5, 7.5,10 mg: 8/day
- Oxycodone IR 15, 20, 30 mg: 4/day
- Oxycodone/APAP: 6/day
- Oxycodone/ibuprofen: 6/day
- Oxymorphone: 4/day

Click here to view a summary of the PDL changes.

BlueCare Tennessee Changing to 30-Day Readmission Review Period in November

BlueCare Tennessee will begin using a 30-day readmission look-back period for members 21 or older starting Nov. 1, 2017. A re-admission is a preventable, unplanned admission of a patient to the same facility for a condition or complication related to the original hospital stay.

This policy applies to all readmissions except those in the BlueCare Tennessee Provider Administration Manual specifically listed as readmissions that MAY be approved for authorization and payment. Claims for patients re-admitted under these circumstances aren't eligible for multiple payments at facilities that are paid on a DRG or per diem basis and are subject to retrospective claims review and recovery.

Free Transportation for Your TennCare Kids Patients

If you have TennCare Kids patients who can't get to their appointments for services because they don't have a ride, let them know they have an option. Southeastrans will get them to and from their visit with you at no charge. To schedule a ride, please have them call one of the following numbers:

BlueCare East Region – 1-866-473-7563

BlueCare Middle Region – 1-866-473-7564

BlueCare West Region – 1-866-473-7564

TennCare*Select* – 1-866-473-7565

Review of 2016 ASH Claims Begins in October

During the fourth quarter of 2017, we will begin a review of all BlueCare, TennCare*Select* and CoverKids claims submitted in 2016 that include an absolute or possible abortion, sterilization or hysterectomy (ASH).

If your practice submitted an ASH claim for a procedure conducted last year, we may contact you to request records if they weren't submitted with the claim.

Billing Limit for Private Duty and Home Health Agencies

When providing care for BlueCare Tennessee members who are 21 or older, please note that the State's level 1 and level 2 daily allowable benefit limits for home health aide and home health nursing is eight hours per day. Claims submitted outside the benefit limits will be denied.

Medicare Advantage

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

Prior Authorization Required for Medicare Advantage and BlueCare Plus

Beginning Oct. 1, 2017, the provider-administered specialty medications listed below will require prior authorization for Medicare Advantage and BlueCare Plus plans.

Adagen	Krystexxa	Supprelin LA
Aldurazyme	Lumizyme	Sylvant
Arranon	Portrazza	Temodar (IV)
Folotyn	Remodulin	VPRIV
Kanuma	Ruconest	Yondelis

You can find information on all provider-administered specialty medications requiring prior authorization for each line of business on our website.

2013 Jimmo v. Sebelius Settlement Clarifies Skilled Nursing and Therapy Benefits

CMS wants you to know about two changes to therapy guidelines that resulted from the settlement. The Jimmo Settlement Agreement (January 2013) explained that Medicare covers skilled nursing care and skilled therapy services under its skilled nursing facility, home health and outpatient therapy benefits when a beneficiary needs skilled care to maintain function, prevent or slow decline/deterioration (provided all other coverage criteria are met). Because of the settlement, program manual revisions were made to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

- Skilled nursing services are covered when these services are necessary to maintain the patient's current condition, prevent or slow down further deterioration, as long as the beneficiary requires skilled care for the services to be safely and effectively provided.
- Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates the specialized judgment, knowledge and skills of a qualified therapist ("skilled care") are necessary to perform a safe and effective maintenance program. The program to maintain the patient's current condition or to prevent or slow further deterioration is covered as long as the beneficiary requires skilled care for the safe and effective performance of the program.

Administrative Approval Updates for Home Health Skilled Nursing Visits*

Effective Oct. 1, 2017, Medicare Advantage is reducing the number of days it takes to get administrative approval on initial Home Health Skilled Nursing Visit requests. To better facilitate extension requests, the number of days will go from 30 to 14 days.

Initial requests for these visits will be approved for up to seven visits over a timeframe of up to 14 days. This should be sufficient to cover an initial evaluation and up to three visits per week for two weeks. No clinical information is necessary other than a diagnosis for these administrative approvals. If you make an additional request after the initial visit approval or 14-day timeframe, it will be considered an extension request, which will require supporting clinical documentation for a medical necessity review.

If you need to request more than seven visits within or beyond the 14-day timeframe on your initial request, please submit all supporting documentation for medical necessity review with this request.

Administrative approvals don't apply to home health related rehabilitation services visits (speech, physical and occupational therapies), which will be reviewed and approved based on medical necessity.

Billing for Home Health Care Supplies

Supplies on the BlueCross Home Health Agency Non-Routine Supply List should be billed using the appropriate revenue and HCPCS codes effective for the date of service. Supplies will be denied if they're not billed this way.

Reimbursement for supplies not included on the list used in conjunction with the above skilled nursing services is included in the maximum allowable for the home health service. The supplies won't be reimbursed or authorized separately even if requested by another provider in lieu of the home health agency. Supplies not used in conjunction with a home health visit aren't billable by the home health agency provider.

The only supplies you may bill in addition to the above home health skilled nursing services are those indicated on the BlueCross Home Health Agency Non-Routine Supply List (found in the billing section of the provider administration manual) along with the appropriate revenue code.

Notice of Medicare Non-Coverage

According to CMS regulations, home health agencies, skilled nursing facilities and comprehensive outpatient rehabilitation facilities are responsible for delivering Notice of Medicare Non-Coverage to the member or the authorized member representative.

CMS requires the notice be delivered at least two days before the member's authorized services end. Days won't be extended because of untimely delivery of the notice by the facility. If the member's services last less than two days, the home health agency, skilled nursing facility or comprehensive outpatient rehabilitation facility must provide the notice to the member at the time of admission to the home health agency or facility.

Please fax the Notice of Medicare Non-Coverage to BlueAdvantage by noon the day after you receive it:

Attn: BlueCross BlueShield of Tennessee Care Management 1-888-535-5243 or 1-423-535-5243.

You can find the Notice of Medicare Non-Coverage form on our website at http://www.bcbst.com/providers/medicare-advantage/forms.shtml.

Revenue Code 510 (Hospital-Based Clinic Services)*

Effective Dec. 1, 2017, we're changing the payment structure for hospital-based clinic services for Medicare Advantage plan members. When a member receives Evaluation & Management (E&M) professional services with a procedural service on the same day by the same provider:

- Payment for provider-based clinic professional services includes any technical or facility fees.
- Any additional technical or facility fee billed with Revenue Code 510 won't be paid and will be identified on provider remittances as provider responsibility.

Providers and facilities may not bill Medicare Advantage members for the facility fees associated with provider-based clinic visits.

Note: "Same Provider" means any physician, other health care practitioner, or the provider or facility that owns or operates the provider-based clinic on or off campus.

Quality Care Partnerships

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

2018 Medicare Advantage Quality Care Partnerships Performance Measures

Our Medicare Advantage (MA) plans will be sending quality amendments for 2018. Below is the list of planned measures. Please speak with your Quality Incentive Consultant if you have any questions.

Measures Applicable to Both Gain Share Contracts and Quality Amendments							
Measure Name	Measure Type	Weight	2018 Star Ratings Projected Cut Points				
			1 Star	2 Star	3 Star	4 Star	5 Star
Adult BMI Assessment (ABA)	Process (Non-Continuous)	1	<43%	43%	62%	90%	98%
Breast Cancer Screening (BCS)	Process (Non-Continuous)	1	<45%	45%	65%	71%	78%
Colorectal Cancer Screening (COL)	Process (Non-Continuous)	1	<60%	60%	64%	73%	84%
Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed	Process (Non-Continuous)	1	<48%	48%	63%	75%	83%
Medication Reconciliation Post-Discharge (MRP)	Process (Non-Continuous)	1	<20%	20%	34%	57%	70%
Osteoporosis Management in Women Who Had a Fracture (OMW)	Process (Non-Continuous)	1	<23%	23%	36%	53%	72%
Comprehensive Diabetes Care (CDC) - HbA1c Control (<9.0%)	Outcome (Continuous)	3	<51%	51%	64%	78%	86%
Controlling High Blood Pressure (CBP)	Outcome (Continuous)	3	<40%	40%	58%	66%	77%
Medication Adherence for Cholesterol (Statins)	Outcome (Continuous)	3	<67%	67%	74%	79%	84%
Medication Adherence for Hypertension (RASA)	Outcome (Continuous)	3	<73%	73%	77%	81%	85%
Medication Adherence for Oral Diabetes Medications (OAD)	Outcome (Continuous)	3	<72%	72%	78%	81%	85%
Plan All-Cause Readmissions (PCR)	Outcome (Continuous)	3	<13%	13%	10%	8%	6%
Additional Measures Applicable only to Quality Amendments							
Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy	Process (Non-Continuous)	1	<94%	94%	95%	97%	99%
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Process (Non-Continuous)	1	<55%	55%	74%	77%	82%

Note: Measures and cut points for the MA Star Ratings Program are determined by CMS and are based on prior year performance of all MA plans. To adjust for industry improvement in the upcoming year, BlueCross retains the right to adjust the cut points based on statistical analysis of industry trends from prior years' performance.

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.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

CAQH Solutions | PROVIEW™

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

† 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 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
***Select*Community**	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
Email:	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

NOVEMBER 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, please click here.

Effective Dec. 1, 2017

- Implantable Hypoglossal Nerve Stimulation (New)
- Noninvasive Techniques for Evaluation and Monitoring of Chronic Liver Diseases (Revision)

Effective Dec. 20, 2017

- Bariatric Surgery (Revision)
- BRCA1, BRCA2 and PALB2 Testing for Breast, Ovarian and Other Cancers (Revision)
- Cardioverter Defibrillators (Revision)
- Genetic Testing (CFTR-mutations) for Cystic Fibrosis (Revision)
- Osteochondral Allografting (Revision)
- Osteochondral Autograft (Revision)
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty (Revision)

Effective Jan. 1, 2018

- Applied Behavioral Analysis (ABA) (Revision)
  (Prior authorization request fax forms for ABA services will be available on our website prior to the effective date of this policy.)

INSIDE THIS ISSUE

Prior Authorization Required for Vyxeos

Beginning Nov. 1, 2017, Vyxeos will be added to the Provider-Administered Specialty Drug Lists and will require a prior authorization for all lines of business.

You can find information on all provider-administered specialty medications requiring prior authorization on our website.

- BlueCare Tennessee
- Commercial
- CoverKids
- BlueCare Plus (HMO SNP)SM
- Medicare Advantage

Ventricular Assist Device (VAD) Dressing Supply Allowance Updated

Effective Dec. 1, 2017, supplemental information will no longer be required when filing claims for VAD Dressing Supplies billed with HCPCS Codes Q0508 and Q0509, unless specifically requested. These codes are for "miscellaneous supply or accessory for use with an implanted ventricular assist device."

Historically, VAD dressing supply allowances have been made based on the policy for codes without established fees i.e. they were determined by invoice. BlueCross has conducted an in-depth analysis of codes Q0508 and Q0509 to address provider concerns about the process to obtain reimbursement. In this analysis, we reviewed data from paid claims along with invoice documents supplied by providers to establish a reasonable allowable. This reimbursement will be a monthly rate allowance for claims filed for dates of service Dec. 1, 2017, and after.

Availity® Coming Soon

You will soon have access to the most up-to-date online tools for working with us on the Availity provider engagement portal at Availity.com. With Availity, you can interact securely with BlueCross and other participating health plans without using multiple systems. You can review remittance advices, claims status, eligibility and benefits plus these BlueCross-specific features through Availity:

- Unified Member Search – This custom member search will closely match our capabilities in BlueAccessSM and will include search options by SSN, name and DOB.
- BlueCard® – Searches for your out-of-state patients will be available in the same interface, which means you'll no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- Claims Management Tool – This upgraded tool features a customized search function, so you can find rejected and adjudicated claims. You'll also be able to see your full claim lifecycle in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications.

Watch for information soon on the actions you will need to take as we begin the migration. Be sure to select someone in your organization who will create and manage accounts. The Availity organization administrator will be responsible for setup, which includes registering the organization, setting up and assigning access to users, as well as other applicable registration and setup activities.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.

Preparing for the 2017 – 2018 Flu Season

It's important that you help set preventive care measures to protect your patients during this time of year. Please educate all patients and parents of children older than 6 months of age on the importance of getting a yearly flu vaccine.

Please make every effort to schedule your high-risk patients for a flu shot as early as possible this flu season. To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations.

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. Please 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 people 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 isn't available under VFC.For more information, please call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

Medicare Advantage

- Intradermal vaccine
  This is a covered benefit.

CoverKids

- Vaccine and administration
  This is a covered benefit.

Note:

- Code 90756 will become effective on Jan. 1, 2018, for Flucelvax Quadrivalent – antibiotic-free vials (2017-2018 NDCs 70461-0301-10 and 70461-0301-12). Prior to the implementation/effective date, codes 90749 or Q2039 may be billed for this product.
- Code 90674 became effective on Sept. 1, 2016, for BlueCare, and Jan. 1, 2017, for all other lines of business for Flucelvax Quadrivalent – preservative and antibiotic-free syringes (2017-2018 NDCs 70461-0201-01 and 70461-0201-11).

Help Bust Flu Shot Myths

You play an important role in making sure our members have accurate information about flu shots. Here are some common misconceptions and answers you can share with your patients:

It might give me the flu.

The flu shot can't cause the 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 the flu. 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.

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are going into effect Jan. 1, 2018, for air ambulance providers (rotary or fixed-wing):

- NPI and the appropriate taxonomy codes are required to distinguish between ground charges and air charges when filing claims.
- You must include pick-up and drop-off ZIP codes, mileage, etc.

Member cost share can be significant for this type of service, so please try to work with in-network providers.

You can find updated billing guidelines for Commercial plans in your BlueCross BlueShield of Tennessee Provider Administration Manual.

Non-Emergent Air Ambulance Transportation Requires Prior Authorization for Commercial plans*

Starting Jan. 1, 2018, prior authorization is required for non-emergent air ambulance transportation. Prior authorization won't be required for emergency transport (e.g., from the scene of an accident when ground isn't appropriate or would pose a threat).

To arrange non-emergent air ambulance transport for a patient with BlueCross Commercial benefits, please request prior authorization by calling BlueCross at 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. ET.

This prior authorization requirement may affect your patients if an out-of-network air ambulance is used for non-emergent transportation.

Coordinating Care for Patients Taking Antipsychotic Medications

Comprehensive care and coordination between primary care physicians (PCPs) and behavioral health providers is important for patients taking antipsychotic medication. Prior to starting a patient on an antipsychotic medication, consider consulting with behavioral health providers for alternative treatments, such as psychological assessment and therapy. Alternative treatment could be crucial, since some patients taking antipsychotic medication may be at risk for diabetes and heart disease.

Here are some helpful resources you can use as you determine appropriate treatment options for your patients taking antipsychotic medication:

- Call on our Behavioral Health team. We can schedule and make referrals.
- Consult with one of our Behavioral Health medical directors to discuss alternative medications by calling our Primary Care Physician Consultation line at 1-800-367-3403.
- Refer your patients to a Behavioral Health Case Manager, who can offer personal assistance with local resources, and health coaching for some plans. Here's how your patients can reach our Behavioral Health Case Management team:
  - Commercial: 1-800-818-8581
  - BlueCare℠, TennCare*Select* and CoverKids: 1-888-416-3025

Please look for more information and resources in our Behavioral Health Toolkit.

Overpayment Recovery Update*

Beginning Jan. 1, 2018, BlueCross BlueShield of Tennessee will recover overpayments through an offset to the provider's remittance advice 30 days from the date of notification. Please do not send a check for the overpayment amount. If checks are sent to BlueCross, they will be returned to the payee.

Non-Compliance Denials

Please note that non-compliance denials aren't subject to reconsideration. However, you have 60 days to submit an appeal related to a non-compliance denial. Please complete and submit the Provider Appeal Form located on our provider webpage under the forms section. If you send the Reconsideration Form, it will delay your appeal, so be sure to use the correct form. If you need help or have questions, please call the Provider Service Line.

Tips For Coding Professionals

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

Using Right and Left Laterality Modifiers to Ensure Commercial Claims Payments

We want to help you make sure that your claims process efficiently and without any issues through our updated claims editing software. We will let you know when items that trigger a denial start appearing on a regular basis.

The following items require right (RT) and left (LT) laterality modifiers to process correctly:

DME – Wheelchair Claims

- All wheelchair accessories with a "bilateral" component require RT/LT modifiers
- All accessories billed with same code for a different level (e.g. pelvic supports, thoracic supports) require a separate line for each level
- All accessories billed with same code for front and rear components (e.g. casters) require a separate line for each section

Drugs

- J732x Hyaluronan or derivative codes (i.e. currently J7320 – J7328) require an RT/LT modifier if injections are made bilaterally.

Medicare Advantage Coding for Consultation Services

Starting Jan. 1, 2018, Medicare Advantage will no longer recognize CPT® procedure codes for consultation services (CPT® codes 99241-99245 and 99251-99255). When billing Medicare Advantage claims, you'll be required to use the appropriate Evaluation and Management (E&M) codes when you provide services previously coded as consultations.

For office or outpatient consultations, use E&M codes 99201-99205 or 99211-99215, and 99221-9922 for inpatient consultations. Please bill your emergency department consultations as emergency department visits (99281-99285).

For more coding tips see the Code Editing section on our website.

BlueCare Tennessee

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

TennCare Registration is Required for Providers to Participate in BlueCare and CoverKids Networks

Federal regulations require providers participating in our BlueCare, TennCareSelect or CoverKids networks to be registered with the Division of TennCare. Providers must have a valid, active Medicaid ID from TennCare before submitting an application to participate in the BlueCare Tennessee networks. Applications without a Medicaid ID can't be processed.

In addition, we are required to terminate contracts with providers who are not registered with TennCare. BlueCare Tennessee members who are assigned to primary care physicians who are removed from the network will be reassigned to other network providers.

To register with the Division of TennCare please visit the TennCare Provider Registration website or if you have questions about your current registration please contact TennCare Provider Services at 1-800-852-2683 and choose option 5 or email Provider.Registration@tn.gov.

Preventing Falls Can Help Save Lives

With the support and assistance of providers like you, our goal is to help CHOICES members maintain safety during their daily activities. Falls are a major safety risk for these members. They can be costly, devastating and deadly. One in five falls causes a serious injury like a broken bone or blow to the head. They become even more dangerous if the person is taking certain medicines (like blood thinners).

What You Can Do

Usually, a fall results from the interaction of two or more risk factors. By working together with your staff, you can develop ways to keep the member's environment safe.

Assist Members with Daily Living

By providing stand-by assistance, you can help prevent a member from falling sideways.

Medication Awareness

Know the side effects of the medications members take, especially the ones that cause dizziness.

Talk to Family Members

If you have concerns about the people you support, talk to the family. Let them know if you see an increase in falls, dizziness or balance issues and ask for their support in keeping the member's living space free from obstacles that could cause them to fall.

Timing is Key in Reporting Critical Incidents

Critical incidents involving CHOICES members must be reported within 24 hours of discovery to Customer Service by calling 1-888-747-8955 or by email at CHOICES_CI@bcbst.com. Written reports of the incident are due within 48 hours of discovery.

Critical Incident Categories

- Death
- Major or severe injury
- Life-threatening medical emergency
- Medication error
- Safety issues
- Suspected physical, mental or sexual abuse
- Neglect (a lack of care that could harm the member)
- Theft
- Financial exploitation - improper use of funds

Follow-up reports, including provider investigation, findings and conclusion, must be submitted within 20 days from the discovery date of the incident.

The CHOICES Critical Incident forms are available at bluecare.bcbst.com. You may submit the 48-hour report and 20-day follow-up report by fax at 1-855-292-3715 or email at CHOICESQuality@bcbst.com.

In addition to reporting critical incidents involving abuse, neglect or financial exploitation to CHOICES, they must also be reported to Adult Protective Services (APS) or Child Protective Services (CPS) within 24 hours of discovery.

- APS – Phone: 1-888-277-8366 or Fax:1-866-294-3961
- CPS – Phone: 1-877-237-0004

Provider Bonus for Maternity Care

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 offer a few tips on this initiative.

When submitting 0500F, remember to:

- Include the appropriate Evaluation & Management (E&M) Code (99201-99205 or 99211-99215) confirming pregnancy.
- Include the date of the last menstrual period in form locator 14 or Loop 2300 with Qualifier 484.
- Submit the Maternity Care Management Notification Form through BlueAccess or fax to (423) 854-6033.
- Submit at least $10 in billed charges to receive the full bonus.

When submitting 0503F, remember to:

- Include the postpartum code 59430.
- Include the Delivery Date in form locator 14 or Loop 2300 with Qualifier 431.
- Make sure the postpartum visit is complete within 21 to 56 days after delivery.
- Submit at least $10 in billed charges to receive the full bonus.

Please note normal third party liability (TPL) processing guidelines will still apply.

Review of 2016 ASH Claims Continues During Fourth Quarter

During the fourth quarter of 2017, we will continue our review of all BlueCare, TennCare*Select* and CoverKids claims submitted during 2016 that include an absolute or possible abortion, sterilization or hysterectomy (ASH). If your practice submitted an ASH claim for a procedure conducted last year, we may contact you to request records if they were not submitted with the claim.

Billing Changes for Long-Acting Contraceptives Take Effect in November

BlueCare Tennessee and CoverKids will begin reimbursing providers for voluntary reversible long-acting contraceptives (VRLAC) as separate items starting Nov. 1, 2017. Charges for VRLAC devices implanted during the labor and delivery inpatient stay must be billed as part of the inpatient claim. The following is a list of current HCPCS codes that will be affected:

J7297 J7298 J7300 J7301 J7307 Q9984

This change does not affect doctors who perform implants in the hospital. They will still be able to bill for their services using the CPT® code associated with the procedure.

Related information from the Division of TennCare:

- VRLAC Memo from TennCare
- VRLAC Claim Submission

Medicare Advantage

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

New 2018 Benefit for BlueCross' Diabetic Medicare Advantage Members

Diabetic members will be able to take advantage of a new Medicare Diabetes Prevention Program (MDPP) starting in 2018. Through a partnership with Solera Health, members at risk for developing diabetes can learn how to make lasting changes by eating healthier, increasing physical activity and managing the challenges that come with lifestyle change.

MDPP is free to qualifying members and includes:

- Sixteen weekly lessons, followed by monthly sessions for the rest of the year
- A lifestyle health coach who will help set goals and keep participants on track
- Small groups for support and encouragement
- Helpful tools, like wireless scales and fitness trackers

You will be able to refer your patients to the program through BlueCross' Population Health program. Additional details on referring patients will be included in a future edition of BlueAlert.

BlueChoice℠ No Longer Offered in 2018

While BlueCross will continue to offer our BlueAdvantage℠ plan in 95 counties across Tennessee in 2018, we will no longer offer our BlueChoice HMO. A majority of our Medicare Advantage members are enrolled in our PPO and will not be impacted by this change.

We sent our BlueChoice members a letter in early October announcing this change and gave them the option to enroll in BlueAdvantage for 2018. BlueAdvantage has similar benefits including prescription and limited dental coverage within a larger provider network. We also encouraged them to call the number on the back of their identification card to speak with our customer service team if they had any questions. If you have questions, please call our Provider Service line.

Flu Vaccines Keep Your Patients Healthy

With flu season in full swing, remind your patients to get their annual flu shot. It's quick, easy and included in the benefits for BlueCross Medicare Advantage members. Most important, it can help keep them healthy.

Patients 65 and older are at greater risk for serious complications from flu. Because our immune system weakens as we age, almost 90 percent of flu-related deaths happen

in patients older than 65, along with nearly 60 percent of hospitalizations for this same age group. The flu shot is a calendar-year benefit, so it's covered once a year regardless of the number of days between vaccinations.

Your senior patients may receive the regular or newer higher dose vaccine. The higher dose vaccine is 24 percent more effective in those who are 65 and older according to The New England Journal of Medicine.

This time of year is also a good time to review your patient's pneumococcal vaccine status.

High-Tech Imaging "C" HCPCS Code Cross-Reference Document

A new reference document is available to help manage "C" codes for outpatient facilities related to high-tech imaging requests. CMS created the codes for their outpatient facility to augment reimbursement when paying on a per-diem basis. The codes were not created to represent "base" procedure codes like CPT®, "G" or "S" HCPCS codes.

Authorizations are performed on the specific CPT®, "G" or "S" code not based on "C" codes. If a "C" code is submitted for claim payment, it must have an existing authorization on file with the appropriate base procedure code to ensure claim payment. Download the BlueAdvantage & Blue Choice Cross-Reference Table from our Provider page at bcbst.com.

New In-Home Screening Vendor – Matrix Medical Network

Starting Nov. 1, 2017, BlueAdvantage members who have been identified as having gaps in care will be able to receive in-home screenings by Matrix Medical Network, our newest in-home health care vendor.

Matrix will schedule in-home assessments, including bone mineral density screenings, diabetic retinal eye examinations, FIT testing for colorectal cancer and hemoglobin A1C measurements for diabetic patients. These are all screenings that link directly to the Medicare Advantage Stars program.

Matrix will send copies of all test results to each member's primary care physician of record. Please email Jodi (Hazel) Bolen, Manager of Stars Member Experience, if you have questions about this program.

Prior Authorization Required for Medicare Advantage and BlueCare Plus℠

As a reminder, beginning Oct. 1, 2017, prior authorization is now required for the provider-administered specialty medications listed below for the Medicare Advantage and BlueCare Plus plans.

Specialty Medications Requiring Prior Authorization (Effective Oct. 1, 2017)

Abraxane	Benlysta	Fabrazyme	Jevtana	Perjeta	Synribo
Acthar HP	Berinert	Firmagon	Kadcyla	Portrazza	Temodar (IV)
Adagen	Cerezyme	Folotyn	Kalbitor	Proleukin	Thyrogen
Adcetris	Cimzia	Fusilev	Kanuma	Provenge	Trelstar Depot
Aldurazyme	Cinryze	Gazyva	Krystexxa	Remodulin	Tyvaso
Aloxi	Cyramza	Glassia	Kyprolis	Retisert	Vantas
Aralast/Prolastin/ Prolastin C / Zemaira	Elelyso	Halaven	Lumizyme	Ruconest	Vimizim
Arranon	Eligard/ Lupron Depot	Ilaris	Lupron Depot	Signifor_LAR	VPRIV
Arzerra	Empliciti	Iluvien	Marqibo	Soliris	Xiaflex
Beleodaq	Epoprostenol (Flolan/Veletri)	Inflectra	Naglazyme	Somatuline Depot	Yondelis
		Istodax	Onivyde	Supprelin LA	Zaltrap
		Jetrea	Ozurdex	Sylvant	Zoladex

You can find information on all provider-administered specialty medications requiring prior authorization for each line of business on our website.

Quality Care Partnerships

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

2018 Medicare Advantage Quality Care Partnerships Performance Measures

Our Medicare Advantage (MA) plans will be sending quality amendments for 2018. Below is an updated list of planned measures. Please speak with your Quality Incentive Consultant if you have any questions.

Measures Applicable to Both Value-Based Contracts and Quality Amendments							
Measure Name	Measure Type	Weight	2018 Star Ratings Projected Cut Points				
			1 Star	2 Star	3 Star	4 Star	5 Star
Adult BMI Assessment (ABA)	Process (Non-Continuous)	1	<43%	43%	62%	90%	98%
Breast Cancer Screening (BCS)	Process (Non-Continuous)	1	<45%	45%	65%	71%	78%
Colorectal Cancer Screening (COL)	Process (Non-Continuous)	1	<60%	60%	64%	73%	84%
Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed	Process (Non-Continuous)	1	<48%	48%	63%	75%	83%
Medication Reconciliation Post-Discharge (MRP)	Process (Non-Continuous)	1	<20%	20%	34%	57%	70%
Comprehensive Diabetes Care (CDC) - HbA1c Control (<9.0%)	Outcome (Continuous)	3	<51%	51%	64%	78%	86%
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	Process (Non-Continuous)	1	<94%	94%	95%	97%	99%
Controlling High Blood Pressure (CBP)	Outcome (Continuous)	3	<40%	40%	58%	66%	77%
Medication Adherence for Cholesterol (Statins)	Outcome (Continuous)	3	<67%	67%	74%	79%	84%
Medication Adherence for Hypertension (RASA)	Outcome (Continuous)	3	<73%	73%	77%	81%	85%
Medication Adherence for Oral Diabetes Medications (OAD)	Outcome (Continuous)	3	<72%	72%	78%	81%	85%
Plan All-Cause Readmissions (PCR)	Outcome (Continuous)	3	<13%	13%	10%	8%	6%
Additional Measures Applicable only to Quality Amendments							
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Process (Non-Continuous)	1	<55%	55%	74%	77%	82%
Osteoporosis Management in Women Who Had a Fracture (OMW)	Process (Non-Continuous)	1	<23%	23%	36%	53%	72%

NOTE: Measures and cut points for the MA Star Ratings Program are determined by CMS and are based on prior year performance of all MA plans. To adjust for industry improvement in the upcoming year, BlueCross retains the right to adjust the cut points based on statistical analysis of industry trends from prior years' performance.

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.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online.

CAQH Solutions | PROVIEW™

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

† 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 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
***Select*Community**	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
Email:	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

DECEMBER 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with the following revised policy. To read the complete policy information, please click here.

Effective Dec. 20, 2017

- Photodynamic Therapy (PDT) for the Treatment of Cancer, including Barrett's Esophagus (Revision)

2018 Formulary Changes

Each year, BlueCross formularies are reviewed to determine changes based on a drug's effectiveness, safety and affordability. While many changes to the BlueCross formularies are made at the beginning of the year, changes may occur at any time because of market changes such as:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links to view the "What's Changing on the Formulary for 2018":

- 2018 Preferred Formulary Changes
- 2018 CoverKids℠ Formulary Changes
- 2018 Essential Formulary Changes

Last month, we sent letters to our members whose medications are changing to non-formulary status beginning Jan. 1, 2018. Please remind your patients that they can check for formulary changes at bcbst.com.

INSIDE THIS ISSUE

Prior Authorization Required for Besponsa and Rituxan Hycela

Effective Nov. 17, 2017, Besponsa and Rituxan Hycela were added to the Provider-Administered Specialty Drug Lists. All lines of business require prior authorization for these drugs. You can find information on all provider-administered specialty medications that require prior authorization on our websites.

BlueCare Plus℠
BlueCare Tennessee
Commercial
CoverKids
Medicare Advantage

Availity® Provider Portal Opens Dec. 10, 2017 for BlueCross Providers

Starting Dec. 10, 2017, all BlueCross providers will be able to switch from BlueAccess℠ to the Availity Provider Portal for essential administrative tasks. With Availity, you'll be able to interact securely with BlueCross and other participating health plans on one convenient system. You can review remittance advices, claims status, eligibility and benefits. You'll also have access to important BlueCross-specific features, including a payer space that can connect you to other BlueCross applications.

To aid in your transition, BlueAccess will continue running for the next few months. However, it's important to note the provider tool will no longer be available after March 2, 2018. If you haven't already, please be sure to assign someone in your organization to manage your transition to Availity and register at Availity.com. Updates and links to the resources needed for the transition are posted on bcbst.com/providers. Please notify any third-party vendors who are using BlueAccess on your behalf.

The Availity organization administrator is responsible for setup, which includes registering your organization, establishing and assigning access to users, and other important tasks. BlueAccess currently uses a security model based on your BlueCross provider number. Availity manages access at the Organization Tax ID level. When choosing your administrator, it's also important to evaluate how your organization(s) should be setup with Availity so you can effectively manage your staff's access to their specific job functions. As we work with Availity to build further integrations such as Single Sign-On, we will follow the roles and permissions your administrator assigns to manage appropriate access to your data.

Although BlueAccess is going away, all of your claims and payment data, and many of your applications, will still be available. If you have an issue with a BlueCross-specific application on Availity, our eBusiness team is here to train and support you as needed. Of course, you can always call us with any questions you may have about the transition.

Continuing to Improve the Provider Enrollment Process

We continue to explore ways to make the provider enrollment process easier for you. Our online enrollment application has helped make the process more efficient for provider offices and we're working on ways to continue that trend. For example, the application will soon include an update that displays which specific documents are needed based on the provider type along with the capability to upload the information when submitting the online application.

A requirement of the application is to have a valid CAQH ID and permission for us to review that data. Our system will soon verify the information in real time and notify you if there are any issues to resolve. Look for these and other changes in the coming months.

Preparing for the 2017-2018 Flu Season

It's important that you help set preventive care measures to protect your patients during this time of year. Please educate all patients and parents who have children older than 6 months of age on the importance of getting a yearly flu vaccine.

Please make every effort to schedule your high-risk patients for a flu shot as early as possible this flu season. To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations.

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. Please 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 people 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 isn't available under VFC. For more information, please call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

Medicare Advantage

- Intradermal vaccine
  This is a covered benefit.

CoverKids

- Vaccine and administration
  This is a covered benefit.

Note:

- Code 90756 will become effective on Jan. 1, 2018, for Flucelvax Quadrivalent – antibiotic-free vials (2017-2018 NDCs 70461-0301-10 and 70461-0301-12). Prior to the implementation/effective date, codes 90749 or Q2039 submitted with NDC may be billed for this product.
- Code 90674 became effective on Sept. 1, 2016, for BlueCare℠, and Jan. 1, 2017, for all other lines of business for Flucelvax Quadrivalent – preservative and antibiotic-free syringes (2017-2018 NDCs 70461-0201-01 and 70461-0201-11).

Dental Coding Changes

According to the current guidelines set by the American Dental Association (ADA), the following CDT® codes will be deleted as of Jan. 1, 2018: D5510, D5610 and D5620.

The following CDT® codes will be added as of the same date, and will also be covered under the standard DentalBlue contract: D5511, D5512, D5611, D5612, D5621, D5622, D6096, D7979, D9222 and D9239.

If you file a claim with a deleted code on or after Jan 1, 2018, that line item will not be processed and you will be advised to refile with the most current ADA code. For questions, please contact Dental Customer Service at 1-800-523-1478.

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are going into effect Jan. 1, 2018, for air ambulance providers (rotary or fixed-wing):

- NPI and the appropriate taxonomy codes are required to distinguish between ground charges and air charges when filing claims.
- You must include pick-up and drop-off ZIP codes, mileage, etc.

Member cost share can be significant for this type of service, so please try to work with in-network providers.

You can find updated billing guidelines for Commercial plans in your BlueCross BlueShield of Tennessee Provider Administration Manual.

Know When Diagnostic Services Are Included in Global Surgery Reimbursements

For all lines of business, diagnostic services provided within three days of an inpatient admission are included in the global surgery reimbursement (for the same patient and same provider tax ID), unless stipulated differently by the provider's contract. In addition, for some Commercial contracts, diagnostic services within one day of an outpatient surgery are included in global surgery reimbursement. Please refer to your contract for specific guidelines.

Non-Emergent Air Ambulance Transportation Requires Prior Authorization for Commercial plans*

Starting Jan. 1, 2018, prior authorization is required for non-emergent air ambulance transportation. Prior authorization won't be required for emergency transport (e.g., from the scene of an accident when ground isn't appropriate or would pose a threat).

To arrange non-emergent air ambulance transport for a patient with BlueCross Commercial benefits, please request prior authorization by calling BlueCross at 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. ET.

This prior authorization requirement may affect your patients if an out-of-network air ambulance is used for non-emergent transportation.

UPDATE: Technical Component for Professional Services Performed in Free-Standing Ambulatory Surgery Center*

Payment will be made under the physician fee schedule for technical component services provided in a free-standing ambulatory surgery center (ASC) (Place of Service 24). Commercial and BlueCare Tennessee DRG and outpatient case rates paid to all institutions and facilities, other than free-standing ASCs, will continue to include any technical component for professional services provided for institution and facility patients. Reimbursement for the technical component services is part of the all-inclusive global payment made to these institutions/facilities. Provider pathology claims with any (institutional or facility) place of service other than 24 will receive a T33 denial.

Non-Compliance Denials

Please note that non-compliance denials aren't subject to reconsideration. However, you have 60 days to submit an appeal related to a non-compliance denial. Please complete and submit the Provider Appeal Form located on our provider webpage under the forms section. If you send the Reconsideration Form, it will delay your appeal, so be sure to use the correct form. If you need help or have questions, please call the Provider Service Line.

Overpayment Recovery Update*

Beginning Jan. 1, 2018, BlueCross BlueShield of Tennessee will recover overpayments through an offset to the provider's remittance advice 30 days from the date of notification. Please do not send a check for the overpayment amount. If checks are sent to BlueCross, they will be returned to the payee.

Billing Guidelines When the Rendering Provider is Different than Billing Provider

When billing professional claims, the rendering provider NPI should be included only when it's different than the billing provider. Your electronic claims need to include the rendering provider in Loop 2310B and billing provider in Loop 2010AA. We'll only accept paper claims if you can verify technical difficulties or temporary extenuating circumstances exist. In this case, enter the rendering provider in Block 24J and the billing provider in Block 33. This requirement aligns with both Version 5, Release 1, ASC X12 Standards for Electronic Data Interchange Technical Report Type, Health Care Claim: Professional (837) and Version 4.0 7/16 of the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12. We'll reject and return claims if the rendering provider NPI is the same as the billing provider.

Tips For Coding Professionals

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

New Policy for Status T Codes

Effective Jan. 1, 2018, regardless of date of service, BlueCross will follow CMS Policy for National Correct Coding Initiative (NCCI) edits of the National Physician Fee Schedule Relative Value file for Status T codes.

Under these guidelines, additional services payable under the physician fee schedule that are billed on the same date by the same provider will be bundled into the physician services for which payment is made. One example of a Status T code is CPT® 94760. For more details regarding these guidelines, please refer to the CMS website.

High-Tech Imaging CPT® Codes That Require Prior Authorization

Many codes for high tech imaging procedures require prior authorization. The codes that require prior authorization are listed on the company website at bcbst.com.

Codes that require prior authorization for the Commercial lines of business can be found here: bcbst.com/docs/providers/hti/2016HTICodeList.pdf.

Codes that require prior authorization for Medicare Advantage can be found here: bcbst.com/docs/providers/hti/HTICodeList.pdf.

BlueCare Tennessee

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

Billing Requirements for Behavioral Health Providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering the service to BlueCare Tennessee, BlueCare Plus or CoverKids members is different than the billing provider. If an agency bills for services that weren't provided by a licensed clinician, the supervising professional shall be entered on the claim as the rendering provider. Claims submitted without the rendering provider will be rejected and returned unprocessed.

Taxonomy Code Reminder

As a reminder, professional claims need a taxonomy code to be submitted for the billing and rendering NPIs. It's extremely important that both the billing and rendering provider taxonomy codes match the taxonomy codes on file for BlueCross. If you don't submit the appropriate taxonomy codes for BlueCare Tennessee, CoverKids, and BlueCare Plus, your claims may be denied or the reimbursement reduced.

Sick Visit Could be Your Only Chance for a TennCare Kids or CoverKids Checkup

Thousands of kids from low-income homes in Tennessee miss their annual well-care checkups, and the number increases every year. Any time children (patients under age 21) with TennCare Kids or CoverKids coverage are in your office is a great time to make sure their checkups are up to date.

While your patient's visit might be for an illness, shots or a prescription refill, statistics show it could be years before you get another chance to conduct a checkup, especially if your patient is a teenager. TennCare Kids Screening Guidelines allow reimbursement for both a "sick" and "well" visit on the same day, so you don't have to schedule another appointment.

For the correct coding and modifier usage for billing both types of care on the same day, please see the TennCare Kids Screening Guidelines section of the BlueCare Tennessee Provider Administration Manual.

BlueCare Tennessee Now Using 30-Day Readmission Review Period*

On Nov. 1, 2017, BlueCare Tennessee began using a 30-day readmission look-back period for members 21 or older. A readmission is a preventable, unplanned admission of a patient to the same facility for a condition or complication related to the original hospital stay. Claims for patients who are readmitted under these circumstances are not eligible for multiple payments at facilities that are paid on a DRG or per diem basis. These claims are also subject to retrospective claims review and recovery.

This policy applies to all readmissions except those specifically listed in the BlueCare Tennessee Provider Administration Manual as readmissions that may be approved for authorization and payment.

Providers Requesting and Providing Services for BlueCare Tennessee or CoverKids Must Be Registered with TennCare℠

Federal regulations require providers ordering services for BlueCare, TennCare*Select* or CoverKids members be registered with the Division of TennCare. These regulations not only apply to those providing care, they also apply to providers who request care for patients with TennCare coverage.

Providers must have a valid, active Medicaid ID from TennCare before submitting an application to participate in the BlueCare Tennessee networks. Professional and institutional claims that are filed by a provider without a Medicaid ID can't be processed or paid.

Reporting Requirements for Member Death Change in January

Currently, all member deaths under the age of 21 and unexpected deaths over the age of 21 are required to be reported. Starting Jan. 1, 2018, BlueCare Tennessee and CoverKids providers will only need to report unexpected deaths. This change doesn't affect the requirements to report the death of a member while receiving care from home health services nor how providers must report Behavioral Health Adverse Occurrences that may also involve a member's death.

If you need to report a member death, please use the Death of Member Notification Form on our website.

Medicare Advantage

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

2018 Formularies for Medicare Advantage and BlueCare Plus

Each year, we review our prescription drug formularies to make sure the medications we cover for our members are safe, effective and affordable. While many changes to the BlueCross formularies are made at the beginning of the year, changes may occur at any time because of market changes such as:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links to view the 2018 Formularies:

- BlueAdvantage℠
- BlueCare Plus

Last month, we sent letters to our Medicare Advantage and BlueCare Plus members whose medications are changing to non-formulary status beginning Jan. 1, 2018. Please remind your patients they can call us at 1-800-831-2583 for a complete list of drugs their plan covers.

Provider Assessment Form Reimbursement for 2018

In 2018, you'll again be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueChoice℠ patients.

Please use CPT® code 96160 to file a PAF. BlueAdvantage will continue to reimburse the service as E/M Code 96160, with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2018
- $200 for dates of service between April 1 and June 30, 2018
- $175 for dates of service between July 1 and Sept. 30, 2018
- $150 for dates of service between Oct. 1 and Dec. 31, 2018

To receive reimbursement, you must submit the completed form through BlueAccess or fax a completed writable form to 1-877-922-2963. The form should also be included in your patient's chart as part of their permanent record.

You don't need to wait 365 days between PAF submissions. For additional information about the Provider Assessment Form, please visit bcbst.com/providers/quality-initiatives.page.

Change in Authorization for Some Skilled Nursing Care Supplies*

Starting Jan. 1, 2018, we'll require prior authorization for non-routine supplies used for skilled nursing care provided in a patient's home or a facility. Both the supplies and associated service will require authorization.

You can find the Home Health Agency Non-Routine Supply List in the billing section of your BlueCross BlueShield of Tennessee Provider Administration Manual. You won't be reimbursed for charges related to non-routine supplies if they aren't included and reviewed during the authorization. Also, please bill supplies using the appropriate revenue and HCPCS codes when filing claims.

Under Medicare guidelines, routine supplies are inclusive in the per diem reimbursement. They aren't separately reimbursed, even if requested by another provider for the same dates of service.

Flu Vaccines Keep Your Patients Healthy

With flu season in full swing, remind your patients to get their annual flu shot. It's quick, easy and included in the benefits for BlueCross Medicare Advantage members. Most important, it can help keep them healthy.

Patients 65 and older are at greater risk for serious complications from flu. Because our immune system weakens as we age, almost 90 percent of flu-related deaths happen in patients older than 65, along with nearly 60 percent of hospitalizations for this same age group. The flu shot is a calendar-year benefit, so it's covered once a year regardless of the number of days between vaccinations.

Your senior patients may receive the regular or newer higher dose vaccine. The higher dose vaccine is 24 percent more effective in those who are 65 and older according to The New England Journal of Medicine.

This time of year is also a good time to review your patient's pneumococcal vaccine status.

Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

To ensure proper claim payment for requests for lung cancer screening with Low Dose Computed Tomography (LDCT), HCPCS codes G0296 and G0297, the claim must be billed with ICD-10 diagnosis code Z87.891. These codes are limited to reimbursement once per calendar year.

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. Even a minor fall can be serious, so take a moment to talk to your patients about fall prevention and what they can do to make sure their homes are safe.

Please share these fall prevention tips with your patients:

- 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 or carpeting.
- Maintain good lighting, especially in stairwells and halls.
- Install handrails near the toilet, tub and stairways.
- Move items on high shelves to lower ones.
- Wear shoes in the house instead of slippers or bare feet.

New In-Home Screening Vendor – Matrix Medical Network

Beginning Jan. 1, 2018, BlueAdvantage members who have been identified as having gaps in care are able to receive in-home screenings by Matrix Medical Network, our newest in-home health care vendor.

Matrix will schedule in-home assessments, including bone mineral density screenings, diabetic retinal eye examinations, FIT testing for colorectal cancer and hemoglobin A1C measurements for diabetic patients. These are all screenings that link directly to the Medicare Advantage Stars program.

Matrix will send copies of all test results to each member's primary care physician of record. Please email Jodi Bolen, Manager of Stars Member Experience, if you have questions about this program.

BlueChoice No Longer Offered in 2018*

While BlueCross will continue to offer our BlueAdvantage plan in 95 counties across Tennessee in 2018, we will no longer offer our BlueChoice HMO. A majority of our Medicare Advantage members are enrolled in our PPO and will not be impacted by this change.

We sent our BlueChoice members a letter in early October announcing this change and gave them the option to enroll in BlueAdvantage for 2018. BlueAdvantage has similar benefits including prescription and limited dental coverage within a larger provider network. We also encouraged them to call the number on the back of their identification card to speak with our customer service team if they had any questions. If you have questions, please call our Provider Service line.

Quality Care Partnerships

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

Quality Care Quarterly, Your Source for the Latest News on Quality Programs

The Quality Care Quarterly newsletter includes informative articles on our quality programs. Each edition features success stories from your peers, helpful information on clinical measures, tips for using our Quality Care Rewards tool, and more.

The summer edition is still available online on the provider page of our website, under Your Guide to Quality Programs. You can also view it here. Previous editions can be found in the newsletter archives at the bottom of the page.

Each issue is formatted as a printable PDF. Please consider printing copies for your staff, and particularly for all the practitioners in your practice. We want to make sure everyone in our providers' offices has access to this information.

Watch for an email, with a link to the fall/winter edition, from your BlueCross contact in early December.

THCII Episodes of Care Risk/Gain Share Payments and/or Recoupments

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care risk/gain share payments and/or recoupments for the 2016 performance period were released the week of Nov. 19 for the Medicaid line of business.

BlueCross BlueShield of Tennessee offices will be closed Dec. 25 and 26, 2017, and Jan. 1 2018, in observance of the holidays.

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.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online.

CAQH Solutions | PROVIEW™

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

† 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 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
***Select*Community**	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
Email:	eBusiness_service@bcbst.com
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	