of Tennessee

JANUARY 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Upcoming Changes to Utilization Management Guidelines

Effective Feb. 21, 2018, the following Utilization Management Guidelines related to inpatient and surgical care will be updated:

- Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy and Salpingectomy
- Laparotomy for Gynecologic Surgery, Including Myomectomy, Oophorectomy and Salpingectomy

Click here to view all guidelines modified by BlueCross.

Changes to Specialty Pharmacy Network

Specialty Pharmacies participating in the BlueCross BlueShield Specialty Pharmacy Network in 2018 are listed on the Details on Specialty Pharmacy Program page on our website.

The following are changes to our Specialty Pharmacy Network effective Jan. 1, 2018:

- Added as a participating provider:
  - Caremax Pharmacy of Loudon, dba Paragon Infusion
  - FFP Holdco, LLC Factor Support Network Pharmacy
  - FFP Holdco, LLC, dba Medex BioCare
- No longer participating:
  - Kroger Specialty Pharmacy, Inc.

How can you help?

Advise your BlueCross Commercial patients to:

- Check the list of specialty pharmacies in their network by visiting the Details on Specialty Pharmacy Program page on our website.
- Switch to a specialty pharmacy in their network to pay less for specialty prescriptions. If they don't choose a specialty pharmacy on the list, they'll pay more.
- Contact a consumer advisor if they need help. Our consumer advisors are available Monday through Friday from 8 a.m. to 6 p.m. (ET).

INSIDE THIS ISSUE

Prior Authorization Required for Mylotarg and Kymriah

As of Dec. 7, 2017, Mylotarg and Kymriah were 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 websites.

BlueCare Plus℠
BlueCare Tennessee
Commercial
CoverKids
Medicare Advantage

Change in Authorization for Some Skilled Nursing Care Supplies

Starting Jan. 1, 2018, prior authorization is required for non-routine wound care 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 included in the per diem reimbursement. They aren't separately reimbursed, **even if requested by another** provider for the same dates of service.

Have You Registered for Availity®?

The Availity Provider Portal is now open for BlueCross providers to access information and interact with BlueCross and other health plans through a single system to review remittance advices, claims status, eligibility and benefits.

Availity also features a BlueCross-specific payer space, which lets you see updates from BlueCross and use our custom applications. For example, to visit our Quality Care Rewards tool, you'll go to Payer Spaces in the Availity Provider Portal, and then select BlueCross BlueShield of Tennessee.

Exclusive features for BlueCross providers include:

- **Unified Member Search** – This custom member search within the Eligibility and Benefits Inquiry tool closely match our capabilities in BlueAccess℠, and includes search options utilizing patient ID, Social Security number, member name, and date of birth.
- **BlueCard®** – Searches for your out-of-state members are available in the same interface through Eligibility and Benefits Inquiry and Claim Status (New), which means you'll no longer have to use a separate application to view your out-of-state members (a valid member ID and prefix are required).
- **Claim Status (New)** – 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.

If you haven't registered for Availity, it's time to get started at Availity.com. If you're already an Availity user, you can set up your BlueCross account from the dropdown menu on your Availity dashboard. Also, you should notify any third-party vendors who are using BlueAccess on your behalf.

What you need to do to get started:

- 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.
- To register, go to Availity.com and click REGISTER in the upper right corner of the home page, select Let's get started! and follow the instructions in the Availity registration wizard.

To aid in your transition, BlueAccess for providers will continue running through March 2, 2018, but won't be available after that time. Please contact your eBusiness Regional Marketing Consultant if you have additional questions or need help transitioning to the Availity portal.

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 what 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.

Proper Copays for Nurse Practitioners in a Specialist's Office

If you have a nurse practitioner working in a specialist setting, you may not be collecting the correct copays. When a nurse practitioner is registered with BlueCross as a specialist provider, you must collect the specialist copay, not the copay for a primary care provider (PCP).

Please refer to this table for collection guidelines for nurse practitioner services:

Provider/Clinical Setting	Copay
Nurse Practitioner	PCP
Nurse Practitioner, Acute Care	Spec
Nurse Practitioner, Adult Health	PCP
Nurse Practitioner, Family Practice	PCP
Nurse Practitioner, Gerontology &Adult Health	Spec
Nurse Practitioner, Neonatal	Spec
Nurse Practitioner, Oncology	Spec
Nurse Practitioner, Pediatrics	PCP
Nurse Practitioner, School	Spec
Nurse Practitioner, Women's Health (OB/GYN)	PCP/Spec

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. 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 became 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 implementation/ effective date, codes 90749 or Q2039 submitted with NDC may be billed for this product.

Code 90674 became effective 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).

Reminder:
FDA labeling, including "approved for use" information, should be consulted when selecting the appropriate agent for specific beneficiaries.

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are now in effect 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 sha re 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

Prior authorization is now 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 Aware of Member Rights and Responsibilities

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

For your convenience, we publish our current member rights and responsibilities online in our provider administration manuals. To review this information, you can link to these manuals from the Quick Links section of 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 Benefit Limits for Opioids Begin Jan. 16, 2018

TennCare is changing the benefit limits for opioids to help to address the increasing negative health outcomes associated with the opioid epidemic in Tennessee. TennCare, through its pharmacy benefits manager Magellan Health, will strengthen existing opioid coverage limits for first-time and non-chronic opioid users.

Effective January 16, 2018, TennCare will limit acute opioid therapy coverage for ALL new and non-chronic opioid users as follows:

- A member can receive opioid prescription coverage for up to 15 days in a 180-day period at a maximum dosage of 40 morphine milligram equivalents (MME) per day.
  - All first-fill scripts within a 180-day period will be limited to a five-day supply of a short-acting opioid at a maximum dose of 40 MME per day without the need for prior authorization.
  - After the first-fill prescription, a member can receive up to an additional 10 days of opioid treatment at a maximum dose of 40 MME per day in each 180-day period, with pre-authorization.
- Any long-acting opioid agent will require prior authorization.

For more information, please see the following notices that were mailed to providers in December.

- TennCare Opioid Provider Letter
- BlueCare Tennessee/TennCare Opioid Provider Memo

TennCare Member Benefit Renewal Flier for Your Office

TennCare routinely sends redetermination packets to members every month to assess their eligibility status for another year. TennCare created a benefit renewal flier for provider offices to remind members about how important it is for members to open these packets and take action. Please help remind your patients by printing the flier and posting in your office.

Documenting Your Patients' Well-Child Visits

When your patients covered by BlueCare Tennessee or CoverKids receive their well-child visit, make sure all seven required components of the exam are recorded.

Your patients' medical records should document the following during the exam:

- Complete health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/ behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Shots (as necessary)
- Health education

The medical record should also indicate:

- Assessments of your patients' nutrition and physical activity
- If the child is uncooperative or the exam was refused

Helpful services are available from the Tennessee Chapter of the American Academy of Pediatrics website for the required components of the TennCare Kids exam as well as required medical record documentation criteria.

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.

Medicare Advantage

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

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.

Additional Medicare eligibility criteria includes:

- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 30 pack-years
- Current smoker or one who has quit within the last 15 years
- A written order for an LDCT
- Counseling on risk factors and screening

Annual Wellness Exams and 2018 Member Incentives

An annual wellness exam is an important first step to a healthy 2018. Patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. They may also be eligible to earn a reward for completing the exam. You can help your BlueAdvantage and BlueCare Plus patients earn additional rewards for their healthy living by scheduling a check-up early.

In 2018, members will need to take two steps to be eligible for rewards:

- BlueCross Medicare Advantage members will need to "opt in" to the rewards program with OnLife Health, our rewards partner. Each member will receive a welcome kit in January detailing opt-in instructions, which can be online or by phone.
- An annual wellness claim must be on file for members to receive additional rewards in 2018 for other needed screenings. Annual wellness exams should be filed with 99387, 99397, 99385, 99395, 99386, 99396, 96160, G0402, G0438, G0439, plus appropriate E/M codes.

Note: The Annual Wellness Exam is a calendar year benefit, which means each member is entitled to one wellness exam annually, regardless of the number of days between each exam. It's not necessary to wait 365 days between exams.

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 BlueAdvantage and BlueCare Plus 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.

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 Availity and 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.

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

FEBRUARY 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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Medical Policy Updates/Changes

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

Effective Feb. 21, 2018

- Coronary Computed Tomography Angiography (CCTA) (Revision)

Effective March 1, 2018

- Ablation Treatments for Barrett's Esophagus (Revision)
- Novel Biomarkers for Diagnosis and Management of Prostate Cancer (Revision)
- Positron Emission Tomography (PET) for Miscellaneous Applications (Revision)

New Outpatient Drug Testing Policy

Effective April 1, 2018, urine/serum drug testing will be limited to 20 episodes per annual individual benefit period. An episode is defined as either a presumptive or confirmatory test, or both, for the same date of service per provider billed on the same claim. A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test is a definitive or combined qualitative/quantitative test. This policy does not apply to BlueCare Tennessee, CoverKids℠, FEP or our Medicare Advantage members.

INSIDE THIS ISSUE

New Prior Authorization Requirements

Effective Jan. 1, 2018, the following provider-administered specialty medications require prior authorization for all lines of business:

- Aliqopa
- Exondys 51

Effective Jan. 18, 2018, the following provider-administered specialty medications require prior authorization for all lines of business:

- Yescarta
- Fasenra
- Triptodur
- Mepsevii

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

All Blue Workshops 2018 Coming to a City Near You

Save the date for our annual All Blue Workshops. We're mailing invitations soon, so be on the lookout for yours. You'll also be able to find more details on our registration page.

- **Tuesday, March 6** – Chattanooga (Downtown Marriott)
- **Wednesday, March 14** – Memphis (DoubleTree)
- **Thursday, March 15** – Jackson (DoubleTree)
- **Wednesday, March 21** – Nashville (Franklin Cool Springs Marriott)
- **Tuesday, April 24** – Johnson City (Millennium Centre)
- **Wednesday, April 25** – Knoxville (Holiday Inn World's Fair Park)

It's Time to Register and Get Started with Availity®*

The Availity Provider Portal opened in December for BlueCross BlueShield of Tennessee providers. Now, you can use a single system to transact with BlueCross and other health plans. Register today, and begin reviewing remittance advices, claims status, eligibility and benefits right online. Availity also features a BlueCross-specific payer space, which lets you see updates from BlueCross and use our other applications. For example, to access our Quality Care Rewards tool, go to Payer Spaces in the Availity Provider Portal, select BlueCross BlueShield of Tennessee, and then click on Quality Care Rewards.

Exclusive features for BlueCross providers include:

- **Unified Member Search** – This custom member search within the Eligibility and Benefits Inquiry tool will closely match our capabilities in BlueAccess℠ – including search options by patient ID, social security number, member name and date of birth.
- **BlueCard®** – Searches for your out-of-state members will be available in the same interface through Eligibility and Benefits Inquiry and Claim Status (New). This means you'll no longer have to use a separate application to view your out-of-state members (a valid member ID and prefix will still be required).
- **Claim Status (New)** – 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.

If you haven't registered for Availity, it's time to register and get started at Availity.com. If you're already an Availity user, you can access BlueCross by selecting "BCBS TENNESSEE" as the payer in the Tennessee region. Be sure to review available role assignments specific to BlueCross functionality within the "Maintain Organization" section of the My Account Dashboard.

Here's how to get started:

1. **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.
2. **Go to** Availity.com and click **REGISTER** in the upper right corner of the home page. Next, select **Let's get started!** and follow the instructions in the Availity registration wizard.

To aid in your transition, BlueAccess for providers will continue running through March 2. It will not be available after that date. Please be sure to notify any third-party vendors who are using BlueAccess on your behalf. If you have questions or need help transitioning to the Availity portal, please contact your eBusiness Regional Marketing Consultant.

Quality Program Participants Must Register for Availity by Feb. 17

Starting Feb. 17, 2018 the following applications will only be available through the Payer Spaces in the Availity Provider Portal:

- Quality Care Rewards (QCR) Tool
- Episodes of Care Quarterly Reports (THCII)
- Patient Centered Medical Home Quarterly Reports (THCII)
- TN HealthLink Enrollment & Quarterly Reports (THCII)

Please make sure your practice is using Availity by Feb. 17, 2018 to avoid possible disruption.

Enrollment Process Update

We're committed to improving our enrollment experience so it's easy and efficient for you. We appreciate your patience as we continue to refine our enrollment process. In the meantime, here are some important pointers and updates:

Please use a Provider Enrollment Form (PEF) if you're:

- A new provider to BlueCross
- Adding a network
- Changing/adding a specialty
- A non-credentialed radiologist, anesthesiologist, pathologist, emergency services (RAPS) provider (for pre-approval purposes)

Please use a Change Form if you're:

- Updating existing providers (demographics)
- Adding new locations (tax change) when the provider is already credentialed

This will help speed the process for providers who are already in a BlueCross network.

Issues we are working to resolve:

- Some providers receive a "500 Error" when submitting enrollment applications. If this happens to you, please use another browser (Chrome/Firefox) and it should work as expected.
- We're adding the capability to upload miscellaneous documents. For now, please email your supporting documents to ProviderSupport@bcbst.com with reference to your PEF and tracking numbers. We may also ask you to email certain documents if we aren't able to access it in our system.

If you have any questions, please email us at ProviderSupport@bcbst.com or call our Provider Service line at 1-800-924-7141. We'll continue to post updates in future BlueAlerts.

Dental Credentialing/ Re-Credentialing

All dental network providers are required to be credentialed as specified in the amended and restated contract, with re-credentialing occurring every three years. If you've been in our dental network longer than the last three years, you'll need to be re-credentialed.

To prepare for re-credentialing, please confirm your information – including the attestation and all applicable required documentation (DEA licensure, state licensure and current liability information) – is still accurate with the Council for Affordable Quality HealthCare, Inc. (CAQH). We collect all provider data and credentialing information from CAQH, a universal credentialing application and central repository used by all health plans for credentialing.

If you have any questions, please call us at 1-800-357-0395.

2018 HEDIS® Medical Record Requests to Begin

Each year, we are required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. These measures determine whether members received the care and screenings they needed and if the care improved their health.

Soon, we'll be requesting medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/ postpartum care, medication management and well-child visits.

For your convenience, we can help coordinate your record submission using any of these methods:

- Remote access into your EMR
- Secure email
- Fax
- On-site collection
- Our web-based portal

Thank you for your cooperation and support of this requirement.

Preparing for the 2017-2018 Flu Season

We appreciate your help in taking 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.

To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations – especially for your high-risk patients.

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- Vaccine and administration
  Intramuscular flu vaccine is a covered benefit for those 6 months of age and older.
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  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 became effective 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 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).

Reminder: FDA labeling, including "approved for use" information, should be consulted when selecting the appropriate agent for specific beneficiaries.

Tips for Coding Professionals

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

Changes to High-Tech Imaging Program Prior Authorization for Commercial Plans

The following list of CPT® codes now require prior authorization through the High Tech Imaging Program administered by eviCore. This change became effective Jan. 1, 2018.

- 0501T
- 0502T
- 0503T
- 0504T

Before submitting prior authorization requests, please verify member benefits/eligibility through Availity® at Availity.com. For more information about registering with Availity, visit our provider page at bcbst.com/providers/availity.page. You may also call our Provider Service Line to verify benefits/eligibility.

Prior authorization requests can be submitted through Availity via Payer Spaces, through BlueAccess via eHealth Services, by phone at 1-888-693-3211 or by fax at 1-888-693-3210.

BlueCare Tennessee

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

Psychosocial Rehabilitation Services Update

Beginning Feb. 1, 2018, BlueCare will be using a revised medical necessity guideline for Psychosocial Rehabilitation (PSR). BlueCare, the Division of TennCare, other Managed Care Organizations (MCOs) and providers worked in collaboration to develop a consistent approach across all MCOs. Please refer to the following link for more information. https://www.bcbst.com/providers/UM_Guidelines/default.htm

Seven Required Parts of a TennCare Kids Checkup

When your patients covered by BlueCare Tennessee receive their well-child checkup, please document all seven required components of the exam, which include:

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests
- Immunizations
- Health education/ anticipatory guidance

It should also indicate assessments of your patients' nutrition and physical activity.

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

Helpful services are available from the Tennessee Chapter of the American Academy of Pediatrics for the required components of the TennCare Kids exam as well as required medical record documentation criteria.

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.

Medicare Advantage

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

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 patients.

Please use CPT® code 96160 to file a PAF, which will be reimbursed 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, please submit your claim and the completed PAF within 30 days of the face-to-face visit with your patient. You'll be able to submit this information through BlueAccess until Feb. 17, 2018. After this date, you'll need to submit forms through Availity® at availity.com. For more information about registering with Availity, visit our provider page at bcbst.com/providers/availity.page. You may also fax a completed Provider Assessment Form to 1-877-922-2963.

The form should also be included in your patient's chart as part of their permanent record.

Annual Wellness Exams and 2018 Member Incentives

An annual wellness exam is an important first step to a healthy 2018. 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. You can help your BlueCross Medicare Advantage patients earn additional rewards for their healthy living by scheduling a checkup early.

In 2018, BlueCross Medicare Advantage members will need to "opt in" to the rewards program with OnLife Health, our rewards partner. Each member received a welcome kit in January detailing opt-in instructions, which can be done online or by phone.

Note: The annual wellness exam is a calendar year benefit, which means each member is entitled to one wellness exam annually, regardless of the number of days between each exam. **It's not necessary to wait 365 days between exams**.

New Benefit for Pre-Diabetic Medicare Advantage Members

Starting April 1, 2018, we're rolling out a new required benefit for our pre-diabetic Medicare Advantage members. In partnership with Solera Health, we're offering the Medicare Diabetes Prevention Program (MDPP).

The program teaches members who are at risk for developing diabetes how to make lasting changes by eating healthier, increasing physical activity and managing the challenges that come with lifestyle change.

The program is free to qualifying members and includes:

- Sixteen weekly lessons followed by monthly sessions for the rest of the year
- A lifestyle health coach to help set goals and keep participants on track
- Small group setting for support and encouragement
- Helpful tools, like wireless scales and fitness trackers

You'll also be able to refer your patients to the program through the BlueCross Population Health program. Please look for more information, including details on physician referrals, in a future edition of BlueAlert.

Remind Your Patients About Flu Vaccines

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 BlueAdvantage and BlueCare Plus℠ 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.

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
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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 PlusSM	1-800-299-1407
BlueChoiceSM	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 2018

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. The following policy will be archived and no longer active 30 days after this BlueAlert notification. It has been determined that this procedure is now generally considered standard/conventional practice and is supported by the American Academy of Orthopaedic Surgeons.

- Unicompartmental Knee Replacement

Availity® Replaces BlueAccess℠ for Providers*

Availity is now your single system to transact with BlueCross and other health plans. If you're not registered for the Availity Provider Portal, please register now to avoid disruption of important business processes. For FAQs and more information about registering with Availity, visit Availity.com/bcbst.

If you need additional help registering or have questions about your Availity account, you can:

- Call Availity Client Services at 1-800-AVAILITY (282-4548). Support is available Monday through Friday from 8 a.m. to 7 p.m. ET (excluding holidays).
- Call BlueCross eBusiness Technical Support at (423) 535-5717, option 2. Representatives are available Monday through Thursday from 8 a.m. to 6 p.m. and Fridays from 9 a.m. to 6 p.m. ET. You can also email ebusiness_techsupport@bcbst.com.
- Contact your eBusiness Regional Marketing Consultant. Your consultant will be happy to answer your questions and help you transition to the Availity portal.

INSIDE THIS ISSUE

A New Look for Online Authorizations Through Availity

We've recently updated our online authorization tools to help make this process even more convenient. You can find the tools by clicking the "Authorization Submission/ Inquiry" tile from Availity's BlueCross Payer Space. We hope you find these tools useful and that they offer a more streamlined experience.

Please note that BlueCross BlueShield of Tennessee will remain your primary source for authorizations for our members through the Availity Payer Spaces. Authorizations for BlueCard members can be obtained through Availity's Multi-Payer Authorizations and Referrals tool.

If you have questions or need help transitioning to the Availity portal, please contact your eBusiness Regional Marketing Consultant.

THCII Episodes of Care: Quarterly Reports

The Episodes of Care Quarterly Reports are now available for review.

Please login to Availity to view your reports. If you believe you should have reports, but can't access them, please call eBusiness at (423) 535-5717 and select option 2.

For more information related to Episodes of Care, please visit our BlueCare Tennessee and Commercial websites.

New Outpatient Drug Testing Policy

Urine/serum drug testing will be limited to 20 episodes per annual individual benefit period, effective May 1, 2018. An episode is defined as either a presumptive or confirmatory test (or both for the same date of service per provider billed on the same claim). A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test is a definitive or combined qualitative/quantitative test. This policy does not apply to BlueCare Tennessee, CoverKids, FEP or our Medicare Advantage members.

Changes to Morphine Milligram Equivalent Calculations

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

On Jan. 1, 2017, BlueCross adopted a safety edit regarding a member's Morphine Milligram Equivalent (MME) daily dose. This safety edit requires any member exceeding 200 mg MME per day to have a prior authorization. At the same time, CMS announced an update regarding a graduated conversion factor for methadone.

Effective Jan. 1, 2018, we adopted the graduated conversion factor for methadone based on the updated CDC calculations and CMS regulations. The new conversion factor logic is listed below, along with a link to the CDC's website for guidance in calculating total daily MME.

Daily Methadone Dose (Methadose)	Conversion Factor
Up to 20 mg per day	4
21 – 40 mg per day	8
41 – 60 mg per day	10
> 60 mg per day	12

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

Prior Authorization Requirement for Genetic Testing

Beginning May 1, 2018, BlueCross will require prior authorization for genetic testing for some Commercial members. Please check for additional information in upcoming issues of the BlueAlert newsletter.

New Prior Authorization Requirements for Specialty Medications

Visco-3 was added to the provider-administered specialty medications requiring a prior authorization for all lines of business effective Jan. 1, 2018.

The following provider-administered specialty medications require a prior authorization for all lines of business effective Jan. 26, 2018:

- Luxturna
- Durolane
- TriVisc

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

New Skilled Nursing Facility Benefit for FEP Members

Federal Employee Program (FEP) members with Standard Option coverage have a new skilled nursing facility (SNF) benefit with an annual maximum of 30 days. The Basic Option will continue to use flexible benefits when approved by Case Management for SNF coverage. This criteria checklist can help you determine if a patient is eligible for the benefit:

- Will the patient benefit from short-term SNF services with a goal of returning home?
- Is the patient enrolled in case management before admission to the SNF? The case manager must have a signed member consent form before SNF admission can be approved.

Before admission, you must perform a functional status and preliminary development assessment including:

- Neurological and cognitive
- Musculoskeletal status and functional mobility
- Integumentary
- Medications and therapies – medication reconciliation must occur between the transferring facility, receiving SNF and plan case manager before SNF admission
- Renal
- Cardiopulmonary
- Mental health
- Nutritional and gastrointestinal, including the ability to swallow and digest, and the need for special diets
- Psychosocial assessment
- Educational needs

You'll also need prior authorization (handled by the applicable case manager) – and an approved treatment plan, including proposed therapies and a stated need for daily SNF care.

If your facility provides skilled nursing services, you should have received a detailed letter and sample consent form in January. If you have questions, please call the FEP Provider Service Line.

Use Correct Forms to Ease Enrollment Process

In order to provide a smooth enrollment process, we'd like to share some important reminders:

- We've replaced our paper Provider Enrollment Forms (PEFs) with convenient, online forms for all individual practitioners.
- Practitioners should use the online PEF when submitting an initial enrollment or additional network request. Look for the orange "Apply Now" button on bcbst.com/providers/
- For all other requests (TIN change, address change, name change, etc.), please use the Commercial Practitioner Change Form.

If you need additional information, please contact our Provider Service Line.

Tips for Coding Professionals

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

Announcing Two New CMS Modifiers

CMS has established guidelines for using new modifiers, FY and JG, when billing charges for the following:

- X-Ray Taken Using Computed Radiology – requires **Modifier FY**
- 340B Acquired Drug – requires **Modifier JG**

As of Jan. 1, 2018, providers are required to use these modifiers when billing these charges for our Medicare Advantage members, which will result in an applicable payment reduction.

Beginning March 1, 2018, claims for all other lines of business will require these modifiers **for informational purposes only**. If BlueCross decides at a later date to use these as pricing modifiers, we'll notify you in advance.

BlueCare Tennessee

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

Abortion, Sterilization and Hysterectomy Code Notice

Beginning April 1, 2018, all claims filed with an ICD-10 and CPT® code that clearly, or even possibly, indicate an abortion, sterilization or hysterectomy (ASH) was performed for the purpose of rendering someone incapable of reproduction, must include:

- Completed certification/consent forms (if applicable), and
- Supporting medical documents (detailed history and physical and/or office notes, operative report, pathology report, ultrasound report of fetal demise, if applicable).

Model of Care Training

BlueCare Plus offers Model of Care (MOC) training for all primary care providers. CMS requires all primary care providers to participate in annual training, which describes the framework for our dual eligible special needs plan BlueCare Plus. Providers who complete MOC training between Jan. 1 and March 31, 2018, will receive a 1 percent bonus to your base rate of reimbursement. You can find registration link on our website.

Tips for Coding EPSDT and Well-Child Visits

The Tennessee Chapter of the American Academy of Pediatrics offers free training and resources to help providers properly code preventive care services for TennCare Kids members. When you use the right coding for preventive care, you help speed the claims process and are more likely to receive correct payment for the care you provide.

When you keep up-to-date records, external reviews and medical audits are much easier and more effective, too.

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

Coding Change for Long-Acting Contraceptive Kyleena

Beginning Nov. 1, 2017, BlueCare Tennessee and CoverKids began reimbursing providers for voluntary reversible long-acting contraceptives (VRLAC) billed as separate items, including Kyleena. Kyleena remains on the VRLAC list, however as of Jan. 1, 2018, coding for this drug changed from Q9984 to J7296. Code Q9984 is no longer eligible for reimbursement. Please use the updated code when billing for this drug in the future.

New Guidelines for Requesting Home Health Services Begin May 1

All TennCare℠ managed care organizations, including BlueCare Tennessee, will soon require providers to submit a patient plan of care for their BlueCare and TennCare*Select* patients with requests for home health services. Beginning May 1, 2018, initial requests for nursing care or home health aides under codes S9122, S9123, S9124 and T1000 must include the following home health agency forms:

Plan of Care Agreement – This form outlines the expectations of services to the patient and will require signatures from the patient, patient's representative and home health agency.

Plan of Care Form – The agreement between the home health agency and your patient with specific details about care the patient will receive, times they will receive it and who'll provide the care.

Caregiver Training Checklist – This form will serve as confirmation that all training elements were addressed with the caregiver and the person was properly trained.

Large Orders of Incontinence Products Require Medical Necessity Review

When ordering incontinent products for your BlueCare and TennCare*Select* patients through Medline, remember that quantities >200 per month require medical necessity review for diapers, underpads and pull-up's.

Submit prior authorization requests for these supplies by phone, fax or email.

- Phone: 1-877-853-7558
- Fax: 1-866-557-2737
- Email: BlueCareTennessee@medline.com

CoverKids and BlueCare Tennessee Benefits Not Identical

While the programs are similar, the benefits for CoverKids are not the same as BlueCare and TennCare*Select*. The major difference in the programs is funding. CoverKids is part of Tennessee's Children's Health Insurance Program (CHIP), while BlueCare Tennessee covers your patients in the Medicaid program. For more information see the BlueCare Tennessee Provider Administration Manual.

You can find a list of covered services in the BlueCare, TennCare*Select* or CoverKids Member Handbooks.

Provider Subcontracting Rules

Providers who participate in the BlueCare Tennessee Network are not allowed to subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior agreement, claims for services provided by the subcontractor could be denied and previous payments could be subject to recoup.

An example of unapproved subcontracting is in the area of antigen therapy. Network providers can't subcontract with a vendor to prepare antigen therapy and submit claims indicating the antigen therapies were prepared by the provider.

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

Report Home Health Critical Incidents Within 24 Hours

A home health critical incident includes significant events involving a BlueCare Tennessee member who is receiving authorized home health services. If you or a member of your home health staff discovers a BlueCare or TennCare*Select* member who has suffered a critical incident, it must be reported to us within 24 hours of discovery.

Home health critical incidents include the following when they occur during the provision of home health services:

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

Please fax your completed forms to the BlueCare Quality of Care Oversight Department at 1-855-339-3022.

For more information about Home Health Critical Incident reporting, please see the BlueCare Tennessee Provider Administration Manual.

Medicare Advantage

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

Changes to Our Medicare Advantage Quality+ Partnerships Incentive Program

If you participate in the Medicare Advantage Quality Incentive Program, you should receive a letter in early March announcing changes that will impact reimbursement rates. If you haven't received your letter or need more information about these changes, please call your Medicare Quality Outreach contact.

Diabetic Statin Use Added to Stars Program

CMS has introduced a new 2018 Stars program measure focused on diabetic statin use, and it will also be part of the Medicare Advantage quality program for 2019.

This measure is based on the number of diabetic patients aged 40-75 who start using a statin or statin combination medication. It overlaps with medication adherence measures for statins and diabetes medications that encourage patients to continue with prescribed therapy. According to the American Diabetes Association data, diabetic patients have better outcomes when they also control their cardiovascular risk factors.

2018 Inpatient Only List Updates

CMS has released its updated 2018 Inpatient Only list. Under payment rules, services on the list can only be paid if they're billed as an inpatient service. The table below lists added and removed, but you can view the entire 2018 Inpatient Only List on our website.

Codes Removed	
0051T	Implant total heart system
0052T	Replace thrc unit hrt syst
0053T	Replace implantable hrt syst
0255T	Evasc rpr iliac art bifr s&i
0293T	Ins lt atrl press monitor
0294T	Ins lt atrl mont pres lead
0309T	Prescrl fuse w/instr l4/l5
27447	Total Knee arthroplasty
34800	Endovas aaa repr w/sm tube
34802	Endovas aaa repr w/2-p part
34803	Endovas aaa rpr w/3-p part
34804	Endovas aaa repr w/1 –p part
38405	Endovas aaa repr w/long tube
34806	Aneurysm press sensor add-on
34825	Endovasc extend prosth init
34826	Endovasc exten prosth addl
34900	Endovasc iliac repr w/graft
43282	Lap paraesoph her rpr w/mesh
43772	Lap rmvl gastr adj device
43773	Lap replace gastr adj device
43774	Lap rmvl gastr adj all parts
55866	Laparo radical prostatectomy
75952	Endovasc repair abdom aorta
75953	Abdom aneurysm endovas rpr
75954	Iliac aneurysm endovasc rpr

Codes Added	
0483T	Tmvi percutaneous approach
0484T	Tmvi transthoracic exposure
0494T	Prep & cannulj cdvr don lung
0495T	Mntr cdvr don lng 1st 2 hrs
0496T	Mntr cdvr don lng ea addl hr
31241	Nsl.sins ndsc w/artery lig
33927	Impltj tot rplcmt hrt sys
33928	Rmvl & rplcmt tot hrt sys
33929	Rmvl rplcmt hrt sys f/trnspl
43286	Esoph tot w/laps moblj
43287	Esphg dstl 2/3 w/laps moblj
43288	Esphg tot thrsc moblj
58575	Laps tot hyst resj mal
92941	Prq card revasc mi 1 vsl

Medicare Advantage Readmissions Program Clarification

Starting May, 1, 2018, if an inpatient services claim is fully denied for a Medicare Advantage hospital readmission within 48 hours of an acute hospital discharge or other fully-denied readmission claim, the associated professional provider claims will also be denied.

New Oxygen Approval Timeframe

In February, BlueAdvantage (PPO)SM changed the oxygen authorization approval timeframe to a 12-month rolling period from the date of request. This change will result in fewer total authorizations, because approvals only need to happen on a true 12-month basis – not a calendar year. This is different from the prior process that approved up to 12 months of oxygen within the current calendar year.

Annual Wellness Exams and 2018 Member Incentives

An annual wellness exam is an important first step to a healthy 2018. 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 as recommended by their provider. They may also be eligible to earn a reward for completing this exam.

In 2018, BlueCross Medicare Advantage members need to "opt in" to the rewards program with Onlife® Health, our rewards partner. Each member received a letter in March detailing opt-in instructions. We encourage members to opt in online, although they also may complete the process by phone or mail.

Note: The Annual Wellness Exam is a **calendar year** benefit, which means each member is entitled to one wellness exam annually, regardless of the number of days between each exam. **It's not necessary to wait 365 days between exams.**

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- 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
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BlueCare PlusSM	1-800-299-1407
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of Tennessee

APRIL 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with revised policies. To read the complete information, click Upcoming Medical Policies.

Effective May 1, 2018

- **Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal and Prostate** (Revision)
- **Diagnosis and Treatment of Sacroiliac Joint Pain** (Revision)
- **Prostatic Urethral Lift** (Revision)
- **Serum Tumor Markers for Breast Malignancies** (Revision)

Is Your Tax ID Number Updated for Availity® Usage?

Thank you for helping us transition to Availity. Please remember that each provider's NPI must be linked to the Tax ID Number (TIN) we have on file for your organization(s). To make sure each provider's NPI is correct and linked to the correct Tax ID Number:

- Go to the "BCBS TN" section at Availity.com.
- Go to My Providers > Express Entry to confirm your NPI.
- Go to My Account Dashboard > Maintain My Organization to confirm your TIN. (Availity sends these numbers to us so they can be matched to the TIN we have on file.)

If your TIN has changed since enrollment, or you need additional help, please contact your eBusiness Regional Consultant at (423) 535-5717, option 2 or eBusiness_service@bcbst.com.

INSIDE THIS ISSUE

Need help with Availity?

Now that the Availity Provider Portal has replaced BlueAccess℠ for providers, we want to make sure you have the support you need for important business transactions.

If you need help or have questions about your Availity account, please:

- Call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday from 8 a.m. to 7:30 p.m. ET (excluding holidays).
- Call BlueCross eBusiness Technical support at (423) 535-5717, option 2. Representatives are available Monday through Thursday from 8 a.m. to 6 p.m. and on Fridays from 9 a.m. to 6 p.m. ET. You can also email ebusiness_techsupport@bcbst.com.
- Contact your eBusiness Regional Marketing Consultant. Your consultant will be happy to answer your questions and help you transition to the Availity portal.

If you need training on the Availity tool:

1. Click **Help & Training**, and then click **Get Trained**.
2. In the Search field at the top of the page, type **BCBS of Tennessee**.
3. Then select **Availity Portal Administration for BCBS of Tennessee Providers – On-Demand**
4. **Or contact your** eBusiness Regional Marketing Consultant

Thank you for your patience through our transition to Availity.

Prepare for New Behavioral Health Treatment Record Audits with Online Training

The processes for behavioral health treatment record audits are changing during the second quarter of 2018. These changes will apply to all lines of business and we want to help you get ready for them. We've created a WebEx training presentation with details and directions about the new processes. If you have any questions, please contact your Behavioral Health Network Manager at 1-800-924-7141.

New Behavioral Health Forms

We're pleased to announce new tools that should simplify the process of obtaining prior authorizations for your patients. Please use these new forms when requesting prior authorizations for your patients covered by BlueCare℠, TennCare*Select*, CoverKids℠, BlueCare Plus (HMO)℠ and BlueAdvantage lines of business.

The new forms are as follows:

- Mental Health Inpatient Request Form
- Mental Health Outpatient Request Form
- Provider Discharge Form
- Behavioral Health Out of Network Request Form
- Psychiatric Residential Treatment Request Form
- Psychological Testing Form

These forms are located on the forms page. Please discontinue use of the previous forms that were used for these services and use the new forms for your patients covered by these lines of business.

New Prior Authorization Requirements for Specialty Medications

Bortezomib (J9999), a new generic drug to market, was added to the provider-administered specialty medications that require prior authorization for all lines of business effective March 2, 2018.

You can find information on all provider-administered specialty medications that require prior authorization on our website.

New Outpatient Drug Testing Policy

Please note our timeline has changed. Beginning June 1, 2018 urine/serum drug testing will be limited to 20 episodes per annual individual benefit period. An episode is defined as either a presumptive or confirmatory test (or both for the same date of service per provider billed on the same claim). A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen.

A confirmatory test is a definitive or combined qualitative/quantitative test. This policy does not apply to BlueCare Tennessee, CoverKids, FEP or our Medicare Advantage members.

Temporary Suspension of Payment Policy for Anatomic Pathology Services Provided at Facilities for Commercial Plans

We understand some providers have been confused about billing and payment practices when anatomic pathology services are provided at facilities. Even though this has been a long-standing payment practice, we've elected to temporarily suspend this policy for 2018 services.

You should have received a letter in late March announcing this decision. In the letter, we stated we'll accept and pay claims for the technical component of anatomic pathology services submitted:

- By physicians and other providers;
- For patients receiving these services in a facility setting between Jan. 1 and Dec. 31, 2018.

We will resume our regular payment policy again for services that occur on and after Jan. 1, 2019.

Under this policy, we pay facilities an all-inclusive rate for inpatient and outpatient services. This includes payment for all services and supplies associated with the inpatient and outpatient services (unless there's a contractual exception).

- This facility payment includes the technical component for professional services provided while a patient is in a facility setting.
- This policy applies regardless of where the technical component is performed – or what relationship exists between the facility and the professional performing the service.

If you have any further questions, please contact your BlueCross Network Manager.

Reporting Management of Testosterone

When assessing how your testosterone replacement therapy patients respond or react to treatment, BlueCross recommends conducting in-office evaluations at three and six months after starting therapy, then annually after your patient is stabilized.

There are always exceptions to this guidance because your patients may need evaluation services at more frequent intervals due to treatment complications or other reasons. If this happens, please **clearly document** why you needed to provide evaluation and management services more often, as well as report those services appropriately with modifier 25 when billed with other services that bundle for the same date of service.

Modifier 25 is used to report a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service (and not to bypass the bundling edit by indicating that only lab results were discussed). Those types of services are considered integral to the administration of testosterone replacement therapy and not a separately identifiable evaluation and management service.

Prior Authorization Requirement for Genetic Testing

Please note out timelines have changed. Beginning June 1, 2018, you'll need to request prior authorization from eviCore for molecular and genomic testing for our Commercial fully-insured and individual members. You may log in or call us at 1-888-693-3211 to obtain authorization.

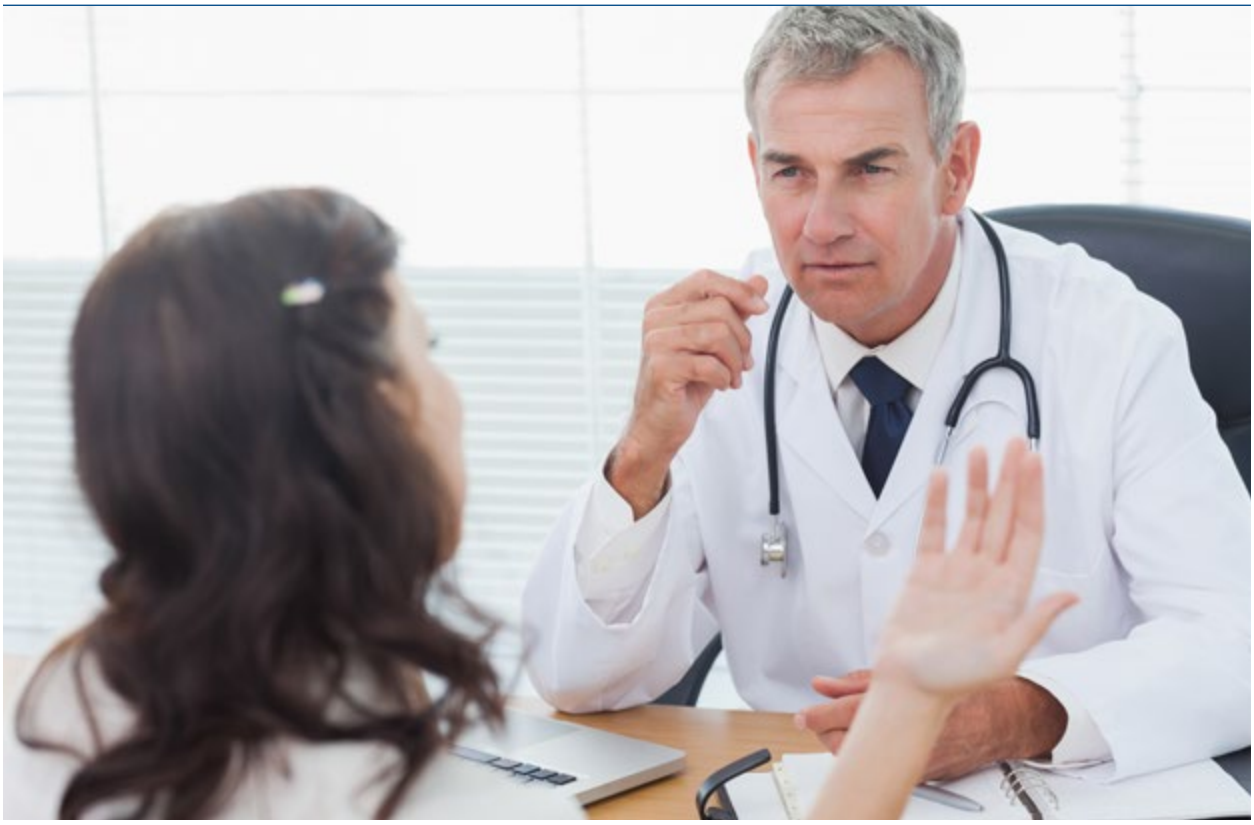
You can also learn more about this important change by registering for online orientation designed to help you and your staff with the new molecular and genomic testing program.

During these sessions, you'll learn more about prior authorization requirements as well as how to navigate eviCore's website, where you'll find Clinical Guidelines and request forms. Get the orientation schedule and other program resources, including step-by-step instructions on how to register for training, by clicking here.

Please call eviCore's Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.

BlueCare Tennessee

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



Coordinating Patient Care is Key

The coordination of a patient's care is essential for healthy outcomes. If you're a primary care physician (PCP), please remember to ask your patients if they've seen other providers since you last saw them. These can include visits to:

- Specialists
- An emergency room
- Urgent care

Also be sure to ask your patients if they've received durable medical equipment, physical therapy or other services from other providers. It's always a good idea to encourage the discussion of treatment plans they've received elsewhere, so you can request information from the other provider(s).

If you are not the patient's PCP, obtain the name of the patient's primary physician and share medical assessments, prescriptions or treatment provided.

Note: This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus plans.

Annual CAHPS Survey Includes Questions About Member Experiences With Physicians

Every year, CMS conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We're sharing this information with you, because we think it's important for you to know the survey includes questions about the care you're providing.

Here are a few examples of the questions your patients will see:

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

Note: This information applies to BlueCare, TennCare*Select*, CoverKids and BlueCare Plus plans.

Visit Bright Futures for Kids' Well-Care Schedules

The American Academy of Pediatrics (AAP) recommends a schedule of comprehensive age-specific, preventive health care screenings, which we use as the standard of care for your young BlueCare and TennCareSelect patients. These recommendations are known as the Periodicity Schedule, and you can find them on the AAP website.

In addition to covering scheduled periodic checkups, BlueCare and TennCare*Select* also cover other inter-periodic screens for kids. Children should have 12 TennCare Kids check-ups before their third birthday. After they turn three, they should have a check-up every year up to age 21.

Medicare Advantage

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

New Medicare Advantage ID Cards

In an effort to protect seniors from fraudulent use of Social Security numbers, combat identity theft and safeguard taxpayer dollars, CMS will launch an initiative that includes removing SSN numbers from member ID cards. Some members may begin receiving new cards as early as April 1, depending on the schedule outlined by CMS.

CMS will provide more information about the changes on a dedicated website, as well as via mail campaigns and webinars, among other activities. We'll share more information in upcoming issues of the BlueAlert newsletter.

Provider Stars Ratings Now Available in Availity

BlueCross' Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2017 calendar year. You may now visit Availity to view your 2017 Stars rating.

After logging in to Availity through Availity.com and accessing the Quality Rewards tool, click on your Medicare Advantage scorecard and view your Stars rating at the top of the scorecard.

Effective April 1, 2018, Stars ratings, which are calculated by the previous year's performance, impact your reimbursement rates. Please refer to the rate attachment in your rebasing rate notification letters mailed at the end of March.

You can reference your contract amendments for information about the Medicare Advantage base rate, quality adjustment and total earning potential.

Medicare Advantage Home Health Billing Guidelines Reminder

Medicare Advantage requires a HCPCS code to be submitted for all outpatient physical, occupational, and speech therapy services. Skilled nursing, medical social services, and home health aide services should also be submitted with the appropriate HCPCS code. These codes should correspond with the Revenue Code being billed.

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

Also, please make sure billing units for home health services are filed as 1 unit for each 15-minute increment. Please refer to the Medicare Advantage section of the BlueCross BlueShield of Tennessee Provider Administration Manual for additional home health billing information.

New Benefit for Pre-Diabetic Medicare Advantage Members

On April 1, 2018, we rolled out a new CMS benefit for our pre-diabetic Medicare Advantage members through our partnership with Solera Health. Our Medicare Diabetes Prevention Program is available for members at risk of developing diabetes and free for those who qualify.

The National Institutes of Health and the CDC proved the program decreased the risk of developing Type 2 diabetes by 58 percent for those who lose 5 to 7 percent of their body weight through diet and exercise changes.

The program includes:

- Sixteen weekly lessons followed by monthly sessions for the rest of the year
- A lifestyle health coach to help set goals and keep participants on track
- A small group setting for support and encouragement
- A focus on healthier food choices and increased activity levels

BlueCross Medicare Advantage members are eligible for the program if they have a BMI >25 (>23 for Asian descent), and at least one of the following blood tests:

- Fasting plasma glucose of 110-125 mg/dL
- Two-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- Hemoglobin or A1C test with a value between 5.7-6.4 within the previous 12 months. Patients with previous history of diabetes (excluding gestational) or end stage renal disease aren't eligible for the program, as outlined by CMS.

You'll also be able to refer your patients to the program through BlueCross' Population Health Program at 1-800-611-3489 or fax 1-800-727-0841. If you have any questions about this benefit, please call our Provider Service Line.

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 PlusSM	1-800-299-1407
BlueChoiceSM	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

MAY 2018

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 revised policies. To read the complete policy information, click Upcoming Medical Policies.

Effective May 30, 2018

- Transcatheter Hepatic Arterial Chemoembolization (Revision)

Effective June 1, 2018

- Electromagnetic Navigation Bronchoscopy (Revision)
- Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies (Revision)

Helpful Tips for Availity® Users

Now that we've transitioned from BlueAccess℠ to Availity, we understand you may have questions about using the new portal. Here are some helpful tips when using Availity.

Pop-up blockers

- Pop-up blockers need to be enabled for all domains, i.e., Availity.com, bcbst.com and vendor sites.
- Additional details are available in the Help section at Availity.com.

Authorizations

- Clinical notes must be in plain text only.
  - This includes lowercase and uppercase letters. Letters with accents, such as è, are not allowed.
  - This includes all numbers.
  - These are the only special characters that can be used: ! @ # : $ & ( ) \ - ` . + , / " * ? = % ' ; < > -

INSIDE THIS ISSUE

- When documents are copied and pasted, some characters may be misinterpreted by the browser. Some of these uncommon characters could be: ¥, ÿ, ã, ¾, ©, etc.

Regions Not Available, Registration or Navigation Issues

- Availity is a multi-payer portal. If you aren't seeing all of the regions you should have access to, please contact Availity Client Services at the number listed below. They can also help with registration or navigation problems.

Reminders

- Every user must have a unique User ID, and there should be no sharing of Accounts/User IDs.
  - Sharing accounts between multiple people will terminate sessions for the person already logged on. Availity security will not allow multiple users to use shared accounts.
- When registering users with Availity, please do not share email addresses. Each user should enter the email address where they can receive emails specific to their User ID.

Availity offers all the same capabilities as BlueAccess, and more. Recently released feature:

- Remit PDF Link: Providers can now access their BlueCross remit for Paid or Denied claims in Claim Status (NEW) at Availity.

If you need help or have questions about your Availity account, please:

- Call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday from 8 a.m. to 7:30 p.m. ET (excluding holidays).
- Call BlueCross eBusiness Technical support at (423) 535-5717, option 2. Representatives are available Monday through Thursday from 8 a.m. to 6 p.m. and on Fridays from 9 a.m. to 6 p.m. ET. You can also email ebusiness_techsupport@bcbst.com.
- Contact your eBusiness Regional Marketing Consultant. Your consultant will be happy to answer your questions about the Availity portal.

Updating Communication Materials from BlueAccess to Availity

Now that we've transitioned to Availity, we're in the process of updating all references to BlueAccess in our communication materials. These include our provider administration manuals and documents on our websites. Our goal is to have these documents updated by the end of second quarter, so we appreciate your patience. If you have questions about using Availity, please contact your eBusiness Regional Marketing Consultant.

Member ID Number Prefix Update

We want you to know about a recent change we made to our Member ID card prefixes. Effective April 15, 2018, we modified them to allow numeric characters in addition to the traditional alpha-only ones.

We made this decision to expand the pool of prefixes needed to support the various BlueCross plans. In addition to the three-character, alpha-only prefixes, you'll begin seeing alpha-numeric prefixes, e.g., A2A, 2AA, 22A, AA2, 2A2, A22. The Federal Employee Program will continue to use Member ID numbers that begin with an R followed by eight numeric characters.

Remember, claims should be submitted with the Member ID number exactly as it appears on the Member ID card including the prefix. We use prefixes to identify the member's type of coverage, obtain health plan contract information and route claims to the correct Home Plan through the BlueCard and Inter-Plan Programs.

To allow you time to transition to the new prefixes, we'll verify the Member ID prefix through May 31 and make corrections if needed. Starting June 1, however, we'll begin to reject claims with an invalid prefix.

If you have any questions, please call BlueCross Provider Service.

BlueCross to Soon Remove Step in the Contracting and Credentialing Process for Physician Assistants and Nurse Practitioners*

In the near future, BlueCross will remove the requirement for physician assistants (PA) and nurse practitioners (NP) to complete supervising or admitting forms as part of the contracting and credentialing process. Instead, we'll obtain admitting information from the CAQH application and the supervising physician information from the medical boards indicated by the PA or NP. Please review your information to confirm that it's up-to-date. These changes will appear in the third quarter editions of the BlueCross and BlueCare Tennessee Provider Administration Manuals.

Changes to NICU Utilization Management and Care Management Services

Starting Sept. 1, 2018, BlueCross will handle all utilization management and care management services for neonatal intensive care unit (NICU) babies covered by Commercial plans. Previously, Progeny helped us with these services.

To request authorizations or care management services, please call our Provider Service line for authorizations at 1-800-924-7141. For case management, call 1-800-818-8581, ext. 6900.

Federal Employee Program (FEP) Adds Healthy Maternity Program

Healthy Maternity, a program for expectant mothers, is now available to FEP members in Tennessee. This program links mothers-to-be with personalized support from maternity nurses and access to online resources. The program offers:

- Confidential maternity health advice
- Personalized one-on-one support from a dedicated maternity nurse
- Prenatal information and online pregnancy resources
- Help with benefits and how to get the most out of them during and after pregnancy
- Details about treatment, care and immunization schedules for the baby

If you have patients who are expecting a baby, please share this information with them. They can enroll in this no-cost program by calling 1-800-818-8581.

Prior Authorization Requirements for New Specialty Medications Recently Added to Market

We've added the following specialty drugs, recently added to market, to the list of provider-administered specialty medications that require prior authorization for all lines of business:

Trogarzo (J3590) – effective April 20, 2018

Ilumya (J3590) – effective April 30, 2018

You can find information on all provider-administered specialty medications that require prior authorization on our website.

Prior Authorization Requirement for Genetic Testing

Beginning June 1, 2018, you'll need to request prior authorization from eviCore for molecular and genomic testing for our Commercial fully-insured and individual members. You may log in or call 1-888-693-3211 to obtain authorization.

You can also learn more about this important change by registering for online orientation designed to help you and your staff with the new molecular and genomic testing program. During these sessions, you'll learn more about prior authorization requirements and how to navigate eviCore's website, where you'll find clinical guidelines and request forms.

Click here for the orientation schedule and other program resources, including step-by-step instructions on how to register for training. Please call eviCore's Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.

Note: You may submit requests to eviCore through BlueCross' payer spaces within the Availity provider portal or by calling 1-888-693-3211 to obtain authorization

New Outpatient Drug Testing Policy

Beginning June 1, 2018, urine/serum drug testing will be limited to 20 episodes per annual individual benefit period. An episode is defined as either a presumptive or confirmatory test (or both for the same date of service for each provider billed on the same claim).

A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test identifies the drugs in a patient's system as well as the exact amount present at the time the sample was taken.

This policy does not apply to BlueCare Tennessee, CoverKids, FEP or our Medicare Advantage members.

BlueCare Tennessee

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

Lab Services Provider Change in BlueCare Tennessee Network

While Quest Diagnostics continues as a BlueCare Tennessee and CoverKids network provider for laboratory services, Quest's subcontract with American Esoteric Laboratories (AEL) has ended. As a result, your office should no longer send lab work for BlueCare members to AEL. Please send all lab tests for BlueCare Tennessee and CoverKids members directly to Quest, with the exception of hospital in-patient lab work or testing allowed under the Lab Exclusion List.

If you need help transitioning to Quest, please contact their representative in your area.

Region	Name	Phone Number
Chattanooga	Eric Penney	(423) 443-6571
Johnson City	Chris Maupin	(423) 444-2729
Kingsport	Dea Bevins	(423) 242-8937
Knoxville North	Denise Doster	(865) 306-4539
Knoxville South	Kay Cunningham	(423) 408-4905
Memphis	Judy Guthrie	(901) 483-6850
Nashville North	Lynn Bates	(615) 517-9457
Nashville	Roxanne Carreon	(615) 512-9667
Nashville South	Heather Lund	(615) 210-7034
West Tennessee	Paula Hill	(901) 337-4292

Children with Special Needs Require TennCare Kids Services Too

Children with special needs often receive extra care and visits to specialists or primary care practitioners 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 the BlueCare Tennessee Provider Administration Manual.

Applied Behavior Analysis (ABA) Guideline Changes

Please note the following guideline changes to ABA:

- Although we strongly encourage a parent or guardian to be engaged and participate in ABA, we may make exceptions depending on extenuating circumstances.
- We believe evidence that supports ABA continues to be limited because of wide variations in methodology, findings and philosophical bias, which makes well-defined conclusions difficult.

Updated ABA medical necessity guidelines will be available June 1.

Prior Authorization for Knee Braces to Start June 1

Starting June 1, 2018, providers in the BlueCare Tennessee and CoverKids networks who supply or service a knee brace that exceeds $200 will need prior authorization. The No Prior Authorization Required list on bluecare.bcst.com will be updated June 1, 2018 to reflect this change. Providers who are out of network will be required to request prior authorization for any service or supply related to knee braces. Please look for more information in the June BlueAlert.

Reimbursement for Revenue Code 0761 Ends June 1

Beginning June 1, 2018, facilities in the BlueCare Tennessee and CoverKids networks will not receive reimbursement for Revenue Code 0761 (Treatment Room Services). This code is often billed incorrectly when observation codes 0729, 0762, 0769 or surgical code 0360 would be appropriate.

Medicare Advantage

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

Provider Stars Ratings Are Available in Availity

BlueCross' Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2017 calendar year. You can visit Availity to view your 2017 Stars rating.

After logging in to Availity through Availity.com and accessing the Quality Rewards tool, click on your Medicare Advantage scorecard and view your Stars rating at the top of the scorecard.

As of April 1, 2018, Stars ratings, which are calculated by the previous year's performance, impact your reimbursement rates. Please refer to the rate attachment in your rebasing rate notification letter mailed at the end of March.

You can reference your contract amendments for information about the Medicare Advantage base rate, quality adjustment and total earning potential. Please refer to our website for a complete listing of providers with ratings of 4 Stars and above.

New Medicare Advantage ID Cards

In an effort to protect Medicare enrollees from fraudulent use of Social Security numbers (SSN), combat identity theft and safeguard taxpayer dollars, CMS is launching an initiative to remove SSNs from member ID cards. Some members may have already received new cards, depending on the schedule outlined by CMS. You can find more information about how the new Medicare number will impact you in the Providers section on the CMS website.

Scam Alert for Medicare Enrollees

Medicare will never call Medicare enrollees uninvited and ask them to give personal or private information to get their new Medicare number and card. Scam artists may try to get personal information from enrollees, like current Medicare numbers, by contacting them about their new card. If someone asks your patients for information or money, or threatens to cancel health benefits if they don't share personal information, your patient should hang up and call 1-800-MEDICARE (1-800-633-4227).

Medicare Advantage Home Health Billing Guidelines

Medicare Advantage requires HCPCS codes to be submitted for all outpatient physical, occupational, and speech therapy services. Skilled nursing, medical social services and home health aide services must also be submitted with the appropriate HCPCS code that correspond with the Revenue Code being billed.

Starting July 1, 2018, home health services not billed with the appropriate Revenue Code/HCPCS Code combination will be rejected.

Please refer to the current Medicare Advantage section of the BlueCross BlueShield of Tennessee Provider Administration Manual for additional home health billing information.

Type of Service	Description	Revenue Code	Procedure Code
Home Health Agency Visits	Home Health Agency Physical Therapy	421	G0151
			G0157
			G0159
	Home Health Occupational Therapy	431	G0152
			G0158
			G0160
	Home Health Speech Therapy	441	G0153
			G0161

BlueCross Partners with CIOX Health to Collect Medical Records

As a Medicare Advantage organization, we're required to submit risk adjustment data to CMS. We've started our annual Medicare risk adjustment medical records data review to make sure we submit complete risk adjustment data to CMS.

We've partnered with CIOX Health to obtain medical records beginning in late April and early May. You may soon receive a letter with a list of requested member records, instructions and options on how to send the medical records to CIOX. Please follow the return instructions provided with your letter.

Administrative Approval Updates for Home Health Physical, Occupational and Speech Therapy*

Effective May 1, 2018, we'll approve initial home health requests for physical therapy, occupational therapy and speech therapy for Medicare Advantage members for up to seven visits in a 14-day timeframe. The number of visits and timeframe is sufficient to cover an initial evaluation, and three visits per week for two weeks. We won't need clinical information for administrative approvals other than a diagnosis. We'll consider additional requests beyond the initial visit approval and timeframe as extension requests, which will require supporting clinical documentation for a medical necessity review.

If you need 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 your request. This is in addition to the current process in place for Home Health Skilled Nursing visits.

Limits for Positive Airway Pressure Devices (PAP) & Urologic Supplies

Effective July 1, 2018, BlueAdvantage will begin enforcing the maximum number of units allowed for certain respiratory assistance device accessories and urologic supplies based on CMS Local Coverage Determinations for:

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea
- Urological Supplies

You'll be reimbursed for eligible accessories and supplies according to the applicable fee schedule. We won't cover any units billed that exceed the maximum number allowed.

Quality Care Partnerships

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

THCII Episodes of Care: Interim Performance and Preview Reports

Episodes of Care Interim Performance and Preview Reports for Commercial and Medicaid lines of business will be available later this month.

Please login to Availity 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.

Health Scorecards Sent to Members with Gaps in Care

This month, we'll start sending health scorecards to our Commercial, Medicare Advantage, BlueCare Plus℠, BlueCare Tennessee and CoverKids members. These scorecards alert them to screenings and care they need to get, and include customized health tips. Members are encouraged to share their scorecards with their physicians during office visits, so they can discuss important health recommendations. If you need additional information about our quality measures and gaps in care, please refer to the Quality Care Rewards page at bcbst.com/providers.

Preventing and Reporting Member Falls

Every year, one of every three adults over the age of 64 suffers a fall. In addition, once they've experienced a fall, they're at a greater risk for more. While every fall doesn't lead to an injury or require a Critical Incident Report, it's important to notify the member's Support Coordinator, Care Coordinator and/or Case Manager. This helps them provide better care for your patient.

Falls are the main reason older adults visit the emergency room. And since more than half of these falls happen at home, it's important to help reduce their risks. Here are some steps you can suggest to your patients to help reduce the risk of falls in their home:

- Remove clutter and items that could cause a trip like: small furniture, rugs and electrical cords.
- Ensure 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.
- Ensure any dark areas are well lit and add nightlights in areas such as the kitchen, bathrooms and hallways.
- Encourage use of walkers or canes.
- Make sure proper shoes are worn.

Working together, we can help to prevent falls.

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 PlusSM	1-800-299-1407
BlueChoiceSM	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 2018

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 revised policies. To read the complete policy information, please click Upcoming Medical Policies.

Effective July 1, 2018

- Saturation Biopsy for Diagnosis and Staging of Prostate Cancer (Revision)

Effective August 1, 2018

- Bariatric Surgery (Revision)

The following medical policy will be archived and no longer active 30 days after this BlueAlert notification. We've determined that there's no longer a need for our Commercial and BlueCare Tennessee Utilization Management departments to maintain this policy.

- DNA-Based Testing for Adolescent Idiopathic Scoliosis

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee's Health Care Practice Recommendations web page has a new look! For ease of navigation, we've arranged practice guidance by clinical issue. We've also provided behavioral health resources that speak to the current topics of *Autism*, *Depression* and *Substance Abuse*.

You can see these updates on our website at http://www.bcbst.com/providers/hcpr. You may also request paper copies of any listed clinical practice guideline by calling (423) 535-6705.

INSIDE THIS ISSUE

Requirements of the New Provider Stability Act

On April 5, 2017, Governor Bill Haslam signed into law the Provider Stability Act (PSA) – a new Tennessee mandate intended to increase transparency and accountability between Tennessee health plans and contracted health care providers. This law, which will take **effect Jan. 1, 2019**, will require Tennessee health plans to:

- Notify health care providers of any material change made at the sole discretion of the insurance entity to a previously released provider manual or a reimbursement rule and policy at least 60 days before the effective date of the change
- Notify health care providers of any change to a provider's fee schedule and the effective date of the change at least 90 days prior to the effective date of the change
- Limit fee schedule changes to once in a 12-month period
- Send all Provider Stability Act notices and disclosures to a dedicated email address supplied by the provider

The PSA only applies to contracted Commercial providers in Tennessee.

How You Can Help

As part of the Provider Stability Act, we'll need to collect a dedicated contracting email address so we can notify you of changes to the Provider Administration Manual, reimbursement rules, fee schedules and policy changes. We'll continue to share updates about this law and how you can provide your preferred email address in future BlueAlert articles.

BlueCross Partners with CIOX Health to Collect Medical Records

As a commercial health insurance organization, we're required to submit medical records to support the Risk Adjustment Data Validation Audit (RADV). We've partnered with CIOX Health, who will start obtaining medical records on our behalf in mid-June. You may receive a letter with a list of requested member records, instructions and options on how to send the medical records to CIOX. Please follow the return instructions provided with your letter.

Prior Authorization Requirement for Genetic Testing

Beginning June 1, 2018, you'll need to request prior authorization from eviCore for molecular and genomic testing for our Commercial fully-insured and individual members. Self-funded accounts will have the option soon. You may log in or call 1-888-693-3211 to obtain authorization. You can also learn more about this important change by registering for online orientation designed to help you and your staff with the new molecular and genomic testing program. During these sessions, you'll learn more about prior authorization requirements and how to navigate eviCore's website, where you'll find clinical guidelines and request forms.

Click here for the orientation schedule and other program resources, including step-by-step instructions on how to register for training. Please call eviCore's Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.

Note: You may submit authorization requests to eviCore through BlueCross' payer space within the Availity provider portal or by calling 1-888-693-3211.

Prior Authorization Requirements for New Specialty Medication Recently Added to Market

Effective May 25, 2018, we added Crysvita (J3590) to the provider-administered specialty medications that require prior authorization for all lines of business. This is a new specialty drug recently added to market.

You can find information on all provider-administered specialty medications that require prior authorization on our website.

Reimbursement Guidelines for Oral Medications in the Practitioner's Office

Oral prescription medications must be dispensed and billed by the member's pharmacy benefit manager based on the written order of the physician. BlueCross does not reimburse any oral medications in the practitioner's office whether administered in the office or dispensed for home use. If an oral medication is administered in the practitioner's office, you must bill the most appropriate HCPCS code for an oral prescription medication or over the counter non-prescription medication.

For more information about reimbursement guidelines for medications not requiring a prescription, please see the Provider Administration Manual.

Submitting Contract-Related Items? Use Our Current Address or Go Online

Even though we moved to Cameron Hill nearly 10 years ago, we still sometimes receive correspondence and notices that were mailed to our old address. If you're mailing documents or anything else related to your contract, please use our current address:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

Even better, you can submit information or communicate with us online. Please email us at PNS_GM@bcbst.com or submit an application using the Provider Enrollment Form at bcbst.com.

Look for additional enhancements to our online Change Form – which will take place during the next few months – in the Provider section of bcbst.com.

Changes to NICU Utilization Management and Care Management Services

Starting Sept. 1, 2018, BlueCross will handle all utilization management and case management services for neonatal intensive care unit (NICU) babies covered by Commercial plans. Previously, Progeny helped us with these services.

To request authorizations, please call our Provider Service line at 1-800-924-7141. For case management, call 1-800-818-8581, ext. 6900.

Printed Commercial Prior Authorization Letters to Be Discontinued

Starting this month, Commercial prior authorization approval letters will be sent by fax. We will no longer mail approval letters. This will speed up the approval process and prevent misrouted letters. Prior authorization requests may be made by fax or phone, and you can get immediate approvals on some authorizations by logging in to the Availity Provider Portal for online authorization requests. You may print web authorization approvals for your records. For FAQs and more information about registering, please log in to Availity.

Global Surgical Package Billing and Guidelines

BlueCross updated its claims payment process in August 2017 to include a more careful analysis during the pre-payment phase of claims editing. The goal is to deliver payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability for all lines of business. Periodically, we publish reminders to help you with claims submissions. Here are a few reminders about global surgical package billing.

- The global surgical package includes reimbursement to the surgeon for the surgical procedure and related care before, during and after the procedure.
- CMS established global periods for certain surgical procedures. These assigned periods can be zero days, 10 days or 90 days.
- Global periods are determined based on the guidelines published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums and Transmittals. These documents are available at www.cms.gov.
- If Medicare does not assign a global period for certain procedures, BlueCross will assign a global period based on a similar service.

Helping Parents Hesitant to Immunize and Documenting Refusals

Parents want to do what's best for their children. They often ask doctors about car seats, baby gates, bottles and many other questions about how to keep their child safe.

Some parents have heard rumors for years about the dangers of immunizations. As a health professional, you know they're safe and have greatly reduced the mortality rate of kids due to related diseases. In fact, they're an important part of preventive health care for kids. You can help educate hesitant parents about immunizations with resources from the American Academy of Pediatrics website.

It's important to note that every parent/guardian or patient has the right to refuse vaccines. If the parent/guardian or patient decides not to get recommended immunizations, documentation of their refusal must be in the patient's medical record. Resources for documenting the refusal are available on the American Academy of Pediatrics website.

New Outpatient Drug Testing Policy

Beginning June 1, 2018, urine/serum drug testing will be limited to 20 episodes per annual individual benefit period. An episode is defined as either a presumptive or confirmatory test (or both for the same date of service for each provider billed on the same claim).

A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test identifies the drugs in a patient's system as well as the exact amount present at the time the sample was taken.

This policy does not apply to BlueCare Tennessee, CoverKids, FEP or our Medicare Advantage members.

Code Editing Clarification

In March of 2017, we posted a notification about our new claims editing system, which was later deployed in August of that year. The article stated that the newly deployed edits would be "all claims processed after implementation date regardless of the [date of service]." With this BlueAlert, we are confirming that "all claims" means claims that are newly adjudicated after the edits were deployed as well as claims that are re-adjudicated after the edits were deployed. To minimize possible confusion, we've enhanced the language on our website to as follows:

> **Edits will be applied on all claims processed (newly adjudicated and re-adjudicated) after the implementation date regardless of date of service.**

You can also review the updated language in the Code Editing section at bcbst.com/providers.

Note: This applies only to the Commercial line of business.

Tips for Coding Professionals

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

Allowance Updated for Electric Breast Pumps (HCPCS Code E0603)

Effective July 1, 2018, supplemental information will no longer be required when filing Commercial claims for electric breast pumps billed with HCPCS Code E0603 unless specifically requested.

Historically, electric breast pump allowances have been based on the policy for codes without established fees – those that are determined by invoice. BlueCross has conducted an in-depth analysis of code E0603 to address provider concerns regarding the process to obtain reimbursement. In this analysis, data from paid claims was reviewed along with provider invoice documents to establish a reasonable allowable. Supplies and accessories needed for the initial provision of the breast pump kit will not be paid in addition to the established Electric Breast Pump E0603 code reimbursement. Additional replacement supplies or accessories are not separately reimbursed. This will be effective July 1, 2018, when billed on the appropriate medical claim form. Some members may have specific group coverage regarding breast pumps; therefore providers may need to verify benefits before providing services.

BlueCare Tennessee

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

Authorization Adjustment is Not Permitted for Home Health Care Missed Shifts

BlueCare Tennessee can't adjust home health care authorizations because of missed shifts. If the amount of home health care hours billed for a member during the week is different than the amount provided, please submit a request for a claim adjustment. This procedure is available in the BlueCare Tennessee Provider Administration Manual.

Please continue to submit all missed shifts using the appropriate form by fax to (423) 535-5254 or (865) 588-4663. If you're reporting a missed shift the same day it will occur, please call us at:

- BlueCare: 1-888-423-0131
- TennCare*Select*: 1-800-711-4104
- CoverKids: 1-800-924-7141
- CHOICES/ECF CHOICES: 1-888-747-8955

If you need help resolving a missed shift because of safety, environmental or enrollee/family barriers, please call Case Management at 1-800-225-8698.

Behavioral Health Facility Audit Questions

Since late 2017, HMS® – a vendor for BlueCare Tennessee – has been conducting claims audits of behavioral health facilities in our provider network. If you'd like more information about the audit process, details are available in the Vendor Audits XIX-2 section of the BlueCare Tennessee Provider Administration Manual, as well as in your BlueCare Tennessee Institution Agreement.

If you have questions about audit requests or audit reports from HMS, please contact them using the contact information listed on your HMS materials before contacting us. HMS will be able to provide specific answers about your facility's audit.

Note: This does not apply to CoverKids.

New Behavioral Health Benefits for CoverKids Members*

Continuous Treatment Team (CTT) and Comprehensive Child and Family Treatment (CCFT) were added as covered benefits for CoverKids members with an effective date of Mar. 19, 2018. Applied Behavioral Analyst (ABA) Services were added as a covered benefit with an effective date of Jan. 1, 2018. While these services are now covered, they do require prior authorization. Please file claims for these services using the codes that apply to your BlueCare Tennessee network contract. If you have questions about claims for these services, our Provider Service staff can help. Please call us at 1-800-924-7141.

Medicare Advantage

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

Changes to Medicare Part D Coverage Determinations and Appeals Process

The Medicare Part D coverage determination and appeal process for BlueAdvantage (PPO) and BlueCare Plus℠ members is currently managed by Express Scripts, Inc. (ESI). Beginning **July 2, 2018**, BlueCross will manage the Medicare Part D coverage determination and appeal process, so providers should submit these requests directly to BlueCross. We'll provide more specific information on how to submit these requests to us in future communications.

New Medicare ID Cards

CMS is launching an initiative to remove Social Security numbers (SSNs) from Medicare Health Insurance ID cards. This is part of an effort to protect Medicare enrollees from fraudulent use of SSN, to combat identity theft and safeguard taxpayer dollars.

Some of your patients may have already received new cards, depending on the schedule outlined by CMS. You can find more information about how the new Medicare number will impact you in the Providers section on the CMS website.

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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.

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.

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

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
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BlueChoice℠	1-866-781-3489
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Monday–Friday, 8 a.m. to 6 p.m. (ET)	
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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
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of Tennessee

JULY 2018

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 revised policies. To read the complete policy information, please click Upcoming Medical Policies.

Effective Aug. 1, 2018

- Accelerated Breast Irradiation and Brachytherapy Boost after Breast-Conserving Surgery for Early-Stage Breast Cancer (Revision)
- Measurement of Serum Antibodies to Infliximab, Adalimumab, and Vedolizumab (Revision)
- Noninvasive Prenatal Testing Using Cell-Free Fetal DNA (cffDNA) (Revision)

Utilization Management Guideline Updates/Changes

We've updated our website to include upcoming changes to select Utilization Management Guidelines. You can find all Utilization Management Guideline updates on the Utilization Management webpage.

Effective Aug. 1, 2018

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

- Hyperemesis Gravidarum

New Prior Authorization Requirement for Provider-Administered Specialty Medication

Akynzeo (J3490), a new-to-market provider-administered specialty medication, requires prior authorization for all lines of business effective June 8, 2018. Find out more about all provider-administered specialty medications that need prior authorization on our website.

INSIDE THIS ISSUE

Prior Authorization Requirement for Genetic Testing*

Prior authorization for molecular and genomic testing for our Commercial fully-insured, individual and select self-funded members is now required from eviCore. You may log in or call 1-888-693-3211 to obtain authorization. You can learn more about prior authorization requirements on eviCore's website, where you'll find clinical guidelines and request forms. Please call eviCore's Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.

Note: You may submit authorization requests to eviCore through BlueCross' payer space within the Availity provider portal, where you can also verify benefits, or by calling 1-888-693-3211.

New Outpatient Drug Testing Policy for Commercial Plans

As of June 1, 2018, urine/serum drug testing is limited to 20 episodes per annual individual benefit period. An episode is defined as either a presumptive or confirmatory test (or both for the same date of service for each provider billed on the same claim). Billing for both tests for the same member on the same day is considered one episode.

A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test identifies the drugs in a patient's system as well as the exact amount present at the time the sample was taken.

BlueAlert℠ Switches to Downloadable PDF Format Only

We understand that your time is valuable, so we want to make sure you get the BlueCross updates you need quickly and conveniently. Starting July 1, 2018, our BlueAlert Provider Communications newsletter will be available as a downloadable PDF only. With just one click, you can download, save and share.

Go to Availity® for Benefits and Eligibility Information

In the near future, all providers except Dental will have to go to Availity.com to determine benefits and eligibility status – not our Provider Service Line.• We understand you may prefer phone communication.However, that takes longer and can keep us from answering more complex calls. When we make this switch, we'll offer a quicker way to get information by phone if you can't find what you need online. If you haven't used Availity yet, we encourage you to try it now. We'll update you on further developments in the coming weeks.

•For now, Dental providers can access Benefits and Eligibility status by phone while we update Availity. We'll notify you if you're required to access this information on Availity.

Requirements of the New Provider Stability Act

On April 5, 2017, Governor Bill Haslam signed into law the Provider Stability Act (PSA) – a new Tennessee mandate intended to increase transparency and accountability between Tennessee health plans and contracted health care providers. This law, which will take **effect Jan. 1, 2019**, will require Tennessee health plans to:

- Notify health care providers of any material change made at the sole discretion of the insurance entity to a previously released provider manual or a reimbursement rule and policy at least 60 days before the effective date of the change
- Notify health care providers of any change to a provider's fee schedule and the effective date of the change at least 90 days prior to the effective date of the change
- Limit fee schedule changes to once in a 12-month period
- Send all Provider Stability Act notices and disclosures to a dedicated email address supplied by the provider

The PSA only applies to contracted Commercial providers in Tennessee.

How You Can Help

As part of the Provider Stability Act, we'll need to collect a dedicated contracting email address so we can notify you of changes to the Provider Administration Manual, reimbursement rules, fee schedules and policy changes. We'll continue to share updates about this law and how you can provide your preferred email address in future BlueAlert articles.

Telehealth Billing Changes Start Aug. 1, 2018*

Starting Aug. 1, we'll no longer require the GT modifier in claims filed for telehealth services, per the Centers for Medicare & Medicaid Services (CMS) billing guidelines. However, if this modifier is filed on a claim, we'll still use it for informational purposes.

Please continue to file all telehealth-related services with Place of Service (POS) code 02. This applies for both originating and distant-site providers, and coding it otherwise could affect your reimbursement.

Please note we'll be auditing claims billed outside policy guidelines and/or without a corresponding claim for the same date of service but not filed with POS 02.

Updates to Hearing-Related Products and Services Billing Effective Aug. 1, 2018*

We want to make you aware of some changes going into effect Aug. 1, 2018. When billing for hearing-related services and equipment, please use the most appropriate "V" HCPCS code and number of units. Billing guideline updates include:

- Hearing exams, screenings, hearing aid fitting/orientation/checking, ear impressions, non-disposable ear molds/inserts and conformity evaluations will be reimbursed based on the lesser of line level-covered charges or the network maximum allowable fee schedule.
- Hearing aids will require an invoice showing the cost and be reimbursed based on policy Reimbursement Guidelines for Codes Classified as DME, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable.
- Hearing aid batteries and accessories assisted listening devices, disposable ear molds, dispensing fees, shipping/handling fees, and sales tax won't be separately reimbursed unless the member has specific group coverage. You may need to verify benefits before providing services.
- Not all plans cover hearing aids for all members and some plans contain dollar limits for hearing aids. Please verify benefits before providing services.
- Be sure to include the right side or left side (RT or LT) modifier with the appropriate HCPCS code for unilateral hearing aids as the first line item on the claim. This will help us process your claims more quickly. Please note that any claims for unilateral hearing aids that don't have the correct modifiers will be denied. There is no modifier required for codes identifying bilateral procedures or devices.

These guidelines apply to services billed on professional claims for our Commercial plans, with the exception of the Federal Employee Program, unless otherwise stated in their contract.

Changes to NICU Utilization Management and Care Management Services*

Starting Sept. 1, 2018, BlueCross will handle all utilization management and case management services for neonatal intensive care unit (NICU) babies covered by Commercial plans. Previously, Progeny helped us with these services.

To request authorizations, please call our Provider Service Line at 1-800-924-7141. For case management, call 1-800-818-8581, ext. 6900.

Printed Commercial Prior Authorization Letters Discontinued

Reminder - The Commercial Utilization Management area no longer mails prior authorization notification letters. You will receive notification by fax or electronically for web authorizations. This new method will speed the approval process and prevent misrouted letters. Prior authorization requests may be made by fax or phone, or you can get immediate approvals on some authorizations by logging in to the Availity Provider Portal for online authorization requests.

You may print web authorization approvals for your records. For FAQs and more information about registering, please log in to Availity.

Tips for Coding Professionals

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

Allowance Updated for Electric Breast Pumps (HCPCS Code E0603)

As of July 1, 2018, supplemental information will no longer be required for filing Commercial claims for electric breast pumps billed with HCPCS Code E0603, unless specifically requested.

Historically, electric breast pump allowances have been based on the policy for codes without established fees – those that are determined by invoice. We've conducted an in-depth analysis of code E0603 to address provider concerns regarding reimbursement. We reviewed data from paid claims as well as provider invoice documents to establish a reasonable allowable.

Supplies and accessories needed for the initial provision of the breast pump kit will not be paid in addition to the established Electric Breast Pump E0603 code reimbursement. Additional replacement supplies or accessories are not separately reimbursed.

Some members may have specific group coverage for breast pumps; therefore, providers may need to verify benefits before providing services.

BlueCare Tennessee

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

How to Streamline the Transition from Pediatric to Adult Care

When BlueCare Tennessee members turn 21, their TennCare benefits change. For example, federal law requires that children under 21 receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, some of these services aren't covered by TennCare for adults, like dental, hearing or routine vision services. As part of this transition in coverage, your patients may also encounter limits on home health visits or changes to their private duty nursing coverage eligibility.

We've created an FAQ document that answers common questions about these changes and other TennCare programs and benefits that may help fill gaps in coverage. You can find it under "General" in the provider section of bluecare.bcbst.com. If you have questions about this document or transitioning your patients, please contact your patient's BlueCare Care Coordinator or call 1-800-468-9736.

Weight Assessment and Coding for EPSDT Checkups

EPSDT/TennCare Kids exams require completion and documentation of all seven components, which includes education and guidance. A key element of the education component is counseling for nutrition and physical activity, as well as calculating body mass index (BMI) during the weight assessment. However, claims for checkups are often missing BMI codes. When you enter patient information for EPSDT checkups, please use the following diagnosis codes for children.

Pediatric – BMI Percentile	Diagnosis Code
<5th percentile for age	Z68.51
5th percentile – <85th percentile for age	Z68.52
85th percentile – <95th percentile for age	Z68.53
95th percentile or greater	Z68.54

These requirements do not apply to CoverKids members.

Medicare Advantage

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

Changes to Medicare Part D Coverage Determinations and Appeals Process*

BlueCross now manages the Medicare Part D coverage determination and appeal process for BlueAdvantage℠ and BlueCare Plus℠ members, so please submit your requests directly to us. For easy reference, here's how you can submit Medicare Part D coverage determination and appeal requests:

BlueAdvantage

Phone: 1-800-831-2583

Fax: (423) 591-9514

Mail: BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Online: bcbst.com/providers/medicare-advantage/bappo-pharmacy.page

BlueCare Plus

Phone: 1-800-299-1407

Fax: (423) 591-9514

Mail: BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Online: bluecareplus.bcbst.com/provider-resources/

You may call us during normal business hours, Monday through Friday from 8 a.m. to 9 p.m. ET, or you may leave a voicemail after hours on our secure voicemail. Please be sure to include the following information in your message:

- Member name, date of birth, full address, phone number and member ID
- Provider name, phone number, fax number and full address
- Medication name, quantity and day supply requested
- Type of request (e.g., Coverage Determination or Redetermination)
- Appropriate supporting statement for exception requests including indication for use and previous therapies tried and failed
- If your request is expedited or standard

Vision Refractions Not Covered Effective Sept. 1, 2018

Starting Sept. 1, 2018, BlueAdvantage will no longer cover vision refractions, regardless of the diagnosis or condition being treated. Please refer to the Medicare Advantage section of your BlueCross BlueShield of Tennessee Provider Administration Manual for additional billing information. Your patients can obtain a refraction as part of their supplemental vision benefits through our vision partner, Eyemed. Please note they must use Eyemed's network for these benefits.

Ophthalmology Services Updated to Specialist Copay

CPT® codes for general ophthalmology services (92002, 92004, 92012 and 92014) were updated so a specialist copay is now required instead of a BlueAdvantage covered vision exam copay. This means a Sapphire, Garnet or Ruby plan member's copay dropped from $40 to $35 for these service codes. Please note the copay for members with our Diamond plan is still $30 because the vision exam copay and specialist copay are the same. These services don't include vision refraction.

New Medicare ID Cards

CMS is launching an initiative to remove Social Security numbers (SSNs) from Medicare Health Insurance ID cards. This is to help protect Medicare enrollees from fraud and identity theft, and to safeguard taxpayer dollars.

Some of your patients may have already received new cards, depending on the schedule outlined by CMS. You can find more information about how the new Medicare number will impact you in the Providers section on the CMS website.

Quality Care Partnerships

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

FREE Quality Training for Network Providers

BlueCross is offering a two-day class Aug. 2 to 3, 2018, to promote health care quality. The training class will be held in the BlueCross 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.

Although the training costs $400, 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 2018 class. For more information see our website. To register, email tawanda_malone@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 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 PlusSM	1-800-299-1407
BlueChoiceSM	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 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Upcoming Requirements for the Provider Stability Act

As part of the Provider Stability Act, we'll soon need you to verify your dedicated contracting email address through Availity®. We'll use that email address to notify you of changes to the Provider Administration Manual, reimbursement policy changes and fee schedule changes.

We're in the process of building a Provider Stability Act web page where you can find more information about how to submit your email address through Availity. We'll provide more information in the next few weeks in the Important Initiatives section at bcbst.com/providers. We'll also post detailed instructions in the September BlueAlert.

INSIDE THIS ISSUE

Go to Availity for Eligibility and Benefits Information

Effective Aug. 1, all providers except dental are required to go to Availity.com for eligibility and benefits status – not to our Provider Service Line. Simply log in to Availity.com and click Patient Registration, then Eligibility and Benefits Inquiry.

If you are not registered, go to Availity.com and click Register in the upper right corner of the home page, select Providers, click Register and follow the instructions in the Availity registration wizard.

If you make an inquiry in Availity and can't get the information you need, the system will provide you with a special code to contact Provider Service for help.

For now, dental providers can get eligibility and benefits status by phone. We'll notify you when you need to get this information through the portal.

If you have questions, please contact your eBusiness Regional Marketing Consultant. Thank you for using all of Availity's self-service features.

New Provider Resources on Availity

On July 2, 2018, we uploaded two shared decision-making aids to the Availity portal that may be helpful to orthopedic providers. These aids contain in-depth information about joint replacement surgery, and can help providers and patients as they discuss pain relief options for hip or knee osteoarthritis.

The aids are easy for patients with limited health literacy to use and are certified by the Washington State Health Care Authority. To use them in your practice, simply log in to the Availity portal and go to the BlueCross Payer Space. Then, click on the Resources tab and look for links with the "SDM" label.

If you have questions about these materials, please call your eBusiness Regional Marketing Consultant. For support using the Availity Web Portal, please call Availity Client Services at 1-800-AVAILITY.

Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with revised policies. To read the complete policy information, click Upcoming Medical Policies.

Effective Sept. 1, 2018

- Bio-Engineered Skin and Soft Tissue Substitutes (Revision)
- Keratoprosthesis (Revision)

Let Your Voice Be Heard in Our Upcoming Provider Surveys

Thank you for the care you provide to our members. We know you're dedicated to your patients and we're just as committed to working with you to ensure your satisfaction. Because we're partners in care together, it's important for us to get your feedback about your experiences as a network provider. When you get the provider survey, please take a moment to let us know how we're doing and how we can improve.

Changes to NICU Utilization Management and Care Management Services

Starting Sept. 1, 2018, BlueCross will handle all utilization management and case management services for neonatal intensive care unit (NICU) babies covered by Commercial plans. Previously, Progeny helped us with these services.

To request authorizations, please call our Provider Service line at 1-800-924-7141. For case management, call 1-800-818-8581, ext. 6900.

Individual Providers May Receive Group Contract

New providers joining a practice with one or more providers under a group NPI may soon receive a group contract even if the other affiliated providers have individual contracts. Consolidating contracts of providers who practice together helps improve efficiency for provider offices and for BlueCross by delivering consistent reimbursement rates and reporting requirements to each provider in the practice. It also helps make sure providers all participate in the same networks, which is important for your group's patients. If you have questions about your new group contract or this group contracting initiative, please contact your local provider network representative.

Tips to Help You Enroll as a Network Provider

We've put together a few suggestions to help streamline the network enrollment process.

- Before you begin your application, please visit caqh.org to register with the Council for Affordable Quality Healthcare (CAQH).
- While at the CAQH website, you can use their EnrollHub™ to set up your electronic funds transfer (EFT) and electronic remittance advice. For more information, please see our EFT/ERA Frequently Asked Questions.
- If you plan to participate in the BlueCare Tennessee provider networks, please have a valid Medicaid ID before you apply. To request a Medicaid ID, please visit the State of Tennessee website.
- Sometimes applications are incomplete and we have to cancel them. To help avoid that, we'll let you know when something is missing and give you 30 days to submit it. Please remember to get back to us so you don't have to start over with a new application.

Billing for Medical Supplies and Enteral Formulae

Billing for medical supplies and enteral formulae should be done by durable medical equipment (DME) providers on a monthly basis. Only enough supplies and formulae to meet the member's need for one month should be dispensed at a time. The continued need for these items and the amount on hand must be verified before dispensing additional supplies/formulae. Additional items must be requested by a member or caregiver before being dispensed. Supplies and enteral formulae are not to be automatically dispensed on a predetermined regular basis.

New Outpatient Drug Testing Policy for Commercial Plans

Urine/serum drug testing is now limited to 20 episodes per annual individual benefit period.

An episode is defined as either a presumptive or confirmatory test (or both for the same date of service for each provider billed on the same claim). Billing for both tests for the same member on the same day is considered one episode.

A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test identifies the drugs in a patient's system as well as the exact amount present at the time the sample was taken.

Contract Amendment Relating to Payment for Anatomic Pathology Services Provided at Facilities for Commercial Plans

In March 2018, we announced a temporary suspension of our payment policy for the technical component of some anatomic pathology services. The policy suspension relates to services furnished to Commercial members in facilities (other than free-standing ambulatory surgical centers (ASCs) between Jan. 1 and Dec. 31, 2018.

BlueCross will resume its regular payment policy for these services furnished on and after Jan. 1, 2019.

- Under this policy, BlueCross pays facilities (other than free-standing ASCs) an all-inclusive rate for inpatient and outpatient services.
- This facility payment includes payment for all services and supplies associated with the inpatient and outpatient services, unless there is a contractual exception. This includes the technical component for professional services provided while a patient is in a facility setting.
- The policy applies regardless of where the technical component is performed and regardless of the relationship between the facility and the physician performing the service.

To address some of the confusion providers have raised to our attention, we also are amending all physician and physician group contracts to clarify further our payment policy for these services.

Physician and physician groups will find more information in their contract amendment, which will be sent in the next few weeks. If you have questions in the meantime, please contact your BlueCross Network Manager or check our website.

Prior Authorization Requirement for Commercial Plan Genetic Testing

Prior authorization for molecular and genomic testing for our Commercial fully insured, individual and select self-funded members is now required from eviCore. You may log in, or call 1-888-693-3211 or fax 1-888-693-3210 to request authorization.

Please note, starting Sept. 1, 2018, the following CPT® codes will be added to the existing prior authorization requirements:

0045U	0048U	0053U	0056U	0060U
0047U	0050U	0055U	0057U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity at Availity.com. Once you're in, click Patient Registration, then Eligibility and Benefits Inquiry.

You can learn more about prior authorization requirements and how to navigate eviCore's website, where you'll find clinical guidelines and request forms. Please call eviCore's Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.

BlueCare Tennessee

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

Help Your Patients Get Back-to-School Ready

As families prepare for the new school year, your office will likely begin receiving appointment requests for sports physicals. These visits aren't covered by BlueCare Tennessee. However, you can fulfill your patient's sports physical requirement and receive reimbursement by converting these visits to well-care checkups that meet the American Academy of Pediatrics preventive care guidelines.

The beginning of every school year is also a great time to check in with your patients and make sure they're up to date on all the immunizations they need for school. You can view and print a detailed list of BlueCare Tennessee patients who have gaps in preventive care in the Quality Care Rewards section of the Availity provider portal.

Submit Diabetic Testing Supplies to Pharmacy Benefit Manager

Insulin delivery devices, syringes, blood glucose test strips and other diabetic testing supplies are considered pharmacy items. As a result, they are covered by the Pharmacy Benefit Manager (PBM) Program – not by members' BlueCare, TennCare*Select* or CoverKids medical benefit. To prevent claim denials and reimbursement delays, please bill claims for these items to the PBM.

For more information about the PBM program, please see the BlueCare Tennessee Provider Administration Manual.

Helping Families Prevent and Manage Childhood Asthma in Shelby County

The Changing High-Risk Asthma in Memphis through Partnership (CHAMP) Program at Le Bonheur Children's Hospital offers an asthma program to BlueCare Tennessee members. BlueCare Tennessee members ages 2-18 who have an asthma-related emergency room visit or hospitalization and live in Shelby County are eligible. You may also refer your BlueCare Tennessee patient directly to the program.

Through this program, your patient can take part in sessions including a home visit, development of an Asthma Action Plan, an environmental assessment and support by a community health worker to focus on managing asthma.

In addition to connecting the child to primary care, the goal of CHAMP is to reduce:

- the number of asthma episodes
- complications
- associated hospital, urgent care and clinic visits

For more information about the program, please call (901) 305-1891.

Reimbursement Guidelines for Oral, Topical and Self-Administered Drugs

Self-administered medicines – including oral, topical and injectable – are part of the pharmacy benefit for BlueCare, TennCare*Select* and CoverKids members, not the medical benefit. This means BlueCare Tennessee will only reimburse for these drugs when a licensed pharmacist dispenses them and submits a pharmacy claim.

For more information about these and other reimbursement guidelines, please refer to the Billing and Reimbursement section of the BlueCare Tennessee Provider Administration Manual.

Proof of Timely Filing Reminders

BlueCare Tennessee providers must submit medical claims within 120 days following the date of a medical service or hospital discharge, or within 60 days from the date of the original rejection notice.

Documents that serve as proof of timely filing include:

- **If a claim for medical services is returned**, your proof of timely filing is the black and white copy of the claim with error codes that we returned to you. Please keep this copy of the returned claim.
- **If a claim is accepted or rejected**, we will store an electronic image of the claim in our archives for future reference. We will also generate 277CA Health Care Information Status Notification reports.
- **If a member didn't provide BlueCare Tennessee coverage information at the time of the visit**, you may apply for timely filing reconsideration with documents showing your office confirmed the member had no coverage on the date of the visit and copies of billing statements that show the dates of bills, if members have no other insurance.

Details about proof of timely filing are available in the Billing and Reimbursement section of the BlueCare Tennessee Provider Administration Manual.

Steps to File an Appeal on Behalf of Members

You may submit appeals on behalf of patients who are BlueCare Tennessee members if they, or their authorized representative, have signed an Enrollee Authorized Representative form.

If your patient hasn't received the denied services, or if services are being reduced, terminated or suspended, you may submit an appeal to the Division of TennCare within 60 days of the adverse decision. Please send these written requests to:

TennCare Solutions Medical Appeals
P.O. Box 593
Nashville, TN 37202

You may also fax appeals to 1-888-345-5575.

Please include all medical records related to the appealed service with your written request. To ensure a timely response, please do not file a member appeal on a provider appeal form.

If you prefer to assist your patients in filing an appeal instead of submitting it on their behalf, please provide them a Member Appeal Form or direct them to the filing instructions on the Division of TennCare website.

Note: This does not apply to CoverKids℠.

Updates to CHOICES Critical Incident Reporting

Effective July 1, 2018, CHOICES in Long-Term Services and Supports (LTSS) providers must report critical incidents that:

- Occur during the delivery of covered Home and Community-Based Services (HCBS)
- Are discovered or witnessed by BlueCare Tennessee, providers or fiscal employer agent staff – regardless of whether the provider or other HCBS factors are believed to have contributed to the incident

As a reminder, critical incidents include the following:

- Unexpected death
- Suspected physical or mental abuse
- Theft
- Financial exploitation
- Severe injury
- Medication errors
- Sexual abuse and/or suspected sexual abuse
- Abuse and neglect and/or suspected abuse and neglect

To report a critical incident, please fill out the HCBS CHOICES Critical Incident Report form located in the Provider section of bluecare.bcbst.com. If you have questions about the form or critical incident reporting, please email us at CHOICESQuality@bcbst.com.

ECF CHOICES Event Reporting Changes

The guidelines for Employment and Community First (ECF) CHOICES reportable events have changed. On July 1, 2018, the threshold for the Tier 1 Reportable Event category of theft increased from $500 to $1,000. Additionally, we revised the definition of reportable events to include:

- Events that occur during the delivery of covered services in a home and community-based LTSS setting
- Events that are discovered or witnessed by BlueCare Tennessee, providers or fiscal employer agent staff – regardless of whether the provider or other HCBS factors are believed to have contributed to the event

For more information about reportable events and the notification process following a reportable event, please refer to the ECF CHOICES Provider Section of bluecare.bcbst.com.

Medicare Advantage

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

Prior Authorization Changes for DME Procedures

Effective, Sept. 1, 2018, the following HCPCS codes will require a prior authorization for BlueAdvantage. If the items are supplied by a non-participating provider, these claims will be reviewed against Medicare medical policy prior to payment.

Procedure Description	HCPCS Code
Lumbosacral Orthosis (LSO)	L0631, L0637, L0648, L0650
Thoracolumbosacral orthosis (TLSO)	L0456, L0457, L0464
Intermittent Urinary Catheter	A4353
Collagen Based Wound Filler, Dry Form, Sterile	A6010
Home Ventilator, With Non-Invasive Interface	E0466
Knee Orthosis	L1851, L1852

Advanced Beneficiary Notice (ABN) and Non-Covered Services/Supplies

As a reminder, the ABN used in the original Medicare program is not applicable to any Medicare Advantage programs. When informing a BlueAdvantage or BlueCare PlusSM member that a service is not covered or excluded from their health benefit plan, it's considered an organization determination under 42 CFR, 422.566(b) and requires a formal organization determination denying coverage.

An "ABN waiver" isn't sufficient documentation of this notification, so please request a pre-determination from BlueAdvantage or BlueCare Plus on the member's behalf before you provide any non-covered service/supplies. This includes network providers referring a patient/member to a non-network provider for services and supplies. Please note that effective Sept. 1, 2018, services billed with modifiers GA, GX, GY, or GZ will be denied and you'll be responsible for the cost of the service or supplies.

Changes to Medicare Part D Coverage Determinations and Appeals Process

BlueCross now manages the Medicare Part D coverage determination and appeal process for BlueAdvantage and BlueCare Plus members, so please send your requests directly to us. For easy reference, here's how you can submit Medicare Part D coverage determination and appeal requests:

BlueAdvantage

Phone: 1-800-831-2583
Fax: (423) 591-9514
Mail: BlueCross BlueShield of Tennessee
Medicare Part D Coverage
Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051
Online: bcbst.com/providers/medicare-advantage/bappo-pharmacy.page

BlueCare Plus

Phone: 1-800-299-1407
Fax: (423) 591-9514
Mail: BlueCross BlueShield of Tennessee
Medicare Part D Coverage
Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051
Online: bluecareplus.bcbst.com/provider-resources/

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Quality Care Rewards

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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.

Please log in to Availity 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.

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Phone: Select Option 2 at	(423) 535-5717
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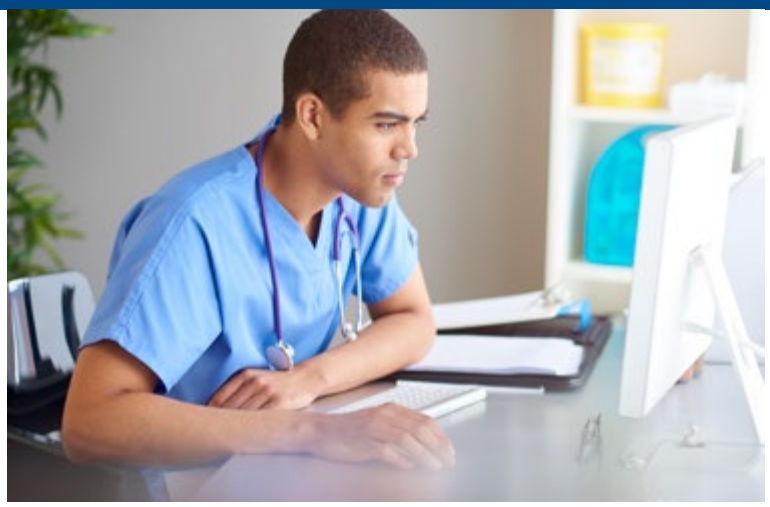
of Tennessee

SEPTEMBER 2018

BlueAlert℠



BlueCross BlueShield of Tennessee, Inc.

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INSIDE THIS ISSUE

Provider Stability Act Alert

Please Provide Your Email Address through Availity

The Provider Stability Act (PSA) goes into effect Jan. 1, 2019, and requires all Commercial Tennessee health plans to communicate activities impacting reimbursement, medical policies and fee schedules by email.

It's important we have your updated information so we can effectively communicate with you.

What You Need to Do

- If you haven't yet, register with **Availity**.
- Go to **Payer Spaces** at Availity.com.
- Select the **Contact Preferences** application to verify your preferences for BlueCross contracts. A step-by-step guide is available on our landing page listed below.

To learn more, please see our step-by-step guide on the Provider Stability Act page at bcbst.com/providers/psa.

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, click Upcoming Medical Policies.

Effective October 24, 2018

- Vulvectomy **(Revision)**
- Diagnosis and Treatment of Facet Joint Pain **(Revision)**
- Non-invasive Positive Pressure Ventilators (In-Home Use) **(Revision)**
- Home Nutritional Support (Total Parenteral/Enteral Nutrition) **(Revision)**

The following medical policies will be archived and no longer active 30 days (October 1, 2018) after this BlueAlert notification. We have determined that there is no longer a need for our Commercial and BlueCare Tennessee Utilization Management departments to maintain this policy.

- **Electrocardiographic Body Surface Mapping** – This particular product is no longer available on the market.
- **Patient-Specific Cutting Guides and Custom Knee Implants Instrumentation for Joint Arthroplasty** – We'll develop a new medical policy that only addresses three-dimensional printed orthopedic implants.
- **Percutaneous Tibial Nerve Stimulation** – We'll transition over to utilizing an MCG Care Guideline that considers this procedure to be appropriate if specific clinical indication criteria are met.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee's Health Care Practice Recommendations web page has updates for Assessment of Cardiovascular Risk from the American College of Cardiology/American Heart Association and *Guidelines for Perinatal Care* from the American Academy of Pediatrics/ American College of Obstetrics and Gynecology. These and other updates are available on our website at bcbst.com/providers/hcpr/index.page.

You may obtain paper copies of any listed clinical practice guideline by calling (423) 535-6705.

Reminder: Contract Amendment Relating to Payment for Anatomic Pathology Services Provided at Facilities for Commercial Plans

In March 2018, we announced a temporary suspension of our payment policy for the technical component of some anatomic pathology services. The policy suspension relates to services furnished to Commercial members in facilities (other than freestanding ambulatory surgical centers (ASCs)) between Jan. 1 and Dec. 31, 2018.

As mentioned in the August BlueAlert, BlueCross will resume its regular payment policy for these services furnished on and after Jan. 1, 2019.

- Under this policy, BlueCross pays facilities (other than free-standing ASCs) an all-inclusive rate for inpatient and outpatient services.
- This facility payment includes payment for all services and supplies associated with the inpatient and outpatient services, unless there is a contractual exception. This includes the technical component for professional services provided while a patient is in a facility setting.
- The policy applies regardless of where the technical component is performed and regardless of the relationship between the facility and the physician performing the service.

To address some of the confusion providers have raised to our attention, we amended all physician and physician group contracts to clarify further our payment policy for these services.

These contract amendments were mailed in mid-August. If you have questions, please contact your BlueCross Network Manager or check our website.

Join Us for a Health Information Technology Program

If you have an interest in Health Information Technology (HIT), you're invited to join us for a special Health Information Technology Accelerator Program starting Sept. 10. This program is a joint effort between BlueCross, the Tennessee Chapter of the Healthcare Information and Management Systems Society (HIMSS) and the Belmont University Center for Executive Education.

HIT professionals lead the training, covering best practices, real-world challenges and the future of health care and technology. The course runs Monday nights from 6:30 to 9:30 p.m. ET, Sept. 10 to Dec. 17. It'll be available on campus at Belmont University in Nashville and simultaneously as a hosted teleconference in the Distance Learning Center at our Cameron Hill location. Space is limited, so we encourage you to reserve your spot as soon as possible. Participants can also dial into the teleconference from a home or work computer.

The course costs $2,495, and attendees will receive HIT certification upon completion. For more information, please contact Erica Eubank at Erica_Eubank@BCBST.com or (423) 535-7053. Registration is open and lasts through Sept. 10.

BlueCross Updating Opioid Prescription Policy Jan. 1

BlueCross continues to support the growing national effort toward more appropriate use of opioids. We've taken action on multiple fronts and continue to push forward, including changes to our opioid prescription policy for Commercial plans that will be effective Jan. 1, 2019. Details about the changes, including prior authorizations and quantity limits, will be available in the October 2018 BlueAlert.

Billing Avastin (Bevacizumab) for Retinal Use

Retinal providers (ophthalmology and pediatric ophthalmology) can now bill compounded Bevacizumab with either J7999 or J9035. As of June 1, 2018, neither code requires an authorization for retinal diseases such as diabetic macular edema, macular edema following retinal vein occlusion and neovascular (wet) age-related macular degeneration when administered by an ophthalmologist or a pediatric ophthalmologist. When using J7999, please refer to our provider administration manuals for additional HCPCS billing guidelines.

Billing Requirements for Faxed Paperwork (PWK) Attachments

When paper documentation is necessary to support an electronic claim, you can use the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to us separately. The actual supporting documentation is faxed with a PWK Fax Cover Sheet, which is matched to your electronic claim using the information supplied on the cover sheet.

A PWK Fax Cover Sheet must be completed for **each** electronic claim and faxed with documentation to (423) 591-9481. The **documentation and fax sheet should be sent on the same day**.

For more information see the BlueCross BlueShield Provider Administration Manual. If you have questions about this process, call eBusiness Technical Support or your eBusiness Regional Marketing Consultant.

Durable Medical Equipment (DME) Billing Guideline Changes

We've updated our billing guidelines for DME. Starting Oct. 1, 2018, DME providers will need to use "99" as the new place of service code when submitting a claim for an item purchased by and delivered to a member at a retail store.

Billing Accuracy and Cost Control

Effective Oct. 1, 2018, you'll be required to submit an itemized statement for all Commercial inpatient facility services that are reimbursed at a percent of charges. The itemized bill should be submitted through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

Billing Requirements for Therapeutic Continuous Glucose Monitoring Systems

Providers should now bill Therapeutic Continuous Glucose Monitoring systems with a durable medical equipment (DME) HCPCS Modifier K Code. Commercial DME prior authorization requirements apply based on the cost of the equipment. Most Commercial plans require prior authorization for DME over $500. Prior authorization requests can be faxed to 1-866-558-0789 or online through Availity.

Two Key Requirements for Ancillary Claims

Claims for ancillary services performed by independent clinical laboratories or specialty pharmacies have two important requirements:

1. The claim must include the name of the referring or ordering provider.
2. Our records must show that the referring/ordering provider practices in Tennessee.

Claims that don't meet both requirements will be denied.

If you have questions about a rejected claim related to this requirement, please contact eBusiness Provider Solutions at (423) 535-5717 (Option 2), Monday through Thursday, 8 a.m. to 6 p.m. (ET) and Friday, 9 a.m. to 6 p.m. (ET) or email eBusiness_Service@bcbst.com.

Update to Commercial Prior Authorization Requirements

Effective Oct. 1, 2018, please note CPT® Codes 64581 and 64590 will no longer require prior authorization for Commercial plans in an inpatient or outpatient setting. For a complete list of services that require prior authorization, see our Commercial Prior Authorization Requirements.

Changes to Commercial Prior Authorization Requirement for Musculoskeletal Procedures

Beginning Nov. 1, 2018, we're partnering with Turning Point Healthcare Solutions to administer prior authorizations for musculoskeletal (MSK) procedures and pain management for select self-funded and all fully insured Commercial groups. To request prior authorization, please visit the BlueCross payer space in the Availity provider portal, where you can also verify benefits. You can also request a prior authorization by calling 1-866-747-0586 or by faxing your request to 1-866-747-0587. Please let us know if you're interested in training and support to help streamline your prior authorization process.

Changes to NICU Utilization Management and Care Management Services

As of Sept. 1, 2018, BlueCross is handling all utilization management and case management services for neonatal intensive care unit (NICU) babies covered by Commercial plans. Previously, Progeny helped us with these services.

To request authorizations, please call our Provider Service line at 1-800-924-7141. For case management, call 1-800-818-8581, ext. 6900.

BlueCare Tennessee

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

Billing Requirement for Facility Claims

In compliance with the ASC X12 837 Institutional Implementation Guide and the NUBC UB04 Data Specifications Manual, the attending provider listed on a facility claim is the individual who has overall responsibility for the patient's medical care and treatment reported on the claim. The NPI submitted on a facility claim as the attending provider's NPI must belong to an individual provider, not a group or facility, or the claim will be rejected.

Note: The only exception to this rule is for CHOICES claims where the billing provider is atypical. In this case, it's appropriate for the attending provider to not be an individual.

Refer Requests for Outpatient Lab Services to Quest Diagnostics

Quest Diagnostics is the exclusive provider of outpatient lab services for BlueCare, TennCare*Select* and CoverKids members. To prevent claims denials and help ensure your patients in these networks receive the benefits of using an in-network lab provider, please order all routine diagnostic tests directly through Quest Diagnostics.

For more information about ordering and billing for outpatient lab services, please refer to the BlueCare Tennessee Provider Administration Manual. Please note some lab services are excluded from the Quest Diagnostics requirement. You may view the Quest Diagnostics Exclusion List, which we update annually, at bluecare.bcbst.com.

Get a List of Your Patients Who Need Well-Care Checks

Many children from low-income homes aren't getting their Early and Periodic Screening, Diagnosis and Treatment (EPSDT) wellness exams as recommended. To find out if your patients are up to date, visit the Quality Care Rewards section of the Availity provider portal.

Select All Gaps to view a list of your patients who still need preventive care. Then, click on Non-Compliant Members to find a detailed record of patients who are past due for their EPSDT checkup. This list, which is updated monthly, includes the number of missed visits and the date of the last wellness check.

For easy reference, click the green X in the top corner of the web page and export the non-compliant member report into an Excel document. You can share this document with your team to use as a guide when scheduling EPSDT visits.

Note: This does not apply to CoverKids.

New Fax Numbers for Reporting Missed Shifts

Unfortunately, missed shifts happen, and we need to know when they do. Although submitting a missed shift form is a requirement, the importance of contacting us is about making sure members get the care they need.

Please note the fax numbers for reporting missed shifts have changed. If you need to report a missed shift, please fax the appropriate form to **(423) 535-1931** or **1-833-744-7587**.

If you're reporting a missed shift on the day it will occur, please call us at:

BlueCare	1-888-423-0131
TennCare*Select*	1-800-711-4104
CHOICES/ECF CHOICES	1-888-747-8955

To get help resolving missed shifts or to report missed shifts resulting from safety, environmental or enrollee/family barriers, please call Case Management at 1-800-225-8698.

Medicare Advantage

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

Changes to Medicare Prior Authorization Requirement for Musculoskeletal Procedures

Effective Nov. 1, 2018, BlueAdvantage will partner with Turning Point Healthcare Solutions for musculoskeletal (MSK) and pain management prior authorizations. To request a prior authorization, please visit the BlueCross payer space in the Availity provider portal, where you can also verify benefits. You can also request a prior authorization by calling 1-888-258-3864.

Prior authorization for physical therapy, occupational therapy and chiropractic services can be requested through the Availity provider portal or by calling 1-800-924-7141.

New Prior Authorization Requirement for Hemophilia-Related Drugs

Starting Oct. 1, 2018, we'll require prior authorization for hemophilia-related drugs for BlueAdvantage and BlueCare Plus members. Currently, these drugs are covered by the member's medical drug benefits and don't require prior authorization. If you don't obtain authorization for these drugs, your claim will be rejected and not paid. The following drugs now require prior authorization, but you can also find the Provider-Administered Specialty Pharmacy Products list in the **Pharmacy Resources & Forms** section of our provider website.

CPT4 Code	Generic Name	Drug Brand Name
J7192	factor viii	Advate
J7207	factor viii	Adynovate
J7210	factor viii	Afstyla
J7186	factor viii/vwf complex	Alphanate
J7193	factor ix	Alphanine SD
J7201	factor ix	Alprolix
J7194	factor ix	Bebulin
J7195	factor ix	BeneFIX
J7175	factor x	Coagadex
J7180	factor xiii	Corifact
J7205	factor viii	Eloctate
J7198	anti-inhibitor coagulant complex	Feiba NF
J7198	anti-inhibitor coagulant complex	Feiba
J7192	factor viii	Helixate FS
Q9995	emicizumab-kxwh	Hemlibra
J7190	factor viii	Hemofil M
J7187	factor viii/vwf complex	Humate-P
J7202	factor ix	Idelvion
J7195	factor ix	Ixinity
J7190	factor viii	Koate-DVI
J7192	factor viii	Kogenate FS
J7211	factor viii	Kovaltry
J7190	factor viii	Monoclate-P
J7193	factor ix	Mononine
J7182	factor viii	Novoeight
J7189	factor viia	Novoseven RT
J7209	factor viii	Nuwiq
J7188	factor viii	Obizur
J7194	factor ix	Profilnine SD
J7199	factor ix	Rebinyn
J7192	factor viii	Recombinate
J7200	factor ix	Rixubis
J7181	coagulation factor xiiia - subunit	Tretten
J7179	von willebrand factor	Vonvendi
J7183	factor viii/vwf complex	Wilate
J7185	factor viii	Xyntha

To start the authorization process, simply log in to Availity and go to the BlueCross Payer Space. Then, click on the Authorization Submission/Review application and select Specialty Pharmacy.

Retrospective Authorizations

Prior authorization must be obtained in the timeframes required. Only the following exceptions will be considered for retrospective review:

- The member did not provide Medicare Advantage insurance information at the time of service.
- The Member ID card was not issued.
- There was an issue with eligibility dates for the member.
- If you have proof that the provider tried to meet prior authorization timing requirements; you must submit a valid copy of the original fax transmittal as documentation.

A request for retrospective authorization review must be received within 180 days of the date of service or the date eligibility is confirmed by the Centers for Medicare & Medicaid Services. You must obtain prior authorization for Medicare Advantage members as episodes occur, during the established timeframes. We will complete all retrospective reviews within 30 calendar days of receiving your request for a standard organization determination.

Post-Service Audit Focuses on High-Level Emergency Department E&M Coding

Starting Nov. 1, 2018, BlueAdvantage will audit claims billed with Level 5 Emergency Department E&M codes to verify the discharge diagnosis justifies high complexity E&M coding. Claims billed with inappropriate E&M codes will be denied and you'll need to file with a lower acuity E&M or request an appeal.

The audit addresses what CMS notes as a sharp increase in Level 5 emergency department coding. It's not to evaluate whether an emergency existed under the Prudent Layperson Standard, or the requirement of a Medical Screening Exam under the Emergency Medical Treatment and Active Labor Act.

Utilization Management Dispute Resolution Process

As outlined in the BlueCross BlueShield of Tennessee Provider Administration Manual, you have 60 calendar days from the original decision to request a utilization management appeal if you disagree with our decision. If we don't receive your appeal request within the allotted timeframe, it won't be eligible for consideration.

If you're not satisfied with the appeal decision, you have the right to binding arbitration. You can find out more about arbitration, as well as our overall appeals process, in our provider administration manual.

Changes to Medicare Part D Coverage Determinations and Appeals Process Effective July 2, 2018

As of July 2, 2018, Express Scripts, Inc. (ESI) no longer reviews Medicare Part D coverage determination and appeal requests for BlueAdvantage and BlueCare Plus members. You should now send Medicare Part D coverage determination and appeal requests directly to BlueCross by using one of the submission methods below:

BlueAdvantage

Provider Service: 1-800-831-2583

Fax Number: 1-423-591-9514

Mailing Address: BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Online: bcbst.com/providers/medicare-advantage/bappo-pharmacy.page

BlueCare Plus

Provider Services: 1-800-299-1407

Fax Number: (423) 591-9514

Mailing Address: BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Online: bluecareplus.bcbst.com/provider-resources/

Please remember, faxes pertaining to Medicare Part D Coverage Determinations and Appeals should *not* be sent to ESI. Instead, send them directly to BlueCross at:

BlueAdvantage 1-423-591-9514

BlueCare Plus 1-423-591-9514

Normal hours of operation for the Medicare Part D Coverage Determinations and Appeals Department are 8 a.m. to 9 p.m., ET, Monday through Friday. You may leave a secure voicemail outside of normal hours of operation.

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 PlusSM	1-800-299-1407
BlueChoiceSM	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

OCTOBER 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Contracting Email Address Required for Provider Stability Act

The Provider Stability Act (PSA) goes into effect Jan. 1, 2019, and requires all Commercial Tennessee health plans to email you about activities impacting reimbursement, medical policies and fee schedules.

It's important we have your updated information so we can reach you.

What You Need to Do

- Log in to Availity®.
  - If you haven't yet, Register for Availity access.
- Go to **Payer Spaces** at Availity.com.
- Select **Contact Preferences** to verify your preferences for BlueCross contracts.
- From the **Contract Details** screen, you'll need to confirm your contracting email address and **Opt In** for these communications.

To learn more, please see our step-by-step guide on the Provider Stability Act page at bcbst.com/providers/psa.

We Need Your Updated Mailing Address, Too

If we can't reach you by email, we'll need to send communications by mail. If your mailing address isn't correct in Availity, please:

1. Download and follow the instructions on our Provider Change Form.
2. Go to CAQH ProView® to make sure your information matches what you've sent to us.

INSIDE THIS ISSUE

Check Eligibility and Benefits Through Availity Self-Service Features

To check eligibility and benefit information, simply log in to Availity, click Patient Registration and then Eligibility and Benefits Inquiry. As a reminder, all providers• except dental are required to go to Availity.com for eligibility and benefits status – not to our Provider Service Line.

If you make an inquiry and can't get the information you need, the system will provide you with a special code to contact Provider Service for help.

For now, dental providers can get eligibility and benefits status by phone. We'll notify you when you need to get this information through the portal.

If you have questions, please contact your eBusiness Regional Marketing Consultant. Thank you for using all of Availity's self-service features.

• This also applies to outsource vendors acting on the provider's behalf.

General Inquiries Through Our Message Center

When submitting a General Inquiry to us through the Availity Message Center, please remember to select the appropriate line of business for the member you're referencing. You can use the drop-down arrow to choose the correct line of business for your inquiry. Selecting the correct line of business will help us direct your inquiry to the proper area for a quicker response. If you have questions about Availity, please choose the Technical Support option to message our eBusiness staff.

Coming Soon – Cite Guideline Transparency

We'll soon offer MCG Care Guidelines' Medicare Compliance Product. It was designed to incorporate Medicare's National Coverage Determinations (NCDs) into the MCG format, which will save time and improve documentation practices. MCG's Medicare Compliance Product is offered within the MCG payer software and Cite AutoAuth.

Reminder: Contract Amendment Relating to Payment for Anatomic Pathology Services Provided at Facilities for Commercial Plans

In March 2018, we announced a temporary suspension of our payment policy for the technical component of some anatomic pathology services. The policy suspension relates to services furnished to Commercial members in facilities (other than freestanding ambulatory surgical centers (ASCs)) between Jan. 1 and Dec. 31, 2018.

As mentioned in our August and September BlueAlert newsletters, BlueCross will resume its regular payment policy for these services furnished on and after Jan. 1, 2019. For additional details, please refer to these newsletters or the Important Initiatives section of our website.

To address some of the confusion providers have raised to our attention, we amended all physician and physician group contracts to clarify further our payment policy for these services. These contract amendments were mailed in mid-August. If you have questions, please contact your BlueCross Network Manager.

2019 Formulary Changes

Each year, we review our BlueCross formularies and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they 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 2019 Formulary Changes listed below:

- 2019 Preferred Formulary Changes
- 2019 CoverKids Formulary Changes
- 2019 Essential Formulary Changes

In November, we'll begin sending letters to our members whose medications are changing to non-formulary status Jan. 1, 2019. We aren't sending letters about every change to their formulary, so please remind your patients to check for changes at bcbst.com.

BlueCross Updating Opioid Prescription Policy Jan. 1

Tennessee faces one of the worst crises of opioid abuse in the country. The widespread, legitimate use of opioids makes controlling misuse and abuse difficult. There's a perception that these pills are safe, because they're not illegal street drugs.

BlueCross continues to explore ways to promote the appropriate use of opioids and keep members safe. We've worked closely with an independent panel of external pain management specialists, oncologists and end-of-life care specialists to inform our decision making. These efforts include changes to our formularies and opioid prescription policy.

Effective Jan. 1, 2019, we're making the following changes for our Commercial♦ (BlueNetworks℠ P, S and M) and CoverKids members: (This policy doesn't apply to TennCare members.)

- Remove OxyContin from formulary and replace with abuse-deterrent drugs (i.e. Morphine/Hydrocodone)
- Place stops on dangerous drug combinations (i.e. opioids/benzodiazepines).
- Reduce the morphine milligram equivalent (MME♦♦) allowed:
  - 120 MME cumulative total
  - Maximum allowed of 200 MME with a prior authorization
  - Note: Medicare Advantage still has maximum allowed of 200 MME
- Add controls for short-acting opioids:
  - Limit new prescriptions for short-acting opioids to seven days
  - Change look-back period for new prescriptions to 120 days
  - Require prior authorization on short-acting opioids prescribed for an extended period (more than 30-day supply in a 90-day period)

♦As with previous clinical changes, requests from members with cancer or those who are receiving palliative or end-of-life treatment will be approved.

♦♦MME represents a drug's potency equivalent to a dose of morphine.

Flu Shots: Preparing for 2018-19 After Last Year's Historic Surge

The last flu season was historically bad, especially for kids. The Centers for Disease Control and Prevention (CDC) recorded 172 pediatric flu-related deaths for the 2017-18 season. Approximately 80 percent of those deaths were children who did not get a flu shot.

As you schedule and prepare for patient visits in the next few months, please remind them about the importance of getting their annual flu shots. The CDC recommends the flu vaccine for everyone 6 months of age and older, with rare exceptions. The importance of a flu shot increases for adults who are considered high risk or who are in homes with infants younger than 6 months old.

Some pediatric offices were in short supply late last season. As a result, they're ordering vaccinations now to be better prepared for their patients, including those who will reach 6 months of age during the upcoming flu season.

New Prior Authorization Requirement for Provider-Administered Specialty Medication

Retacrit (Q5105-non-ESRD/Q5106-ESRD) and Fulphila (Q5108), new-to-market provider-administered specialty medications, now require prior authorization for all lines of business. You can find more about provider-administered specialty medications and prior authorization requirements on our website.

Update to Commercial Prior Authorization Requirements

Effective Oct. 1, 2018, CPT® Codes 64581 and 64590 no longer require prior authorization for Commercial plans in inpatient and outpatient settings. For a complete listing of services that require prior authorization, please see our Commercial Prior Authorization Requirements at bcbst.com.

Change to Prior Authorization Requirement for Musculoskeletal Procedures

Beginning Nov. 1, 2018, we're partnering with TurningPoint Healthcare Solutions, LLC, to administer prior authorizations for musculoskeletal (MSK) procedures for our Commercial, BlueCare Tennessee, TennCare*Select*, BlueCare Plus and BlueAdvantage members.

TurningPoint will also administer prior authorization for Commercial and BlueAdvantage members needing pain management. To request prior authorization, please visit the BlueCross payer space in the Availity provider portal, where you can also verify benefits.

You can also request a prior authorization by calling:

Commercial*	1-866-747-0586
BlueCare Tennessee	1-888-423-0131
TennCare*Select*	1-800-711-4104
BlueCare Plus	1-888-258-3864
BlueAdvantage	1-888-258-3864

*select self-funded and all fully-insured Commercial groups

Please let us know if you're interested in training and support to help streamline your prior authorization process.

Note: CoverKids does not participate in the MSK program.

Ancillary Claim Requirements

Claims for ancillary services performed by independent clinical laboratories or specialty pharmacies have two important requirements:

- Depending on the specialty, the claim must include the referring or ordering provider, and
- Our records must show that the referring/ordering provider practices in Tennessee.

Claims that don't meet both requirements will be rejected.

If you have questions about a rejected claim related to this requirement, please contact:
eBusiness Provider Solutions at (423) 535-5717 (Option 2) or email eBusiness_Service@bcbst.com.

Billing Accuracy and Cost Control

As of Oct. 1, 2018, an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. The itemized bill should be submitted through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

Tips for Coding Professionals

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

Correct Use of Modifiers for Procedure-to-Procedure Edits

Each National Correct Coding Initiative procedure-to-procedure (PTP) edit has a modifier indicator of 0, 1 or 9.

- Modifier indicator **0** indicates NCCI-associated modifiers cannot be used to bypass the edit.
- Modifier indicator **1** indicates NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.
- Modifier indicator **9** indicates the edit has been deleted and the modifier indicator is not relevant.

When an edit may be bypassed by a modifier, and a modifier is clinically supported, the modifier should only be appended to the column two or "bundling" code. While the modifier may be accepted on the comprehensive codes in some instances, it shouldn't be appended to both codes in the code edit pair. This can delay the processing and payment of claims.

Tips for Coding Childhood and Adolescent Vaccines

Vaccines are a key element of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) TennCare Kids exams. To make sure children and teens get the preventive care they need, you can perform a "sick" visit and a "well" check that includes any necessary vaccines on the same day.

When submitting claims for immunizations given during a well check or other type of office visit, please use the following CPT® codes:

Immunization Administration	
CPT® Code	**Description**
90460	Immunization administration through 18, via any route, with counseling, first or only component of each vaccine
+904461	Rach additional vaccine or component, with counseling
90460 and 90461 are reported when patient is 18 years or younger and the physician or other qualified health care professional performs face-to-face vaccine counseling	
90471	Immunization administration ID, IM, subQ, one vaccine (single or combined vaccine)
+90472	Each additional vaccine ID, IM, subQ, one vaccine (single or combined vaccine)
90473	Immunization administration, oral, one vaccine (single or combined vaccine)
+90474	Each additional vaccine, oral (single or combined vaccine)
90471-90474 are reported when the patient is over the age of 18 or when counseling is not performed.	

To review the Immunization Schedules for children and adolescents, please visit the CDC website. A comprehensive list of all codes for Commonly Administered Pediatric Vaccines is available through the Tennessee Chapter of the American Academy of Pediatrics website.

Post-Service Audit Focuses on High-Level Emergency Department E&M Coding

Starting Nov. 1, 2018, BlueAdvantage will audit claims with Level 5 Emergency Department E&M codes to verify the discharge diagnosis justifies high-complexity E&M coding. Claims billed with inappropriate E&M codes will be denied, and you'll need to file with a lower acuity E&M or request an appeal.

The audit addresses what CMS notes as a sharp increase in Level 5 emergency department coding. It is not to evaluate whether an emergency existed under the Prudent Layperson Standard, or the requirement of a Medical Screening Exam under the Emergency Medical Treatment and Active Labor Act.

Clinical Editing Update

As we continue to update and improve our claims payment process to lessen the need to recover payments made inappropriately, we want to offer some tips to help you when you submit claims:

Place of Service Codes

- Supplies and Equipment Provided in the Facility Setting:
  - Medical and surgical supplies and durable medical equipment **shouldn't** be billed by professional or ancillary providers when the place of service is inpatient/outpatient facility or ambulatory surgery center (ASC).
- Evaluation and Management (E&M) Place of Service Restrictions:
  - Be sure to use the appropriate place of service code, which should indicate where services were rendered. Incorrectly reporting the place of service could result in a denial of the claim.

For more information on place of service code reporting, please see CMS.gov.

Diagnosis Codes

E&M services (excluding normal newborn care) billed with 99381-99429 (preventive medicine services) will be denied if the only diagnosis on the claim is an ICD-10 "Z" diagnosis code. According to the ICD Manual Guidelines, ICD-10 "Z" codes (Factors Influencing Health Status and Contact with Health Services) allow for the description of encounters for routine examinations (e.g. a general checkup, examinations for administrative purposes or pre-employment physicals). These codes shouldn't be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases, the specific diagnosis code (from other chapters) is used. If a diagnosis or condition is discovered during a routine exam, it should be reported as an additional code.

BlueCare Tennessee

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

Improving Health in Tennessee

Improving health in Tennessee is a team effort, and we want to help.

We invite you to take the Providers CARE Survey. This questionnaire is designed to help us get to know your patients and their needs. It also lets you share feedback about learning opportunities that may be useful for your practice team.

To fill out the survey, please visit https://www.tn.gov/tenncare/providers/literacy-communication-cultural-competency-and-disparities-in-health-care.html. Your answers will not have your name on them and will be combined with information from other providers.

It matters where your patients **live**, **work**, and **play**. Good health outcomes start in the communities where your patients live. By taking the survey, you'll give us information about challenges your patients are facing in their communities. Our goal is to help you improve your patients' health by:

C= Connecting them with community resources (like food pantries and housing help);

A= Acting for better health by teaching them about their care needs;

R=Reducing stigma by showing compassion to others and taking time to think about your actions and thoughts about yourself and others; and

E= Empowering yourself and others. Take the time to listen to your patients. Treating them with kindness and support can help them take the steps they need for better health and supporting them on their journeys to better health

Improving health in Tennessee is a team effort. By taking the Providers **CARE** Survey you can help us learn more about the needs of your patients that can lead to learning opportunities to assist your practice.

Your answers will not have your name on them and will be combined with information from other providers.

Population Health Management Offers Quality and Effective Coordination of Care

Population Health Management offers high-quality and effective coordination of care for our members with complicated care needs, chronic conditions, high-risk pregnancies, and catastrophic illnesses or injuries. We use referrals, claims, health-risk assessments and other sources to identify members and connect them with specific programs. Activities include behavioral and physical health. When appropriate, they are also integrated with CHOICES and ECF CHOICES care coordination processes.

Our clinical teams help our members and their families so they can make better health care decisions. We educate them about health conditions and their options, and we provide them with the tools and resources they need to make smarter choices. (CHOICES services are not available to CoverKids members.)

To refer your patients to a Population Health Management program, please call 1-888-416-3025.

Providers and Members Eligible for Maternity Care Payments

BlueCare Tennessee obstetric providers can help their patients receive up to $100 toward the purchase of baby supplies, while also earning payments on top of their regular reimbursements for maternity care.

The program includes two visits: a prenatal visit during the first trimester of pregnancy or within 42 days of BlueCare Tennessee enrollment – billed with category II code 0500F, and a postpartum visit within 21 to 56 days of delivery – billed with category II code 0503F.

The steps for getting paid are easy. For each claim that meets the guidelines above, your office will receive $10. The eligibility of your patients to receive $50 gift cards is based on the claims you file and a BlueCare Tennessee checkup form that your patients must return to us. They should bring the form with them and ask the provider to sign it at the visit.

For more information about the Maternity Care Program, including forms, please visit our website.

Please note: CoverKids obstetric providers are eligible for the maternity care payment if they submit claims according to the guidelines above, but CoverKids members are not eligible for gift cards.

Billing Requirement for Facility Claims

In compliance with the ASC X12 837 Institutional Implementation Guide and the NUBC UB04 Data Specifications Manual, the attending provider listed on a facility claim is the individual who has overall responsibility for the patient's medical care and treatment reported on the claim. The NPI submitted for the attending provider on a facility claim must belong to an individual, not a group or facility, or the claim will be rejected.

Note: The only exception to this rule is for CHOICES claims, where the billing provider is atypical. In this case, it's appropriate for the attending provider to not be an individual.

Billing Requirement for Physical, Occupational and Speech Therapy Services

Per CMS guidelines physical, occupational and speech therapy services are defined as services ordered/referred/prescribed by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law. To comply with these guidelines, professional claims submitted for these therapy services without the ordering or referring provider listed will be rejected.

For more information about this requirement see the Electronic Code of Federal Regulations website.

Medicare Advantage

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

Flu Vaccines Keep Your Patients Healthy

The flu season is upon us, so please remind your patients to get their annual flu shot. It's quick, easy and free for BlueAdvantage and BlueCare Tennessee members. Most important, it can help keep them healthy. The flu shot is a calendar-year benefit, so it's covered once a year regardless of the number of days between vaccinations. This is also a good time to review your patient's pneumococcal vaccine status.

Patients 65 and older are at greater risk for serious complications from the 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. Current CDC guidelines recommended the high-dose flu vaccine for those over 65.

New Medicare ID Card Update

Earlier this year, CMS launched an initiative to remove Social Security numbers from Medicare Health Insurance ID cards. This is to help protect Medicare enrollees from fraud and identity theft, and safeguard taxpayer dollars. Some of your patients may have already received new cards, depending on the schedule outlined by CMS. You can find more information about how the new Medicare number will impact you in the Providers section on the CMS website.

Statin Medications for Patients with Diabetes

The Centers for Medicare & Medicaid Services (CMS) created two Star measures related to prescribing statin medications. The measures are for patients diagnosed with diabetes and atherosclerotic cardiovascular disease (ASCVD). During the next few months, our Provider Engagement and Outreach team will share information related to each measure and tips on managing patients using statins.

Home Health and Outpatient Services Administrative Approval Updates

BlueAdvantage has updated its administrative approval process for initial requests for home care and outpatient speech therapy:

- **Home health skilled nursing visits:** up to 13 visits over a 30-day timeframe
- **Speech therapy** (home/outpatient): up to seven visits over a 30-day timeframe

The total number of visits and timeframe given should include the initial evaluation and treatment.

We don't need clinical information for these administrative approvals other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are an extension request, so we'll need clinical documentation for a medical necessity review. If you need more than the number of allowed visits within or beyond a 30-day timeframe on your initial request, please send us supporting documents for a medical necessity review.

Qualified Medicare Beneficiary Program

As a reminder, all Medicare-eligible providers and suppliers, including pharmacies, may not bill Medicare Advantage members enrolled in the **Qualified Medicare Beneficiary** (QMB) program for Medicare cost-sharing. Members enrolled in the QMB program have no legal obligation to pay copays or coinsurance for any Medicare-covered items and services. Please bill these costs to state Medicaid programs.

If you're not sure of a member's QMB status and exemption from cost-sharing before billing, please use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS).

Changes to Physical and Occupational Therapy Prior Authorizations

Beginning Nov. 1, BlueAdvantage will provide prior authorization for physical therapy (PT), occupational therapy (OT), and chiropractic services. You may request prior authorization by logging in to the BlueCross payer space in the Availity provider portal or by calling **1-800-924-7141**.

To make it easier for you, we'll administratively approve the initial request for the following services with notification and diagnosis only:

- PT and OT (home health or outpatient): up to 13 visits over a 30-day timeframe
- Chiropractic request for Spine only (cannot be for maintenance therapy per Medicare guidelines): up to nine visits over a 30-day timeframe

The total number of visits and timeframe given should include the initial evaluation visit and treatment visits.

We don't need clinical information for these administrative approvals other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are an extension request, so we'll need clinical documentation for a medical necessity review. If you need more than the number of allowed visits within or beyond a 30-day timeframe on your initial request, please send us supporting documents for a medical necessity review.

If you need to request more than the number of allowed visits noted within or beyond a 30-day timeframe on your initial request, please submit all supporting documentation for medical necessity review.

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 PlusSM	1-800-299-1407
BlueChoiceSM	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 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Contracting Email Address Required for Provider Stability Act

The Provider Stability Act (PSA) goes into effect Jan. 1, 2019, and requires all Commercial Tennessee health plans to email you about activities impacting reimbursement, medical policies and fee schedules. It's important we have your updated information so we can reach you.

What You Need to Do

- Log in to Availity®.
- If you haven't yet, Register for Availity access.
- Go to BlueCross BlueShield of Tennessee's **Payer Spaces** at Availity.com. A step-by-step guide is available on our Provider Stability Act page at bcbst.com/providers/psa.
- Select **Contact Preferences** to verify your contact information for BlueCross contracts.
- From the **Contract Details** screen, you'll need to confirm your contracting email address and **Opt In** for these communications.

We Need Your Updated Mailing Address, Too

If we can't reach you by email, we'll need to send communications by mail. If your mailing address isn't correct in Availity, please:

1. Download and follow the instructions on our Provider Change Form.

2. Go to CAQH ProView® to make sure your information matches what you've sent to us.

INSIDE THIS ISSUE

Check Eligibility and Benefits Through Availity Self-Service Features

As a reminder, effective Nov. 1, 2018, all providers• except dental are required to go to Availity.com for eligibility and benefits status – not to our Provider Service Line. To check eligibility and benefit information, simply log in to Availity, click Patient Registration and then Eligibility and Benefits Inquiry.

If you make an inquiry and can't get the information you need, the system will provide you with a Fast Path ID to contact Provider Service for help. You must have a valid Fast Path ID for each patient inquiry.

For now, dental providers can get eligibility and benefits status by phone. We'll notify you when you need to get this information through the portal.

If you have questions, please contact your eBusiness Regional Marketing Consultant. Thank you for using all of Availity's self-service features.

• This also applies to outsource vendors acting on the provider's behalf.

All Blue Workshops 2019 Coming to a City Near You

Save the date for our annual All Blue Workshops. We're finalizing details, so watch for more information in upcoming BlueAlerts.

- **March 7, 2019 – Chattanooga**
  Embassy Suites Chattanooga
  2321 Lifestyle Way, Chattanooga, TN 37421
- **March 12, 2019 – Memphis**
  Holiday Inn University of Memphis
  330 Innovation Drive, Memphis, TN 38152
- **March 13, 2019 – Jackson**
  DoubleTree Jackson
  1770 Highway 45 Bypass, Jackson, TN 38305
- **March 18, 2019 – Nashville**
  Marriott Nashville Airport
  600 Marriott Drive, Nashville, TN 37214
- **April 16, 2019 – Kingsport**
  MeadowView Marriott
  1901 Meadowview Parkway, Kingsport, TN 37660
- **April 17, 2019 – Knoxville**
  Knoxville Convention Center
  701 Henley Street, Knoxville, TN 37902

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee's Health Care Practice Recommendations web page has updates for:

- 2017 *Bright Futures™ Guidelines for Prevention and Health Promotion for Infants, Children, Adolescents, and their Families* from the American Academy of Pediatrics
- 2017 *Guidelines for the Management of Heart Failure* from the American Heart Association

These and other updates are available on our website. Paper copies of any listed clinical practice guideline can be obtained by calling (423) 535-6705.

Update: Extension for Reviewing Contract Amendment on Technical Component of Professional Services

In August 2018, we amended all physician and physician group contracts to further clarify our payment policy related to the technical component for professional services provided to BlueCross Commercial members while in a facility setting (other than a free-standing ambulatory surgery center). All physicians and physician groups that contract with BlueCross, including pathologists and other specialists, received these contract amendments.

We understand some physicians and groups were unclear if the contract amendment applied to them, so we've mailed a second letter with further explanation and an extended response time. If you're a physician who does not provide or bill for pathology services, you now have until Nov. 23, 2018 to send us your written response.

As mentioned in our August, September and October BlueAlert newsletters, we'll resume our regular payment policy for the technical component of anatomic pathology services furnished on and after Jan. 1, 2019. For additional details, please refer to these newsletters or the Important Initiatives section of our website. You can also contact your BlueCross Network Manager.

BlueCross Updating Opioid Prescription Policy Jan. 1

Tennessee faces one of the worst crises of opioid abuse in the country. The widespread, legitimate use of opioids makes controlling misuse and abuse difficult. There's a perception that these pills are safe, because they're not illegal street drugs.

BlueCross continues to explore ways to promote the appropriate use of opioids and keep members safe. These efforts include the changes to our formularies and opioid prescription policy listed below. The focus of these changes is not cost reduction, but to help our members and eventually all Tennesseans get the appropriate amount of opioids for their medical conditions.

Effective Jan. 1, 2019, we'll make the following changes for our Commercial (Blue Network P℠, Blue Network S℠ and Blue Network M℠) and CoverKids members◆: (This policy doesn't apply to TennCare members.)

- Remove OxyContin from formulary and replace with abuse-deterrent drugs (i.e. Xtampza and Morphabond)
- Place stops on dangerous drug combinations (i.e. opioids/benzodiazepines).
- Reduce the morphine milligram equivalent (MME◆◆) allowed:
  - 120 MME cumulative total
  - Maximum allowed of 200 MME with a prior authorization
  - Note: Medicare Advantage still has maximum allowed of 200 MME
- Add controls for short-acting opioids:
  - Limit new prescriptions for short-acting opioids to seven days
  - Change look-back period for new prescriptions to 120 days
  - Require prior authorization on short-acting opioids prescribed for an extended period (more than 30-day supply in a 90-day period)

◆As with previous clinical changes, requests from members with cancer or those who are receiving palliative or end-of-life treatment will be approved.

◆◆MME represents a drug's potency equivalent to a dose of morphine.

2019 Formulary Changes

Each year, we review our BlueCross formularies and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they 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 2019 Formulary Changes listed below:

- 2019 Preferred Formulary Changes
- 2019 CoverKids Formulary Changes
- 2019 Essential Formulary Changes

We've sent letters to our members whose medications are changing to non-formulary status Jan. 1, 2019. We're not sending letters about every change to their formulary, so please remind your patients to check for changes at bcbst.com.

Change to Prior Authorization Requirement for Musculoskeletal Procedures*

We're working with TurningPoint Healthcare Solutions, LLC, to administer prior authorizations for musculoskeletal (MSK) procedures for our Commercial, BlueCare Tennessee, TennCare*Select*, BlueCare Plus and BlueAdvantage members.

TurningPoint also administers prior authorization for Commercial and BlueAdvantage members needing pain management. To request prior authorization, please visit the BlueCross payer space in the Availity provider portal, where you can also verify benefits.

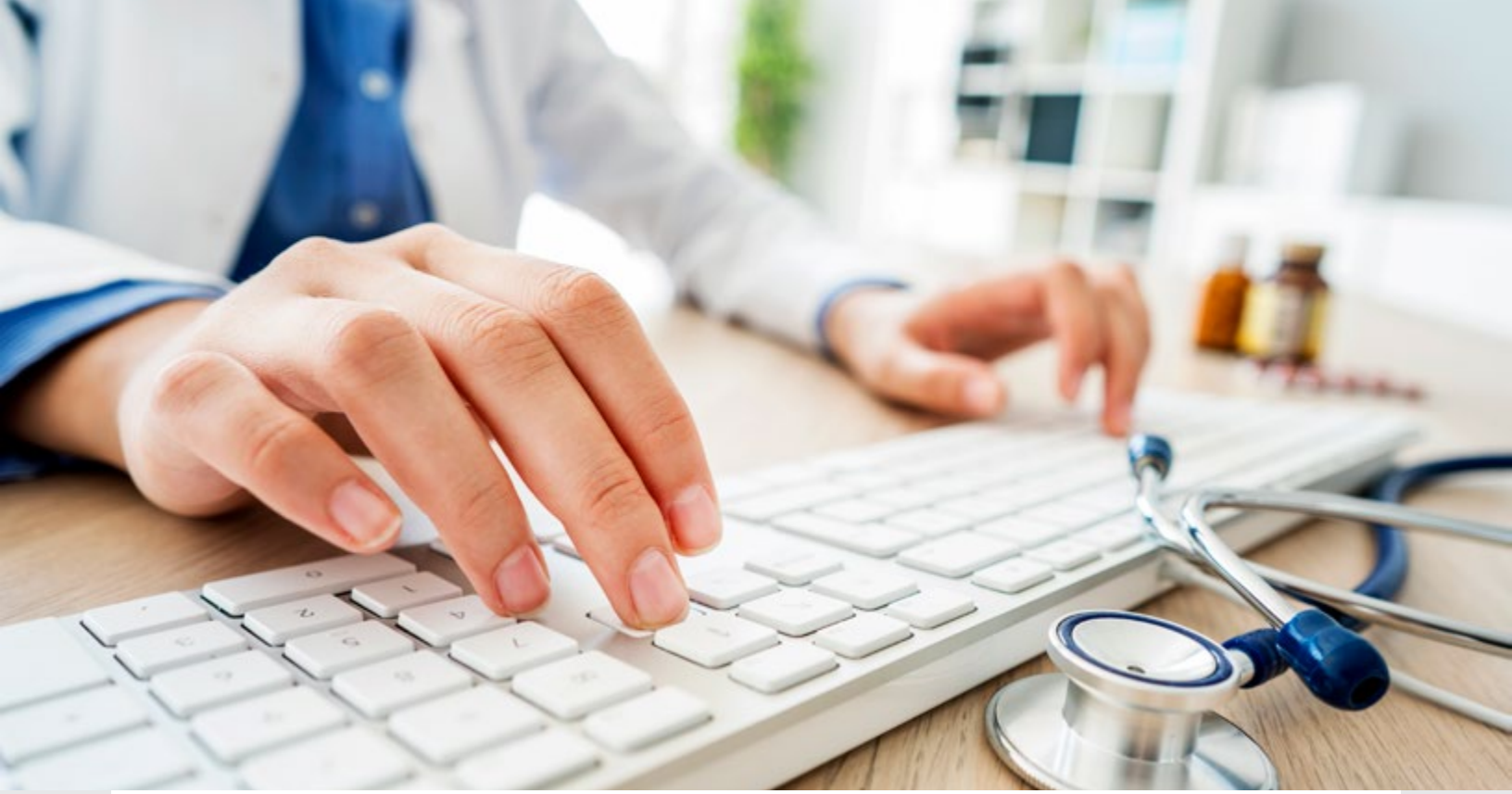
You can also request a prior authorization by calling:

Commercial◆	1-866-747-0586
BlueCare Tennessee	1-888-423-0131
TennCare*Select*	1-800-711-4104
BlueCare Plus	1-888-258-3864
BlueAdvantage	1-888-258-3864

◆ Select self-funded and all fully insured Commercial groups

Contact your eBusiness Marketing Consultant if you're interested in training and support.

Note: CoverKids does not participate in the MSK program.



Prior Authorization Changes to Genetic Testing Program for Commercial Plans

Beginning Jan. 1, 2019, the following genetic testing CPT® codes will require authorization by eviCore:

0067U	0072U	0076U
0069U	0073U	0078U
0070U	0074U	0079U
0071U	0075U	

Please note that CPT® code 0028U will no longer require prior authorization starting Jan. 1, 2019.

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity at Availity.com and clicking **Patient Registration** then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity.com, or you may fax to eviCore at 1-888-693-3210 or by calling 1-888-693-3211.

Autoimmune Infusion Benefit Procedure Changes for Federal Employee Program Members

Starting Jan. 1, 2019, Federal Employee Program (FEP) benefit procedures will change for the autoimmune infusion drug infliximab (brand names Remicade®, Inflectra® and Renflexis®). This drug is currently covered under the member's pharmacy or medical benefits. However, members who receive their first infusion on or after Jan. 1, 2019, will only receive the drug under the medical benefit. Members, who have had autoimmune infusions covered by their pharmacy benefit before Jan. 1, will continue receiving this benefit. If members change FEP benefit plans (e.g., from Standard Option to Basic Option), the drug will be covered under medical benefits regardless of how they previously received it.

Billing Accuracy and Cost Control

As of Oct. 1, 2018, an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. The itemized bill should be submitted through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

Coming Soon - Cite Guideline Transparency

We'll soon offer MCG Care Guidelines' Medicare Compliance Product. It was designed to incorporate Medicare's National Coverage Determinations (NCDs) into the MCG format, which will save time and improve documentation practices. MCG's Medicare Compliance Product is offered within the MCG payer software and Cite AutoAuth.

BlueCare Tennessee

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

Your Partner in Preventive Care

As your partner in improving the health of Tennessee kids, we want to make it easy for you to find best practices and other important information. Our TennCare Kids Toolkit contains a variety of resources about TennCare Kids Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exams and maternity care, including:

- The American Academy of Pediatrics Periodicity Schedule for well-child checks
- Coding and reimbursement information
- Contact phone numbers for BlueCare Tennessee services, including population health, behavioral health referrals, authorization appeals and customer service
- Details about free patient transportation, which is provided by our vendor, Southeastrans
- Best practices for scheduling and completing EPSDT visits
- An inside look at our claims process
- Community outreach opportunities

If you have questions about the information in this toolkit, please contact your Provider Network Manager. If you aren't sure who your Provider Network Manager is, you can locate your contact at bcbst.com/providers/mycontact.

Note: TennCare Kids Tool Kit doesn't apply to CoverKids.

Improving Health in Tennessee

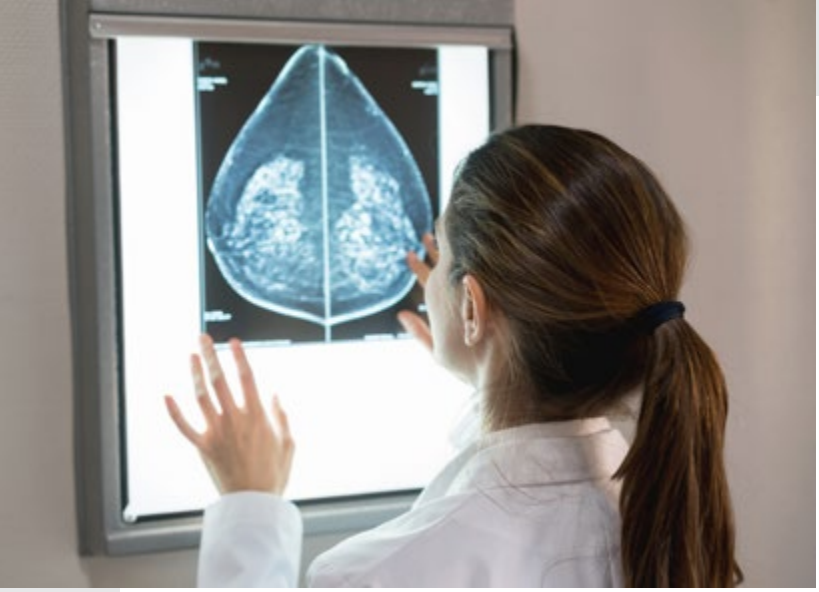
It matters where your patients live, work, and play. Good health outcomes start in the communities where your patients live. Take the Providers CARE Survey and help us learn more about the needs of your patients, as well as learning opportunities that can assist your practice team. Your answers will not have your name on them and will be combined with information from other providers. Thank you for caring about the health of your community!

TennCare Code Updates for Vaginal and C-Section Deliveries

The Division of TennCare℠ recently made changes to the Medicare Severity-Diagnosis Related Group (MS-DRG) codes for vaginal and C-section deliveries. These changes went into effect Oct. 1, 2018. Please see below for a table of codes to use moving forward:

Obsolete MS-DRG Codes for Vaginal Delivery (v.35)	New MS-DRG Codes for Vaginal Delivery (v.36)	Obsolete MS-DRG Codes C-section (v.35)	New MS-DRG Codes C-section (v.36)
767 – Vaginal delivery with sterilization and/or dilation and curettage (D&C)	796 – Vaginal delivery with sterilization/ D&C and major complications and comorbidities (MCC) 797 – Vaginal delivery with sterilization/ D&C and comorbid conditions (CC) 798 – Vaginal delivery with sterilization/ D&C without MCC/CC	None – There are no C-section with sterilization codes in v.35.	783 – C-section with sterilization and MCC 784 – C-section with sterilization and CC 785 – C-section with sterilization but no MCC/ CC
774 – Vaginal delivery with complicating diagnoses	805 – Vaginal delivery without sterilization/D&C but with MCC 806 – Vaginal delivery without sterilization/D&C but with CC	765 – C-section with MCC/CC	786 – C-section without sterilization but with MCC 787 – C-Section without sterilization but with CC
775 – Vaginal delivery without complicating diagnoses	807-Vaginal delivery without sterilization/D&C or MCC/CC	766 – C-section without MCC/CC	788 – C-section without sterilization or MCC/CC

Vaginal and C-section deliveries will continue to be reimbursed at the same rate. For more information, please see the MCO Budget Reduction Notice June 19, 2018, which is available under Announcements in the News and Manuals section of bluecare.bcbst.com.



Partnering to Deliver Quality Care

With your help, we're working to make sure our members get specific clinical care before the end of the year. Addressing these health care needs helps your patients and contributes to a healthier Tennessee.

Here are the areas we're targeting before the end of 2018:

Preventive Screenings

- Breast Cancer
- Cervical Cancer
- Chlamydia

Prescription Measures

- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Antidepressant Medication Management

Our data shows that patients who aren't compliant with the statin measures are usually non-compliant because they don't fill their prescriptions, while those taking antidepressant drugs may not get refills as needed. Transportation to the pharmacy, cost, and beliefs about the medication, such as confusion about why it was prescribed or concerns about side effects, can prevent patients from taking medicines as recommended. We can arrange transportation to and from the pharmacy, and our copays range from $0, $1.50 and $3, depending on the drug. Please talk with your patients about the reasons why they're not taking their prescriptions and encourage them to fill and continue using their medication.

You can find members in need of these and other types of clinical care in the Quality Care Rewards section of the Availity provider portal. For help using Availity, please call (423) 535-5717 and select option 2, or email eBusiness_service@bcbst.com.

Note: This information doesn't apply to CoverKids.

2017 ASH Claims to be Reviewed During Fourth Quarter of 2018

During the fourth quarter of 2018, we'll be reviewing all BlueCare, TennCare*Select* and CoverKids claims submitted during 2017 that include an absolute or possible abortion, sterilization or hysterectomy (ASH).

ASH claims may be eligible for reimbursement if they are filed with the appropriate consent and/or medical necessity forms. The ASH audit, however, includes an in-depth review of documents that may not be required at the time of claims submission, including patient medical records.

If your practice submitted an ASH claim for a procedure from last year, we may contact you to request records if they weren't submitted with the claim. Please note that records not received within the requested timeframe are subject to recoupment.

Coordinating Services for Your School-Age Patients*

BlueCare Tennessee can coordinate medically necessary in-school covered services (including physical, speech, occupational and behavioral health therapies) for our members that are age 20 and younger. In addition to a provider's order for services, the Division of TennCare requires that children and young adults receiving school-based services have an individualized education program (IEP) including that service, as well as a signed parental consent form.

Please note, schools are no longer required to submit students' IEPs prior to delivering these services. However, BlueCare Tennessee is required to conduct regular post-payment sample audits of claims for these services and will request documents including IEPs to support the medical necessity of the school-based services we reimburse.

For more information about the requirements for school-based services, please see the BlueCare Tennessee Provider Administration Manual.

Note: This doesn't apply to CoverKids members.

Medicare Advantage

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

Flu Vaccines Keep Your Patients Healthy

The flu season is upon us, so please remind your patients to get their annual flu shot. It's quick, easy and free for BlueAdvantage and BlueCare Tennessee members. Most important, it can help keep them healthy. The flu shot is a calendar-year benefit, so it's covered once a year regardless of the number of days between vaccinations. This is also a good time to review your patient's pneumococcal vaccine status.

Patients 65 and older are at greater risk for serious complications from the flu. Because the immune system weakens with 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. Current CDC guidelines recommended the high-dose flu vaccine for those over 65.

Provider Assessment Form Reimbursement for 2019

In 2019, you'll again be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage patients.

Please use CPT® code 96160 when filing a PAF claim. BlueAdvantage will continue to reimburse the service as E/M Code 96160, with a maximum allowable charge of:

- $225 for dates of service between Jan. 1 and June 30, 2019
- $175 for dates of service between July 1 and Dec. 31, 2019

To receive reimbursement, you must submit the completed form through the Quality Care Rewards tool. This is located in the BlueCross payer space in the Availity provider portal. You may also fax a completed form to **1-877-922-2963**. The form should also be included in your patient's chart as part of their permanent record in conjunction with a face-to-face encounter.

You don't need to wait 365 days between PAF submissions because they're reimbursed each calendar year. For additional information about the PAF, please visit bcbst.com/providers/quality-initiatives.page.

Changes to Physical and Occupational Therapy and Chiropractic Prior Authorizations

BlueAdvantage now provides prior authorization for physical therapy (PT), occupational therapy (OT) and chiropractic services. You may request authorization in the BlueCross payer space in the Availity provider portal or by calling us at 1-800-924-7141.

To make it easier for you, we'll approve the request for the following services with notification and diagnosis only:

- PT and OT (home health or outpatient): up to 12 visits over a 30-day timeframe
- Chiropractic request for spine only (cannot be for maintenance therapy per Medicare guidelines): up to eight visits over a 30-day timeframe

Initial evaluations don't require prior authorization, so they won't be included in your total number of visits approved within the authorization. This also applies to home health skilled nurse visit administrative approvals.

We don't need clinical information for these administrative approvals other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are considered an extension request, so we'll need clinical documentation for a medical necessity review. If you need more than the number of allowed visits within or beyond a 30-day timeframe on your initial request, please send us supporting documents for a medical necessity review.

For your convenience, here's a list of the following PT, OT and chiropractic codes:

Code	Description
97012	Traction, mechanical
97016	Vasopneumatic devices
97018	Paraffin bath
97022	Whirlpool
97024	Diathermy
97026	Infrared
97028	Ultraviolet
97032	Application to a modality to 1 or more areas: electrical stimulation (manual) each 15 minutes
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, 1 or more areas
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Aquatic therapy with therapeutic exercises
97116	Gait training (includes stair climbing)
97124	Massage, including effleurage, petrissage and/or tapotement (stoking, compression, percussion)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques, 1 or more regions, each 15 mins
97150	Therapeutic procedure(s), group (2 or more individuals)
97530	Therapeutic activities, direct (one to one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one to one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training, direct (one to one) patient contact by the provider, each 15 minutes
97537	Community/work reintegration training, direct (one to one) patient contact by the provider, each 15 minutes
97542	Wheelchair management, each 15 minutes
97545	Work hardening/conditioning: initial 2 hours
97546	Each additional hour (list separately in addition to code for primary procedure)
97597	Debridement, when performed and instructions for ongoing care, per session, total wound surface area, first 20 square cm or less
97598	Each additional 20 square cm or part thereof

Code	Description
97605	Negative pressure wound therapy, including topical applications, wound assessment, and instructions for ongoing care, per session, total wound surface area less than or equal to 50 square cm
97606	Total wound surface area greater than 50 square cm
97750	Physical performance test or measurement with written report, each 15 minutes
97755	Assistive technology assessment, direct one-on-one contact by provider, with written report each 15 minutes
97760	Orthotic management and training, each 15 minutes
97761	Prosthetic training, each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97763	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97799	Unlisted physical medicine /rehab service or procedure
98940	Chiropractic manipulative treatment spinal, 1-2 regions
98941	Chiropractic manipulative treatment spinal, 3-4 regions
98942	Chiropractic manipulative treatment spinal, 5 regions
G0129	Occupational therapy services requiring skills of a qualified occupational therapist, per session 45 minutes or more
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0157	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified physical therapist in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program each 15 minutes
G0281	Electrical stimulation (unattended) to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measureable signs of healing after 30 days of conventional care, as part of a therapy plan of care
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of therapy plan of care

Post-Service Audit Focuses on High-Level Emergency Department E&M Coding

BlueAdvantage now audits claims with Level 5 emergency department E&M codes to verify the discharge diagnosis justifies high-complexity E&M coding. Claims billed with inappropriate E&M codes will be denied, and you'll need to file with a lower acuity E&M or request an appeal.

The audit addresses what CMS notes as a sharp increase in Level 5 emergency department coding. This denial is not stating that the services were not emergent in nature, but rather that the level of coding is unlikely representative of the intensity of services provided in the emergency setting. It isn't to evaluate whether an emergency existed under the Prudent Layperson Standard or the requirement of a Medical Screening Exam under the Emergency Medical Treatment and Active Labor Act.

Single Visit Billing Reminder

When you provide services for a BlueAdvantage patient on the same day and at the same place, please bill this on a single claim. You can find these instructions in the Billing and Reimbursement section of our BlueCross BlueShield of Tennessee Provider Administration Manual. You can prevent claims from being denied or returned and help ensure proper claim reimbursement by following these simple guidelines.

New Medicare ID Card Progress Update

Earlier this year, CMS launched an initiative to remove Social Security numbers from Medicare Health Insurance ID cards to help protect Medicare enrollees from fraud and identity theft. Some of your patients may have already received new cards depending on the updated schedule outlined by CMS. You can find more information about how the new Medicare number will impact you in the Providers section on the CMS website.

Quality Care Partnerships

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

Tell Us What You REALLY Think…About Our Quality Care Quarterly Newsletter

We know you work hard to provide quality care for your patients, and we want to make your job easier. That's why we use our Quality Care Quarterly newsletter to share best practices from your peers and provide information that can help you improve your quality performance.

We'd really like to find out how you feel about this publication and the other resources we provide. It will take you less than five minutes to complete this survey. If there are others in your practice who receive the Quality Care Quarterly, or who work with our BlueCross quality representatives, please forward this survey link to them.

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 PlusSM	1-800-299-1407
BlueChoiceSM	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 2018

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Provider Stability Act Requires Us to Collect Your Contracting Email Address

For the last few months, we've been collecting contracting email addresses for the Provider Stability Act that goes into effect Jan. 1, 2019. The Provider Stability Act requires all Commercial Tennessee health plans to email you about activities impacting reimbursement, medical policies and fee schedules. It's important we have your updated information so we can reach you. If you haven't provided your contracting email address, please do so soon.

What You Need to Do

- Log in to Availity®.
  - If you haven't yet, Register for Availity access.
- Go to **Payer Spaces** at Availity.com.
- Select **Contact Preferences** to verify your preferences for BlueCross contracts.
- From the **Contract Details** screen, you'll need to confirm your contracting email address and **Opt In** for these communications.

To learn more, please see our step-by-step guide on the Provider Stability Act page at bcbst.com/providers/psa.

We Need Your Updated Mailing Address Too

If we can't reach you by email, we'll need to send communications by mail. If your mailing address isn't correct in Availity, please:

1. Download and follow the instructions on our Provider Change Form.

2. Go to CAQH ProView® to make sure your information matches what you've sent to us.

INSIDE THIS ISSUE

Go to Availity to Check Eligibility and Benefits

All providers• except dental are required to go to Availity.com for eligibility and benefits status – not to our Provider Service Line. To check eligibility and benefit information, simply log in to Availity, click **Patient Registration** and then **Eligibility and Benefits Inquiry**.

If you make an inquiry and can't get the information you need, the system will give you a Fast Path ID to contact Provider Service. You must have a valid Fast Path ID for each patient inquiry.

For now, dental providers can continue to get eligibility and benefits status by phone. We'll notify you when you need to get this information through the Availity portal.

If you have questions, please contact your eBusiness Regional Marketing Consultant. Thank you for using all of Availity's self-service features.

•This also applies to outsource vendors acting on the provider's behalf.

BlueCross Updating Opioid Prescription Coverage Policy Jan. 1 – UPDATE

BlueCross continues to explore ways to promote the appropriate use of opioids and keep members safe. These efforts include the changes to our formularies and opioid prescription policy listed below. The focus of these changes is not cost reduction, but rather to help our members and eventually all Tennesseans get the appropriate amount of opioids for their medical conditions.

Effective Jan. 1, 2019, we'll make the following changes to coverage allowances for our Commercial (Blue Network P℠, Blue Network S℠ and Blue Network M℠) and CoverKids members:

- Remove OxyContin from formulary and replace with abuse-deterrent drugs (i.e. Xtampza and Morphabond)
- Place stops on dangerous drug combinations (i.e. opioids/benzodiazepines).
- Reduce the morphine milligram equivalent (MME•) allowed:
  - 120 MME cumulative total
  - Maximum allowed of 200 MME with a prior authorization
  - Note: Medicare Advantage still has maximum allowed of 200 MME
- Add controls for short-acting opioids:
  - Limit new prescriptions for short-acting opioids to seven days
  - Change look-back period for new prescriptions to 120 days
  - Require prior authorization on short-acting opioids prescribed for an extended period (more than 30-day supply in a 90-day period)

Please note that these changes won't effect members who are receiving treatment for certain conditions, so prior authorization requests for the following will receive auto-approval:

- Cancer
- Palliative Care
- Sickle Cell Disease
- End of Life Care

•MME represents a drug's potency equivalent to a dose of morphine.

2019 Formulary Changes

Each year, we review our BlueCross formularies and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they 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 2019 Formulary Changes listed below:

- 2019 Preferred Formulary Changes
- 2019 CoverKids Formulary Changes
- 2019 Essential Formulary Changes

We've sent letters to our members whose medications are changing to non-formulary status Jan. 1, 2019. We won't send letters about every formulary change, so please remind your patients to check for changes at bcbst.com.

Expired License Will Require New Provider Enrollment and Effective Date

Providers who participate in our networks are required to maintain a valid medical license. If a provider's license is revoked or expires, we must remove them from our network immediately to protect patients and the integrity of our network. Providers who want to return to the network must submit a new enrollment application. In these cases, network participation will not be retroactive. Providers will receive a new network effective date.

Autoimmune Infusion Benefit Procedure Changes for Federal Employee Program Members

Starting Jan. 1, 2019, Federal Employee Program (FEP) benefit procedures will change for the autoimmune infusion drug Infliximab (brand names Remicade®, Inflectra® and Renflexis®). This drug is currently covered under the member's pharmacy or medical benefits. However, members who receive their first infusion on or after Jan. 1, 2019, will only receive the drug under the medical benefit. Members who have had autoimmune infusions covered by their pharmacy benefit before Jan. 1, will continue receiving this benefit. If members change FEP benefit plans (e.g., from Standard Option to Basic Option), the drug will be covered under medical benefits regardless of how they previously received it.

New Coverage Option for Federal Employees

FEP members will have a third coverage option starting Jan. 1, 2019. In addition to Standard Option and Basic Option coverage, FEP Blue Focus℠ gives federal employees, especially those just entering the workforce, an opportunity to choose a lower-cost quality health plan that best fits their needs. FEP Blue Focus members will pay just $10 each for their first 10 primary and/or specialty care visits and will pay little or no cost for services that support good health. Read more about FEP Blue Focus here.

Reminder: Resuming Payment Policy for the Technical Component of Anatomic Pathology Services Jan. 1, 2019

As mentioned in our August through November BlueAlert newsletters, we'll resume our regular payment policy for the technical component of anatomic pathology services furnished on and after Jan. 1, 2019.

To help further clarify our payment policy, we also sent contract amendments to all physicians and physician groups that contract with BlueCross, including pathologists and other specialists, in August 2018.

For additional details, please refer to the referenced newsletters or the Important Initiatives section of our website. You can also contact your BlueCross Network Manager.

Coming Soon - Cite Guideline Transparency

We'll soon offer MCG Care Guidelines' Medicare Compliance Product. It was designed to incorporate Medicare's National Coverage Determinations (NCDs) into the MCG format, which will save time and improve documentation practices. MCG's Medicare Compliance Product is offered within the MCG payer software and Cite AutoAuth .

All Blue Workshops 2019 Coming to a City Near You

Save the date for our annual All Blue Workshops. We're finalizing details, so watch for more information in upcoming BlueAlerts.

- **March 7, 2019 – Chattanooga**
  Embassy Suites Chattanooga
  2321 Lifestyle Way, Chattanooga, TN 37421
- **March 12, 2019 – Memphis**
  Holiday Inn University of Memphis
  330 Innovation Drive, Memphis, TN 38152
- **March 13, 2019 – Jackson**
  DoubleTree Jackson
  1770 Highway 45 Bypass, Jackson, TN 38305
- **March 18, 2019 – Nashville**
  Marriott Nashville Airport
  600 Marriott Drive, Nashville, TN 37214
- **April 16, 2019 – Kingsport**
  MeadowView Marriott
  1901 Meadowview Parkway,
  Kingsport, TN 37660
- **April 17, 2019 – Knoxville**
  Knoxville Convention Center
  701 Henley Street, Knoxville, TN 37902

Billing Accuracy and Cost Control

As of Oct. 1, 2018, an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges (including services reimbursed through the BlueCard® Program). Please submit the itemized bill through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

Changes to Our Online Commercial Provider Administration Manual

Beginning in 2019, BlueCross is changing how we publish our online Commercial provider administration manual (PAM).

We're doing this to comply with State of Tennessee Public Chapter No. 88, which requires a health insurance entity to provide notice to a health care provider of any material change made to its previously released provider manual or a reimbursement rule and policy at least sixty (60) days prior to the effective date of change. To accommodate this, we'll begin publishing a special redlined version of the BlueCross Provider Administration Manual **in addition** to the previously released PAM. In this version, providers will be able to easily identify the applicable changes in a red color type.

The redlined version for first quarter 2019 will be published on Feb. 1, 2019, and will allow providers to preview any upcoming billing and reimbursement or policy changes 60 days prior to their actual effective dates. On April 1, 2019 – at the end of the 60-day notice period – both the redlined version and the previously released fourth quarter PAM will be replaced with a single provider administration manual containing all the changes.

This process applies only to our Commercial lines of business and will continue each quarter whenever there are any upcoming changes affecting billing and reimbursement guidelines or policies.

BlueCare Tennessee

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

Best Practices for Combining Well-Child Checks with Sick Visits

Sometimes, the only opportunity you have to perform a wellness check is when patients visit your office because of an illness or other need. Combining visits for acute care and other services, such as sports physicals, helps ensure children throughout our state get the preventive care they need.

TennCare Kids' screening guidelines allow you to be reimbursed for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups performed at the same time as other visits. According to the Tennessee Chapter of the American Academy of Pediatrics, you can bill for both a sick and well visit on the same day if the following criteria are met:

- You may report an additional evaluation and management (E/M) service if you find a problem during a wellness check that requires you to provide care beyond the work-up of a normal preventive visit.
- Your documentation for the visit reflects the extra work done during the appointment. There doesn't need to be a separate note, but documentation should clearly reflect a separate problem.

For more information about EPSDT exams, please visit our **TennCareKids Toolkit**. You can also find free TNAAP EPSDT and coding resources at TNAAP.org.

Note: This information doesn't apply to CoverKids.

Contraception Guidelines for Women of Childbearing Age with Opioid Use Disorder

The Division of TennCare is asking for your help in informing women of childbearing age about the risks of chronic opioid use.

Health care professionals should offer all women of childbearing age, including those with opioid use disorder (OUD), noncoercive contraceptive counseling and discuss different forms of birth control, as well as the effectiveness of each method. Whether a woman is on pharmacotherapy for OUD or using opioids for pain control, a conversation about the importance of contraception is critical.

The American College of Obstetricians and Gynecologists recommends offering immediate postpartum long-acting reversible contraception to reduce unintended or short-interval pregnancy. An excellent time to implant these devices is when women are in the hospital after delivery. Please encourage women already in treatment to consider planning their next pregnancy and ensure that they are on safe medications, their treatment status is stable, and they are ready for the stresses of motherhood on top of treatment or recovery.

If you have any questions, please call our Provider Service Line at 1-800-468-9736.

Reference:
Substance Abuse and Mental Health Services Administration [SAMHSA], Clinical Guidance for Treating Pregnant Women with Opioid Use Disorder, 02 2018

Updates to the Employment and Community First (ECF) CHOICES Reportable Event Management Process*

BlueCare Tennessee is changing the criteria for two ECF CHOICES reportable events.

Please see the following changes that will take effect Jan. 1, 2019:

- Tier 1: Vehicle accident while transporting a person resulting in injury or a moving violation with significant risk of harm (e.g., reckless driving or driving under the influence)
- Tier 2: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued at $1,000 or less (i.e., less than the threshold for misappropriation)

We anticipate receipt of a revised ECF CHOICES Reportable Event Reporting Form to reflect these changes. Until the new form is released, please continue to use the current form and document specifics in the narrative section. We appreciate your help and ask that you please share this information with your team.

Billing Requirement for Physical, Occupational and Speech Therapy Services

CMS guidelines define physical, occupational and speech therapy as services ordered, referred or prescribed by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law. To comply with these guidelines, we must reject professional claims for these therapy services that don't list the ordering or referring provider.

For more information about this requirement see the Electronic Code of Federal Regulations website.

Medicare Advantage

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

Step Therapy for Certain Medicare Part B Drugs

Beginning Feb. 1, 2019, BlueAdvantage and BlueCare Plus will implement step therapy for certain Part B drugs as part of a patient-centered care coordination program. This will affect members that are new to therapy.

Prior authorization and step therapy will be in line with CMS regulations and required for the following Part B drugs: Aloxi®/Sustol®, Fusilev®, Prolia®/Xgeva®, Eylea®, Treanda® and Abraxane®. You can view our online medical policies by clicking here.

BlueAdvantage Outpatient Therapy Authorizations

We've made some outpatient therapy authorization changes, which means we've also changed how you submit these on the web. Use these easy steps to get to the correct web submission forms and route your request appropriately:

- From the Availity Portal, click on the **Authorization Submission/Review** option
- Arrow down to expand the **Authorizations/ Advance Determination Submission** section that lists the available forms
- Select the **Outpatient Therapy Form** for outpatient physical therapy, occupational therapy, speech therapy and chiropractic requests
- Choose **Home Health Services Form** for all home health related services (skilled nurse visits, occupational therapy, physical therapy and speech therapy)
- Musculoskeletal (MSK) authorization requests (large joint and spine surgery/pain management) are reviewed by an external vendor so please select the **Inpatient Confinement** or **Outpatient Surgical Procedure Form** (based on place of service) and enter the MSK code related to the request.

New BlueCare Plus Prior Authorization Requirements

We're making slight changes to some of our BlueCare Plus prior authorization requirements starting Jan. 1, 2019. The list below shows which medical services require authorization, and the **bold** font indicates what's changed since last year:

- All acute care medical and psychiatric facility, long-term acute care, skilled nursing facility (**three-day inpatient requirement is waived**), and medical and substance abuse rehabilitation facility inpatient admissions
- Select musculoskeletal surgical procedures (list of procedures will be posted on website)
- Part B/specialty pharmacy medications
- Durable medical equipment for purchase if the purchase price is greater than $500
- Durable medical equipment rentals
- Orthotics and prosthetics if the purchase price is greater than $200
- Outpatient speech, occupational and physical therapy high-tech imaging
- Non-emergency out-of-network services
- Home health to include all therapies, nursing visits and psychiatric visits
- Non-preferred brands of diabetic testing supplies
- Non-emergency ambulance transportation
- **Home ventilator devices**
- **Wearable defibrillator devices**
- Psychiatric residential facilities
- Detoxification services
- Partial Psychiatric Hospitalization Program **excludes substance abuse**
- Psychiatric day treatment
- Applied behavioral analysis
- Electroconvulsive therapy
- Psychological testing

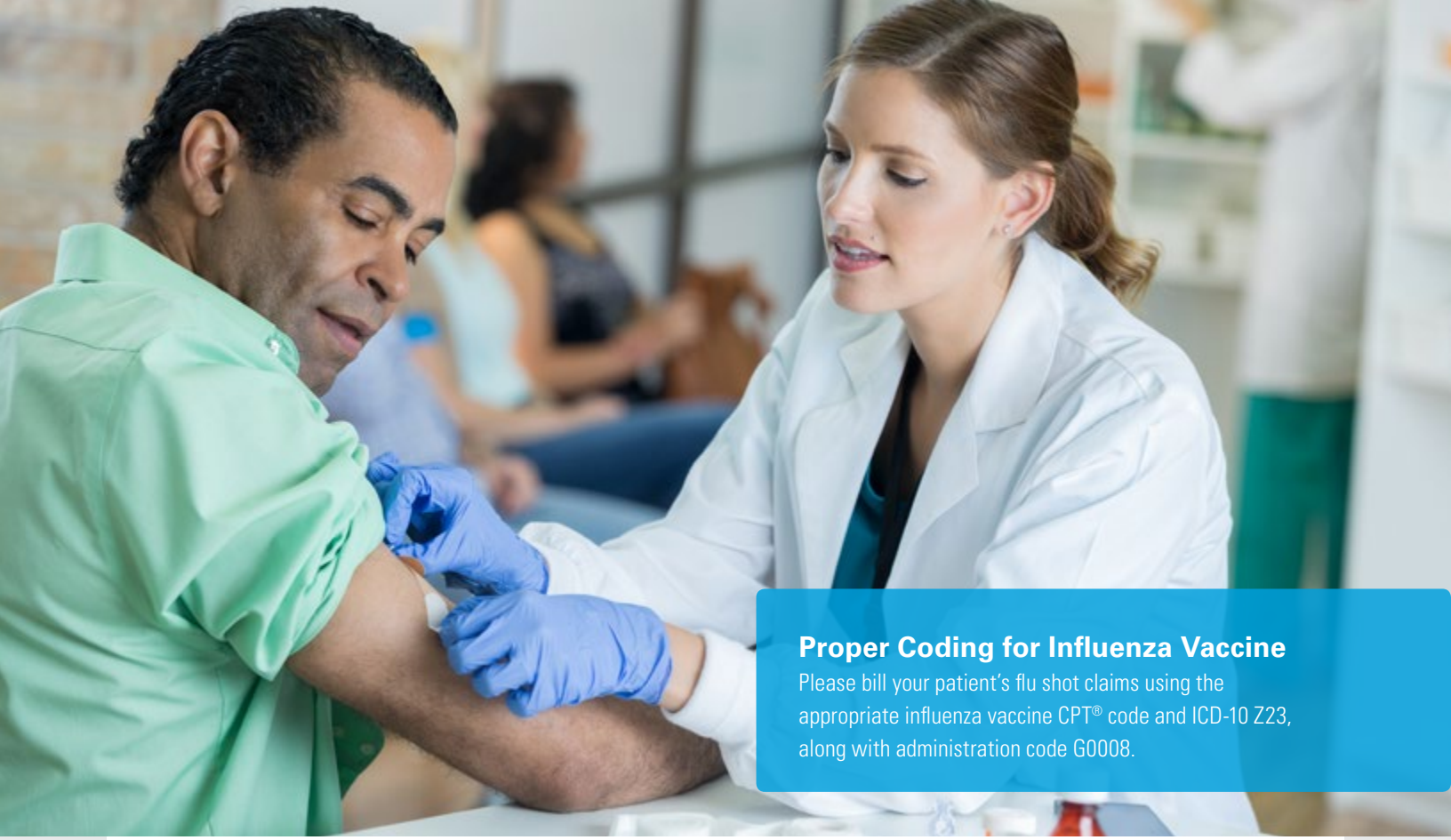
BlueCare Plus Reimbursements for Patient Readmissions

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

- Facilities aren't 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 that results from a modifiable cause related to the index admission discharge diagnosis. This applies to readmission to the same or similar facility or any other facility operating under the same contract.
- 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 may be 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 in that they don't penalize a facility for all diagnoses that could lead to a readmission or adjust all Medicare payments. We apply the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the member who is readmitted.
- The program is designed to encourage you to address transition of care options. CMS considers 31-day readmissions to be an indicator of quality of care.

Please note:

- Members can't 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.



Proper Coding for Influenza Vaccine

Please bill your patient's flu shot claims using the appropriate influenza vaccine CPT® code and ICD-10 Z23, along with administration code G0008.

Provider Assessment Form Reimbursement for 2019

In 2019, you'll again be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage patients.

Please use CPT® code 96160 to file a PAF. BlueAdvantage will continue to reimburse the service with a maximum allowable charge of:

- $225 for dates of service between Jan. 1, and June 30, 2019
- $175 for dates of service between July 1, and Dec. 31, 2019

To receive reimbursement, please submit the form through Availity or fax it to 1-877-922-2963. You should also include the form in your patient's chart as part of their permanent record. The 2019 form will be available online Dec. 1, 2018.

You don't need to wait 365 days between PAF submissions because the benefit is each calendar year. For additional information about the PAF, please visit bcbst.com/providers/quality-initiatives.page.

Reminder: To be included in the 2018 measurement year, BlueCross must receive 2018 PAFs by Jan. 31, 2019.

New Vendor Equian to Conduct Supplementary Post-Payment Claims Review

Starting in 2019, BlueAdvantage will work with Equian, a Medicare Advantage business associate, to perform post-payment claims reviews to verify payment accuracy. Equian will conduct both data mining and medical record reviews in full compliance with HIPAA requirements.

If you have any questions, please contact Tony Carchietta at (423) 535-3590.

Genetic Testing Covered Once Per Lifetime

Genetic tests, which require prior authorization, are only covered once during a member's lifetime, unless the U.S. Food and Drug Administration specifically approves more tests.

For out-of-network testing, we recommend getting a predetermination first so the member isn't charged for tests that may not meet Medicare coverage guidelines. Services provided by an out-of-network genetic testing provider will be reviewed before payment if a predetermination was not obtained to ensure medical necessity against Medicare coverage criteria.

Quality Care Partnerships

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

Measures Applicable to Quality Amendments

Our BlueAdvantage plans will be sending quality amendments for 2019. Below is the list of measures included in the 2019 program. Please speak with your Quality Incentive Consultant if you have any questions.

Measures Applicable to Quality Amendments

Measure Name	Measure Type	Weight	2019 Star Ratings Projected Cut Point			
			2-star	3-star	4-star	5-star
Breast Cancer Screening	Process (Non-Continuous)	1	50%	71%	79%	85%
Colorectal Cancer Screening	Process (Non-Continuous)	1	59%	65%	74%	81%
Osteoporosis Management in Women Who Had a Fracture	Process (Non-Continuous)	1	35%	48%	62%	86%
Diabetes Care - Eye Exam	Process (Non-Continuous)	1	58%	66%	75%	82%
Diabetes Care - Kidney Disease Monitoring	Process (Non-Continuous)	1	2%	89%	97%	99%
Diabetes Care - Blood Sugar Controlled	Outcome (Continuous)	3	41%	70%	80%	89%
Statin Use in Persons with Cardiovascular Disease	Process (Non-Continuous)	1	72%	78%	83%	87%
Rheumatoid Arthritis Management	Process (Non-Continuous)	1	73%	80%	88%	92%
Medication Reconciliation Post Discharge	Process (Non-Continuous)	1	40%	57%	69%	82%
Plan All-Cause Readmission	Outcome (Continuous)	3	11%	9%	8%	4%
Medication Adherence - Diabetes	Outcome (Continuous)	3	74%	80%	83%	87%
Medication Adherence - Hypertension	Outcome (Continuous)	3	84%	88%	90%	91%
Medication Adherence - Statin	Outcome (Continuous)	3	75%	79%	86%	90%
Statin Use in persons with diabetes	Outcome (Continuous)	3	74%	78%	82%	85%

Note: Measures and cut points for the Medicare Advantage Star Ratings Program are determined by CMS and based on prior year performance of all MA plans. To adjust for industry improvement in the upcoming year, we can adjust the cut points based on statistical analysis of industry trends from prior years' performance.

Our offices will be closed Dec. 24, and 25, 2018, and Jan. 1, 2019, in observance of the holidays.

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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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- 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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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
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BlueCare PlusSM	1-800-299-1407
BlueChoiceSM	1-866-781-3489
***Select*Community**	1-800-292-8196
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BlueAdvantage	1-800-841-7434
BlueAdvantage Group	1-800-818-0962
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eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	eBusiness_service@bcbst.com
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