of Tennessee

JANUARY 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Important Changes to Musculoskeletal and Pain Management Prior Authorizations

We want you to know about an important change to our Musculoskeletal (MSK) and pain management prior authorization process because it could impact some of your patients. You now need to contact us for all MSK and pain management authorizations for BlueCare Tennessee, TennCare*Select*, BlueCare Plus (HMO SNP)℠ and BlueAdvantage (PPO)℠ members. The list of procedures and services requiring prior authorization won't change.

Please note we're not changing the prior authorization process for our fully insured and select self-funded Commercial members. TurningPoint Healthcare Solutions, LLC, will continue administering these authorizations.

For MSK or pain management prior authorizations, please call or fax:

BlueCare Tennessee	Phone: 1-888-423-0131	Fax: 1-800-292-5311
TennCare*Select*	Phone: 1-800-711-4104	Fax: 1-800-292-5311
BlueCare Plus	Phone: 1-866-789-6314	Fax: 1-866-325-6698
BlueAdvantage	Phone:1-800-924-7141	Fax: 1-888-535-5243
Commercial	Phone: 1-866-747-0586	Fax: 1-866-747-0587

INSIDE THIS ISSUE

Get the Answers You Need Through Availity®

Through Availity, you can get the answers you need 24 hours a day, seven days a week. Not only can you transact with us online, you have access to other payers, too – all through one convenient single sign-on.

Log in today to:

- Request claim status
- View remittance advices
- Check benefits and eligibility status
- Access other BlueCross applications and updates on the BlueCross-specific Payer Space

To reduce hold times on the phone, please log in to Availity for everyday transactions – especially benefits and eligibility inquiries. Our phone team is no longer able to answer these questions, unless you can't find what you need online. In this case, the system will send you a Fast Path code to get benefits and eligibility help by phone. (For now, Dental providers can still call for this information.)

Need Help Getting Started?

If your office needs help getting started with Availity, contact your eBusiness Regional Marketing Consultant for training and education or visit Availity.com/bcbst.

For questions about the Availity Web Portal, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548), Monday through Friday from 8 a.m. to 7 p.m. ET, excluding holidays.

Eligibility and Benefits Enhancements in Availity

When checking eligibility and benefits through Availity, you'll notice several new enhancements:

- An acupuncture benefit option has been added to **Benefit/Service Type**
- More options are now available by default within the **Health Benefit Plan Coverage** benefit type:
  - Physical Therapy
  - Speech Therapy
  - Occupational Therapy
  - Radiation Therapy
  - Durable Medical Equipment
  - Durable Medical Equipment Purchase
  - Durable Medical Equipment Rental
- Patient relationship has been added to Patient Information, e.g., spouse of subscriber

If you're not using Availity to check eligibility and benefit information, you can simply log in to Availity, click Patient Registration and then Eligibility and Benefits Inquiry.

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

Click to Chat Feature Now Available Through Availity

As we continue to make enhancements to our customer service area, we've started a "Click to Chat" feature that offers you a new way to communicate with us in addition to email and phone. Click to Chat is available in the Payer Space on Availity and is reserved for questions you would normally ask our eBusiness area. For now, Click to Chat isn't available for claim status or benefit and eligibility questions, but we plan to include it in the future.

New BlueCross Opioid Prescription Policy Now in Effect

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, the following changes are in effect for our Commercial (Blue Network P℠, Blue Network S℠ and Blue Network M℠) and CoverKidsSM 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
- 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
- Sickle Cell Disease
- Palliative Care
- End of Life Care

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

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

Understanding our Member's Rights and Responsibilities

We periodically remind members of their rights and responsibilities. These reminders make it easier for our members to access quality medical care and additional services. And these reminders help us comply with regulatory and accrediting requirements.

For your convenience, we publish our current member rights and responsibilities online in our provider manuals. These are available in the Quick Links section of our website.

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. Please submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

New Coverage Option for Federal Employees

Federal Employee Plan (FEP) members now have a third coverage option. In addition to Standard Option and Basic Option coverage, FEP Blue Focus℠ gives federal employees, especially individuals just entering the workforce, an opportunity to choose a lower-cost 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.

Autoimmune Infusion Benefit Procedure Changes for Federal Employee Program Members

Starting Jan. 1, 2019, 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.

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

As mentioned in our August through December BlueAlert newsletters, we're resuming 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.

New Prior Authorization Requirements for Oncology/Radiation Therapy

Beginning March 1, 2019, prior authorization for certain oncology/radiation therapy procedures will be required for some Commercial members. You can check member benefits through Availity Self-Service. For more details on how to do this, please see the Check Eligibility and Benefits Through Availity Self-Service Feature article in this issue.

Tips for Coding Professionals

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

New CPT® Codes for Psychological and Neuropsychological Testing

Beginning Jan. 1, 2019, we're adopting the new CPT® codes for psychological and neuropsychological testing required by the American Medical Association (AMA). Please use them for all claims for dates of service as of Jan. 1, even if the tests were authorized prior to that date. You're welcome to amend or request a retroactive approval to your prior authorization request to include newly covered services (e.g. feedback sessions) if you submitted your request before Jan. 1.

Please note: If you don't use these new codes after Jan. 1, your claims will be denied. However, prior authorization requirements for these tests remain the same.

To order copies of the CPT® manual from the AMA, visit commerce.ama-assn.org/store or call 1-800-621-8335.
If you have questions, please contact your regional Provider Network Manager.

HCPCS G Codes No Longer Required for Physical and Occupational Therapy

Effective Jan. 1, 2019, in alignment with CMS, our BlueAdvantage and BlueCare Plus Medicare Advantage plans no longer require the reporting of functional status (G Codes) related to physical therapy and occupational therapy services. Claims processing and reimbursement will not be impacted if you still choose to file the G Codes.

BlueCare Tennessee

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

Changes to TennCare Preferred Drug List

Recent releases of the Division of TennCare℠ Preferred Drug List (PDL) include changes that may affect some of the medicines your patients take. Please see below for notable updates.

Changes Effective Nov. 1, 2018

Narcan Nasal Spray no longer requires prior authorization for certain patients.

Changes Effective Dec. 1, 2018

Focalin IR is no longer on the list of branded agents classified as generics, and requests for this medication will deny. You can transition patients previously taking this drug to Dexmethylphenidate immediate release, which now has preferred status and is covered for patients with existing prior authorizations.

To view the full provider notices outlining these PDL changes see the Provider Notice for Brand as Generic Removals and Provider Notice for Narcan Nasal Spray documents under Announcements in the News and Manuals Provider section of bluecare.bcbst.com.

Note: The TennCare PDL doesn't apply to CoverKids members.

Explore the Difference between EPSDT and HEDIS®-Compliant Well-Child Exams

There are key differences between the reporting criteria for TennCare Kids' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams and the well-child-visit performance measures outlined by the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS). Here's what you need to know.

EPSDT Visits

Children and adolescents enrolled in BlueCare℠ or TennCare*Select* are eligible for TennCare Kids exams from birth until their 21st birthday. The schedule for EPSDT exams follows the American Academy of Pediatrics Periodicity Schedule.

The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year. Patients are eligible as long as they've had BlueCare Tennessee coverage for 90 continuous days at some point during the fiscal year.

HEDIS Quality Measures

Three performance measures apply to well-child checkups. These measures evaluate whether or not children and adolescents receive the appropriate number of checkups during three key stages: during their first 15 months of life, between ages 3 and 6, and between ages 12 and 21.

The measurement year for HEDIS begins Jan. 1 and ends Dec. 31. To count among a primary care provider's patient population, children must be enrolled in their health plan during the entire calendar year. However, the measures allow one gap in coverage of up to 45 days.

The standalone and diagnosis codes for EPSDT and HEDIS well-child visits are the same; however, you must also include a corresponding CPT® code when billing an EPSDT visit with a listed diagnosis code. For more information about EPSDT exams and coding, please visit our TennCare Kids Toolkit.

Note: This information doesn't apply to CoverKids members.

BlueCare Tennessee 'Pay-and-Chase' Guidelines Change

Patients enrolled in BlueCare℠ or TennCareSelect may also have other insurance. In these cases, providers should bill patients' primary insurance before billing BlueCare Tennessee. TennCare is nearly always considered secondary to other third-party payers.

Sometimes, providers don't realize that patients are enrolled with another insurance carrier before they bill us. In these cases, we may recover payment from providers if certain criteria are met. However, in accordance with federal laws and our contractual agreement with the Division of TennCare, we're required to pay some claims using the "pay-and-chase" approach. This means we'll attempt to recover payment from patients' other insurance, not the provider.

Please note the services for which we're required to use the "pay-and-chase" method have recently changed for pregnant women over age 21. We no longer have to include claims for services delivered to pregnant women over age 21 in the pay-and-chase method.

The Division of TennCare still requires using the "pay-and-chase" approach to pay claims |for the following:

- Preventive pediatric services (including EPSDT exams)
- Services to children on whose behalf child support enforcement is being carried out by the state Title IV-D agency

As a reminder, you may opt to file claims to BlueCare Tennessee as the primary carrier for "pay-and-chase" services, but submitting claims to patients' other carrier first may result in a higher reimbursement rate.

If you have questions, please see The Role of TennCare MCOs in Third Party Liability TennCare Policy Manual. Your provider agreement also outlines information about third-party liability.

Note: This doesn't apply to CoverKids.

Medicare Advantage

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

CMS Opioid Prescription Changes for 2019 Affect Medicare Advantage Plans

The Centers for Medicare and Medicaid Services (CMS) has changed their opioid prescribing guidelines effective Jan. 1, 2019, and they apply to all Medicare Advantage plans. The changes include:

- Prescriptions are limited to a total of 90 morphine milligram equivalent (MME◆) per day.
- Prescriptions for acute pain are limited to seven days for members who don't regularly take an opioid prescription.

More details about the CMS changes are available at their website.

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

Clinical Trial Information

Please report a clinical trial number on your claims for items or services provided in clinical trials, studies, registries or under coverage with evidence development (CED). This is the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov website when a new study appears in the NLM Clinical Trials database.

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 who are new to therapy.

Prior authorization and step therapy will be in line with CMS regulations and will also be 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.

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.

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 soon.

You don't need to wait 365 days between PAF submissions because the benefit is each calendar year. Please see our website for more information about the PAF.

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

Reminder: Administrative Approvals for Home Health, Physical Therapy, Occupational Therapy, Chiropractic and Speech Therapy

BlueAdvantage offers administrative approvals on the initial request for the following services with notification and diagnosis only:

- Home Health Skilled Nursing: Up to 13 visits over a 30-day timeframe (12 visits plus evaluation)•
- PT and OT (home health or outpatient): up to 13 visits over a 30-day timeframe (12 visits plus evaluation)•
- Chiropractic request for spine only (cannot be for maintenance therapy per Medicare guidelines): up to eight visits over a 30-day timeframe (no evaluation related to these services)
- Speech Therapy: Up to seven visits over a 30-day timeframe (six visits plus evaluation) *

•The initial evaluation visits do not require prior authorization. The authorizations will only include the total number of visits and timeframe approved, excluding the evaluation, which does not require a separate authorization.

Clinical information for these administrative approvals is not required other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are considered an extension, and clinical documentation for a medical necessity review is required. If the patient needs more than the number of allowed visits within or beyond the 30-day timeframe of 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.

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.

- In 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. Please select the Inpatient Confinement or Outpatient Surgical Procedure Form (based on place of service) and enter the MSK code related to the request.

Quality Care Partnerships

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

Statin Use for BlueAdvantage Patients with Cardiovascular Disease

The amendment for the 2019 Quality Care Partnerships includes a new performance measure: Statin Therapy for Patients with Cardiovascular Disease. The metric measures the percentage of male members age 21-75 and female members age 40-75, who were identified as having **atherosclerotic cardiovascular disease** and received at least **one** prescription for a **high- or moderate-intensity statin**.

One of the following drugs must be prescribed and dispensed by a pharmacy:

- Atorvastatin
- Fluvastatin
- Lovastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

Note: Heart disease is identified through medical claims for the following diagnosis:

- Ischemic vascular disease
- Myocardial infarction, coronary artery bypass grafting, or a revascularization event such as percutaneous coronary intervention

Measures Applicable to Quality Amendments

Our BlueAdvantage plans have set 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.

Pending Gap Closure Attestation

If you use the BlueCross Quality Care Rewards portal, please review your queue for any pending attestations to close outstanding gaps in care. You must submit pending attestations from the queue **before Jan. 31, 2019**, to be counted for the 2018 measurement year.

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)	

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INSIDE THIS ISSUE

ALL Blue 2019

Register for an All Blue Workshop 2019 in a City Near You

Registration is now open for our annual All Blue Workshops. Space is limited, so sign up today.

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

60-Day Preview Version of Provider Administration Manual Now Available

We're now publishing a preview of the BlueCross BlueShield of Tennessee Provider Administration Manual (PAM) that shows changes that will become effective 60 days later. The Preview PAM doesn't replace the PAM, but is a supplement that highlights added, replaced or removed language, so your office has time to prepare for the upcoming changes. The new Preview PAM includes changes that will be effective April 1, 2019.

Note: This information doesn't pertain to the BlueCare Tennessee Provider Administration Manual.

Get the Answers You Need Through Availity®

Through Availity, you can get the answers you need 24 hours a day, seven days a week. Not only can you transact with us online, you have access to other payers, too – all through one convenient portal.

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- Individual Market Members' PCP information is no longer populated.
- Patient relationship has been added to Patient Information, e.g., spouse of subscriber.

To check eligibility and benefit information, you can simply log in to Availity, click Patient Registration and then Eligibility and Benefits Inquiry.

If you have questions, please contact your eBusiness Regional Marketing Consultant.

Cite Guideline Transparency Tool Now Available

MCG has provided a product called Cite Guideline Transparency (CGT) so you can see MCG and BlueCross BlueShield of Tennessee medical content before requesting an authorization. You can access the tool in Availity or on our Utilization Management web page under the Cite Guideline Transparency link, where you'll also find the CGT quick reference guide.

If you have questions, please contact your eBusiness Regional Marketing Consultant.

New Prior Authorization Requirements for Oncology/ Radiation Therapy

Beginning April 1, 2019, prior authorization for certain oncology/radiation therapy procedures will be required for some Commercial members. Previous articles in BlueAlert indicated a March 1 effective date, but it's been extended to April. You can check member benefits through Availity Self-Service. For more details on how to do this, please see the Eligibility and Benefits Enhancements in Availity article in this issue.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning April 1, 2019, CPT® code 0081U for genetic testing will require authorization by eviCore.

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

Prior authorization requests can be submitted through Availity. You can also fax them to eviCore at 1-888-693-3210 or by calling 1-888-693-3211.

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.

Non-Emergency Air Transport Requires Prior Authorization for FEP Members

If you want to request air ambulance transport for a BlueCross member covered by a Standard, Basic or BlueFocus Federal Employee Program plan, please know you may need to get authorization from BlueCross before the flight. Air transport for emergencies (e.g., from the scene of an accident when ground transport isn't appropriate or would pose a threat) doesn't require approval. Air transport for non-emergencies do.

To arrange non-emergent air ambulance transport for a patient with BlueCross FEP benefits, please call 1-800-572-1003 from 8 a.m. to 6 p.m. ET. This prior authorization requirement may affect your FEP BlueFocus and Basic Option members if an out-of-network air ambulance is used for non-emergency transportation.

2019 HEDIS® Medical Record Requests to Begin

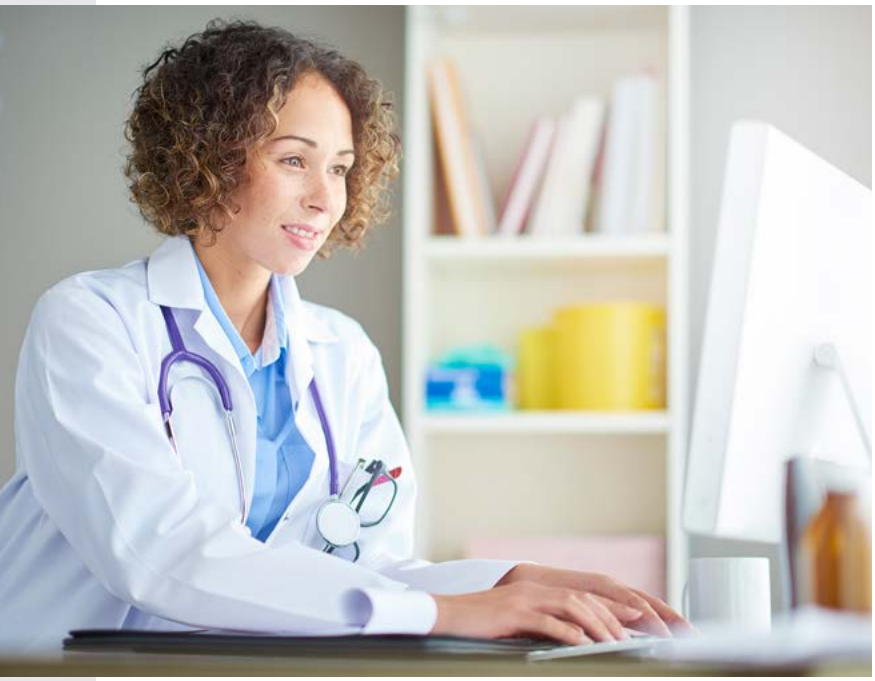
Each year, we're required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. These measures determine whether members received the care and screenings they needed and if the care improved their health.

Soon, you'll receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well-child visits.

For help coordinating your record submission using any of these methods call us at (423) 535-3187.

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

We appreciate your help supporting this requirement.



Tips for Coding Professionals

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

Correct Coding – Usage Changes for Right and Left Modifiers Used Bilaterally

CMS has published new guidelines for modifiers billed by DME Providers for dates of service on or after March 1, 2019. New coding guidelines require each item to be billed on separate claim lines using the RT and LT modifiers with one unit of service (UOS) on each claim line. Claim lines for HCPCS codes requiring use of the RT and LT modifiers, billed without the modifiers or with the modifiers on a single claim line, will reject as incorrect coding.

If you need to bill two of the same items or accessories on the same date of service and used bilaterally, current requirements state you should use RT and LT modifiers on the same claim line and indicate two units of service. For more information, please see Tennessee's Durable Medical Equipment (DME Medicare Administrative Contractor (MAC) For Jurisdiction C.

Correct Use of Modifiers for Procedure-to-Procedure Edits

In October, we published a coding guideline to help providers avoid claim payment delays from using incorrect modifiers for procedure-to-procedure edits. We ask that you review the information to help correct these claim submission errors.

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

- Modifier indicator 0:NCCI-associated modifiers can't be used to bypass the edit.
- Modifier indicator 1:NCCI-associated modifiers may be used to bypass an edit in appropriate circumstances.
- Modifier indicator 9: the edit was 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.

New CPT® Codes for Psychological and Neuropsychological Testing

As of Jan. 1, 2019, we've adopted the new CPT® codes for psychological and neuropsychological testing required by the American Medical Association (AMA). Please use them for all claims for dates of service after Jan. 1, even if the tests were authorized prior to that date. You can amend or request a retroactive approval to your prior authorization request to include newly covered services (e.g. feedback sessions) if you submitted your request before Jan. 1.

Please note: If you don't use these new codes after Jan. 1, your claims will be denied. However, prior authorization requirements for these tests remain the same.

To order copies of the CPT® manual from the AMA, visit commerce.ama-assn.org/store or call 1-800-621-8335. If you have questions, please contact your regional Provider Network Manager.

BlueCare Tennessee

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

Brush Up on the Required Parts of a TennCare Kids Checkup

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have seven key components:

- 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

When your BlueCare Tennessee patients receive their well-child checkups, please document all seven required parts of the exam, as well as assessments of your patients' nutrition and physical activity.

If the patients are uncooperative or the exams were deferred or refused, please be sure to include this information in the patients' medical records.

For more information about the required components of TennCare Kids EPSDT exams and medical record documentation requirements, please visit our TennCare Kids provider page.

Note: This information doesn't apply to CoverKids.

Changes to the TennCare Preferred Drug List

Recent releases of the Division of TennCare Preferred Drug List (PDL) include changes that may affect some of the medications your patients take. Please see below for notable updates.

Effective Nov. 1, 2018

Coreg CR is no longer on the list of branded agents classified as generics, and requests for this medication will be denied. You can transition patients previously taking this drug to carvedilol CR, which is covered for patients with existing prior authorizations.

Effective Jan. 1, 2019

The PDL status changed for certain drugs in the anti-infectives, cardiovascular, central nervous system, endocrine and metabolic, gastrointestinal, oncology agents, and ophthalmics covered drug classes.

To view the full provider notices outlining these PDL changes, please see the Provider Notice for Brand as Generic Removals – Effective Nov. 1, 2018 and Provider Notice for PDL Changes Effective Jan. 1, 2019, documents under Announcements in the News and Manuals Provider section of bluecare.bcbst.com.

Note: The TennCare PDL doesn't apply to CoverKids members.

Reimbursement Update for CPT® Code 90460*

The reimbursement rate for CPT® code 90460 recently increased for providers delivering vaccines through the Vaccines for Children program. Effective Mar. 1, 2019, providers delivering vaccines to children covered by BlueCare and TennCare*Select* will receive reimbursement according to the standard BlueCare and TennCare*Select* fee schedule.

CPT® code 90460 is the administration code for immunizations given to children and teens age 18 and under via any administration route, with counseling by a physician or other qualified health professional, for the first or only vaccine/toxoid component. To learn more about this and other pediatric immunization administration codes, please visit Frequently Asked Questions for the Pediatric Immunization Administration Codes on the American Academy of Pediatrics website.

Note: This reimbursement update doesn't apply to CoverKids.

New Applied Behavior Analysis Referral Form Available Online

We want to make Applied Behavior Analysis (ABA) referrals as easy as possible. So we've updated our ABA referral form and posted it online. The new form includes more fields for patient information, and features larger areas for details about diagnoses.

To use the new form, simply download it, fill it out digitally or by hand, and then send it to us by email or fax. This form will allow us to process your referrals more quickly and help you provide the best care possible for your ABA patients.

New Procedure for Reporting Home Health Missed Visits

The Division of TennCare recently made several changes to the process for reporting missed home health visits. Effective Jan. 1, 2019:

- Home health agencies must have a back-up plan to handle missed visits for each member. This back-up plan should trigger as soon as an agency learns a missed visit is in progress or will take place.
- Agencies must report missed visits within three calendar days by submitting a completed Home Health Missed Visit Form. This form includes directions for submission, as well as necessary fax numbers.
- **If there is no back-up plan in the home or if a member refuses two or more home health staff members, please call us immediately.** Please see the Home Health Missed Visit Form for our contact phone numbers.

Medicare Advantage

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

Expanded Dental Benefits for BlueAdvantage (PPO)℠ Dental Members

We've expanded our dental benefits so you can provide more preventive and comprehensive services for our BlueAdvantage members in 2019.

Our 2019 plans offer an allowance for routine and comprehensive dental services combined. Here's a list of services we cover:

- Cleanings (up to two per year)
- Exams (up to two per year)
- Up to one dental bitewing (limited to four films in a calendar year; all films must be taken on the same date of service).
- Fillings
- Extractions
- Endodontics
- Prosthodontics
- Oral/maxillofacial surgery
- Dentures (up to one set every three years)

Please note this may not be an all-inclusive list.

Covered dental services are allowed at 100% of the maximum allowable of the Commercial Fee Schedule for covered services up to the member's annual maximum.

For more information, please review the member's Dental Benefit information on Availity. If you have any additional questions, please call Provider Service at 1-800-924-7141.

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 who are new to therapy.

Prior authorization and step therapy will be in line with CMS regulations and will also be required for the following Part B drugs: Aloxi/Sustol, Fusilev, Prolia/Xgeva and Eylea. Treanda and Abraxane were previously listed in December and January BlueAlert articles but no longer require step therapy. You can view our online medical policies by clicking here.

BlueCare Plus Model of Care Training

BlueCare Plus providers are contractually required to complete our Model of Care Training after initial contracting, then every year afterwards. This training is designed to promote quality of care and cost effectiveness through coordinated care for our dual-eligible Medicaid and Medicare members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking here.

BlueAdvantage and BlueCare Plus Prior Authorization Criteria for Long-Acting Opioids

BlueCross continues to require prior authorization (PA) for long-acting opioids in 2019. In order for us to process your patient's prior authorization for a long-acting opioid, please provide:

- Documentation of the diagnosis and assessment for the requested drug including:
  - Nature and intensity of pain
  - Past and current pain treatments
  - Underlying or concomitant disorders and conditions
  - Effect of pain on physical and psychological function
  - Physical exam
  - Review of medical history
  - Lab results
- Attestations for:
  - Pain management agreement (signed by the patient and provider in the past six months)
  - Completed aberrant behavior risk assessment tool – such as a Screener and Opioid Assessment for Patients with Pain (SOAPP) for a new opioid user, or a Current Opioid Misuse Measure or Opioid Risk Tool (ORT) for a current opioid user.
  - Review of the state's controlled substance database within the last 90 days
  - Treatment plan that includes goals and monitoring (signed by the patient and the provider)
  - Previous treatment with short-acting opioids at the lowest morphine milligram equivalent dose possible

While these are some of the most important elements, we may require others to complete the prior authorization.
Please click here to view the entire policy on the Use of Opioids in Control of Chronic Pain.

To Request Prior Authorization for Your Patients

- **BlueAdvantage:** Call 1-800-831-2583 or fax your request to (423) 591-9514.
- **BlueCare Plus:** Call 1-800-299-1407 or fax your request to (423) 591-9514.

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.

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 completed form through Availity or fax it to 1-877-922-2963. You also include the form in your patient's chart as part of their permanent record. The 2019 form will be available online soon.

You don't need to wait 365 days between PAF submissions because the benefit is each calendar year. Please see our website for more information about the PAF.

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

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

BlueAdvantage and BlueCare Plus now 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. 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.

Quality Care Partnerships

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

Statin Use for BlueAdvantage Patients with Cardiovascular Disease

The amendment for the 2019 Quality Care Partnerships includes a new performance measure: Statin Therapy for Patients with Cardiovascular Disease. The metric measures the percentage of male members age 21-75 and female members age 40-75, who were identified as having **atherosclerotic cardiovascular disease** and received at least **one** prescription for a **high- or moderate-intensity statin**.

One of the following drugs must be prescribed and dispensed by a pharmacy:

- Atorvastatin
- Fluvastatin
- Lovastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

Note: Heart disease is identified through medical claims for the following diagnosis:

- Ischemic vascular disease
- Myocardial infarction, coronary artery bypass grafting, or a revascularization event such as percutaneous coronary intervention

THCII Episodes of Care Program

New Quarterly Reports for both Medicaid and Commercial will be available sometime in February to Quarterbacks participating in the Episodes of Care Program. If you are a Quarterback having trouble accessing your Quarterly Report, please contact eBusiness Support (423) 535-5717 and press option 2 or by email at eBusiness_service@bcbst.com for assistance.

Measures Applicable to Quality Amendments

Our BlueAdvantage plans have set 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.

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
***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 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Use Availity® to Get the Answers You Need

Through Availity, you can get the answers you need 24 hours a day, seven days a week. Not only can you transact with us online, you have access to other payers, too – all through one convenient portal.

Log in today to:

- Check claim status
- See remittance advice
- Check benefits and eligibility status
- Access our other applications and updates on the BlueCross-specific Payer Space

(continued on page 2, left column)

INSIDE THIS ISSUE

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New Enhancements Added to Eligibility and Benefits

We've added new enhancements to the Eligibility and Benefits Inquiry. You'll now have these options:

- New Benefit/Service types:
  - Allergy and Allergy Testing
- Benefit reset date (calendar year vs. plan year) will now be populated

Check Status of Medicare Crossover Claims

If you need to check claim status or search for out-of-state Medicare crossover claims, you can:

- Select Claims Status and enter information in search field.
  - If claim is not found, click on "Are you looking for a Medicare Primary Claim?"
- Enter required fields and submit.
- Claim list results will display.

For questions about Availity, please call Availity at 1-800-AVAILITY (1-800-282-4548) or our eBusiness technical support team at (423) 535-5717, option 2. You can also send them an email at ebusiness_techsupport@bcbst.com.

For any other questions, contact your Provider Network Manager. You can use our Find Your BlueCross Contact tool on our website to get contact information for your Provider Network Manager.

If you need help getting your office started with Availity, you can contact your eBusiness Regional Marketing Consultant for training and education or visit Availity.com/bcbst.

ALL Blue 2019

Register for an All Blue Workshop 2019 in a City Near You

Registration is now open for our annual All Blue Workshops. Space is limited, so sign up today.

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

Updates to the Provider Dispute Resolution Procedure

We're revising our Provider Dispute Resolution Procedure so you can skip the reconsideration step in the process if you prefer. In the past, we returned any appeals forms that didn't include a processed reconsideration, and asked you to resubmit and go through the reconsideration step first.

Starting April 1, 2019, you may submit an appeal form without first going through reconsideration. That means you'll waive the right to that level of review and your dispute will go directly to appeals. If the dispute remains, the next step is binding arbitration. For BlueCare or TennCare*Select* members providers can also file a request with the Commissioner of Commerce and Insurance for an independent review. The response to a Reconsideration or Appeal under the BlueCross BlueShield of Tennessee Provider Dispute Resolution Procedure will be considered by the State of Tennessee to satisfy the requirement of a Reconsideration under the Independent Review process as defined in Tennessee Code Annotated §56-32-126.

Although we're streamlining this process for convenience, we strongly encourage you to go through the full process and include the reconsideration step so your dispute will be reviewed more than once before binding arbitration.

Please note that this update doesn't apply to our Utilization Management or Provider Audit appeals processes.

Cite Guideline Transparency Tool Now Available

You can now review MCG and BlueCross medical content before requesting an authorization with MCG's new Cite Guideline Transparency (CGT) tool. Find the tool in Availity or on our Utilization Management web page under the Cite Guideline Transparency link, where you'll also find the CGT quick reference guide.

If you have questions, please contact your eBusiness Regional Marketing Consultant.

Allergy Immunotherapy Reimbursement Update

Effective April 1, 2019, we'll be updating our Commercial health plan reimbursement policy for allergy immunotherapy. This long-term treatment decreases allergen sensitivity and relieves symptoms, and is a clinical approach that consists of allergy immunotherapy subcutaneous injections.

Currently, the Commercial benefit defines a dose of allergen immunology as 1cc of extract and limits reimbursement so as not to exceed 30 doses per day. After April 1, our Commercial health plan reimbursement policy for allergy immunotherapy will reimburse an annual limit of up to 160 doses per patient, per year.

To make sure your claims are reimbursed appropriately, please see the specific billing requirements and additional details in the Provider Administration Manual, which reflects this change.

If you still have questions or need more information, please contact your network manager.

New Prior Authorization Requirements for Oncology/Radiation Therapy

Beginning April 1, 2019, prior authorization for certain oncology/radiation therapy procedures will be required for some Commercial members. Previous BlueAlert articles stated a March 1 effective date, but it's been extended to April. You can check member benefits through Availity Self-Service. For more details on how to do this, please see the Eligibility and Benefits Enhancements in the Availity article in this issue.

Changes to High Tech Imaging Program Prior Authorization for Commercial Plans

Beginning May 1, 2019, the following CPT® codes will require authorization through the High Tech Imaging Program administered by eviCore:

76391 77047 77049

77046 77048

Beginning May 1, 2019, the following CPT® codes will be removed from the authorization requirements through the High Tech Imaging Program administered by eviCore:

0159T 77059 C8907

77058 C8904

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

You can submit prior authorization requests through Availity.com, or you may fax to eviCore at 1-888-693-3210 or by calling 1-888-693-3211.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

The following new-to-market medications are on our Provider-Administered Specialty Pharmacy Lists and require prior authorization for all lines of business:

Added Feb. 1, 2019:

Onpattro Takhzyro Lumoxiti

Poteligeo Panzyga Synojoynt

Added March 2, 2019:

Libtayo Revcovi Tegsedi Yutiq

You can find information on all medications that require prior authorization on our website.

Billing Accuracy and Cost Control

Please note that an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. Please submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned. If they're returned, you'll need to resubmit the claim as well as the itemized bill.

BlueCare Tennessee

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

Billing Guidelines for Retinal Use of Avastin (Bevacizumab)

Effective April 1, 2019, ophthalmologists and pediatric ophthalmologists caring for BlueCare, TennCare*Select* and CoverKids members must use HCPCS Code J7999 when billing intravitreal Avastin for treatment of retinal disease. Ophthalmology claims for intravitreal Avastin billed with J9035 will be denied.

For more information about BlueCare Tennessee and CoverKids billing and reimbursement policies, please see the BlueCare Tennessee Provider Administration Manual.

Convert Sports Physicals to Well-Child Exams for Your BlueCare Tennessee Patients

At the beginning of every new sports season, your office probably gets calls from parents who need to schedule their child's sports physical. Stand-alone sports physicals and their corresponding codes aren't covered services for BlueCare, TennCare*Select* and CoverKids members. However, if a child is due for a well-child checkup, you can convert these visits to TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Conducting an EPSDT exam lets you satisfy all components of a sports physical and receive reimbursement for BlueCare and TennCare*Select* members.

Additionally, completing these exams at the same time patients visit your office for sports physicals or other types of care gives you an important opportunity to make sure children and teens who are past due for well-child care get back on track with needed preventive services.

Medicare Advantage

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

Bill Same Dates of Service on Same Claim

When you provide several services to a BlueAdvantage patient on the same day, please bill all of these services as a single claim. Splitting services into multiple claims may cause errors and/or reimbursement delays.

BlueCare Plus Model of Care Training

BlueCare Plus providers are required to complete our Model of Care Training after initial contracting, then every year afterwards. This training is designed to promote quality of care and cost effectiveness through coordinated care for our dual eligible Medicaid and Medicare members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking here.

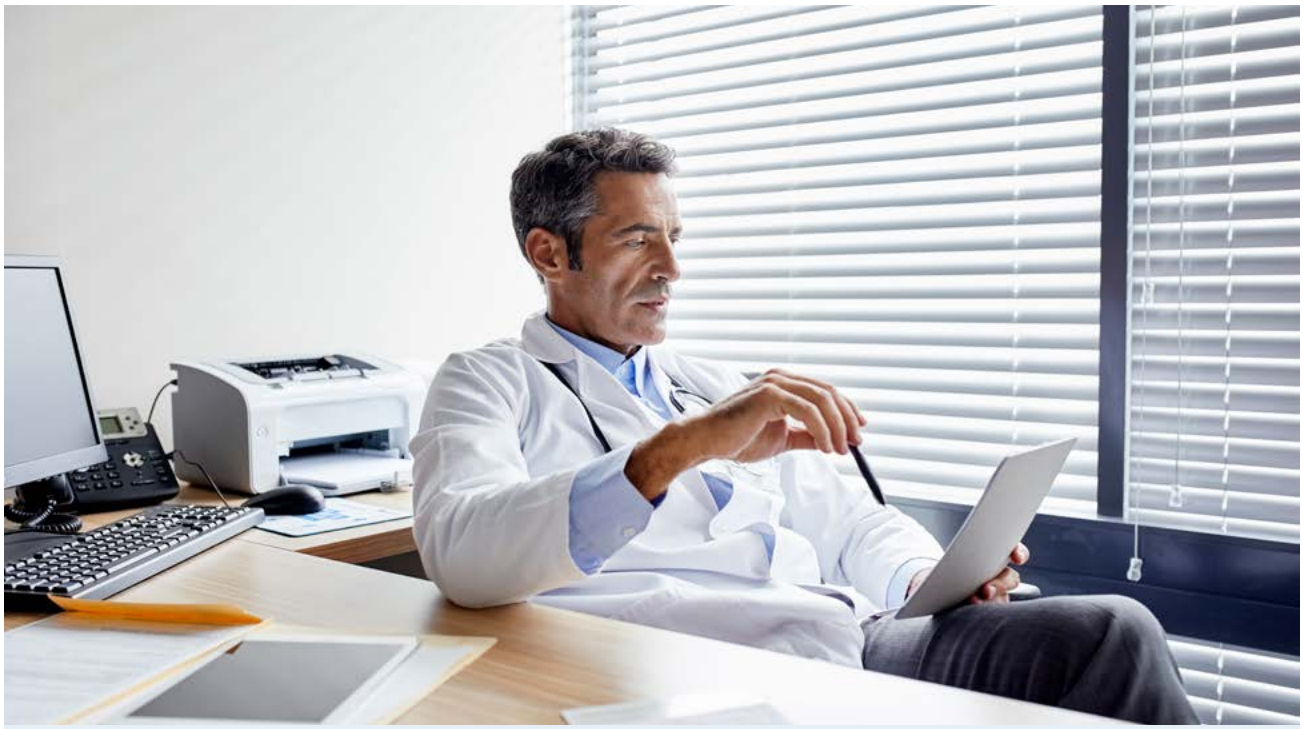
Step Therapy for Certain Medicare Part B Drugs

BlueAdvantage and BlueCare Plus have implemented a step therapy program for certain Part B drugs as part of a patient-centered care coordination program. This only affects members who are new to therapy.

Prior authorization and step therapy is in line with CMS regulations and required for the following Part B drugs: Aloxi/Sustol, Fusilev, Prolia/Xgeva and Eylea. Treanda and Abraxane were listed in December and January BlueAlert articles but no longer require step therapy. You can view our online medical policies by clicking here.

Quality Care Partnerships

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



Reimbursement Changes as Part of Our Medicare Advantage Quality+ Partnerships Incentive Program

If you participated in our Medicare Advantage Quality Incentive Program in 2018, we'll send you a letter later this month announcing changes that will impact reimbursement rates for services on or after April 1, 2019. If you haven't received your letter or need more information about these changes, please call your Medicare Quality Outreach contact.

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.

Important Note:

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

- Email a completed Provider Change Form and any attachments to us at PNS_GM@bcbst.com.
- Update your provider profile on the CAQH ProView™ website.
- **Questions?** Call 1-800-924-7141

Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

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
***Select*Community**	1-800-292-8196
Available Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-841-7434
BlueAdvantage Group	1-800-818-0962
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	eBusiness_service@bcbst.com
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

of Tennessee

APRIL 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Use Availity® to Get the Answers You Need

Through Availity, you can get the answers you need 24 hours a day, seven days a week. Not only can you transact with us online, you have access to other payers, too – all through one convenient portal.

Log in today to:

- Check claim status
- See remittance advice
- Check benefits and eligibility status
- Access our other applications and updates on the BlueCross-specific Payer Space

New Enhancements Added to Eligibility and Benefits

We've added new enhancements to the Eligibility and Benefits Inquiry. You'll now have these options:

- New Benefit/Service types:
  - Allergy and Allergy Testing
- Benefit reset date (calendar year vs. plan year) will now be populated

Check Status of Medicare Crossover Claims

If you need to check claim status or search for out-of-state Medicare crossover claims, you can:

- Select **Claims Status** and enter information in the search field.
  - If the claim is not found, click "Are you looking for a Medicare Primary Claim?"
- Enter required fields and submit.
- Claim list results will display.

INSIDE THIS ISSUE

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For questions about Availity, please call Availity at 1-800-AVAILITY (1-800-282-4548) or our eBusiness technical support team at (423) 535-5717, option 2. You can also send them an email at ebusiness_techsupport@bcbst.com.

For any other questions, please contact your Provider Network Manager. You can use our Find Your BlueCross Contact tool on our website to get contact information for your Provider Network Manager.

If you need help getting your office started with Availity, you can contact your eBusiness Regional Marketing Consultant for training and education or visit Availity.com/bcbst.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

Our Health Care Practice Recommendations web page has two new behavioral health additions for 2019:

- The **American Academy of Family Physicians (AAFP)** Diagnosis and Management of ADHD in Children
- The **American Academy of Child & Adolescent Psychiatry (AACAP)** Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders

You can find both documents on our website. If you'd like to request a paper copy of our clinical practice guidelines, please call us at (423) 535-6705.

Updates to the Provider Dispute Resolution Procedure Now on Hold

Last month we ran a BlueAlert article about upcoming updates to the **Provider Dispute Resolution Procedure**. The updates included revising the process so you have the choice to skip the reconsideration step.

However, this update is now on hold until further notice for all lines of business. We apologize for any inconvenience this may have caused. Please stay tuned to BlueAlert for future updates to the Provider Dispute Resolution Procedure.

ALL Blue 2019

Last Chance to Register for the 2019 All Blue Workshops in Kingsport and Knoxville

Don't miss your chance to attend our annual All Blue Workshops in Kingsport and Knoxville. Space is limited, so click on the links below to register.

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

Allergy Immunotherapy Reimbursement Update*

Effective April 1, 2019, we've updated our Commercial health plan reimbursement policy for allergy immunotherapy. This long-term treatment decreases allergen sensitivity and relieves symptoms, and is a clinical approach that consists of allergy immunotherapy subcutaneous injections.

Prior to April 1, the Commercial benefit defined a dose of allergen immunology as 1cc of extract. It also limited reimbursement to not more than 30 doses per day. Our Commercial health plan reimbursement policy for allergy immunotherapy now reimburses an annual limit of up to 160 doses per patient, per year.

To make sure your claims are reimbursed appropriately, please see the specific billing requirements and additional details in our updated Provider Administration Manual.

If you still have questions or need more information, please contact your Provider Network Manager.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

The following new-to-market provider-administered specialty medications will be added to the Provider-Administered Specialty Pharmacy Lists April 2, 2019, and require prior authorization for all lines of business:

- Udenyca
- Khapzory

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

Special Message from BlueCross BlueShield of Florida for Commercial Providers Who Serve Publix Employees Living in Tennessee and Bordering Counties

Applied Behavioral Analysis (ABA) therapy benefits are now available for Publix employees and their children who have autism spectrum diagnosis (ASD). ABA therapy benefits are managed by a dedicated coordinator through the Publix plan's case management program, which is administered by Florida Blue's vendor Companion Benefit Alternatives (CBA).

ABA therapy covers specific services for members with ASD. A treatment team made up of a certified technician and a qualified health professional (typically a board-certified behavioral analyst or a board-certified assistant behavioral analyst) provide behavioral therapy. And although therapy doesn't include speech, physical or occupational therapy, these benefits are still covered under the Publix medical plan.

Please note that Florida Blue won't cover ABA therapy services unless members receive prior authorization by CBA. An initial request for ABA therapy requires a treatment plan, signed and submitted by a licensed physician.

For more information about Florida Blue's ABA therapy benefits or how to obtain prior authorization, please call **1-800-868-1032**, ext. 25634 or email autismsupport@companiongroup.com.

New Prior Authorization Requirements for Oncology/Radiation Therapy

Prior authorization for certain oncology/radiation therapy procedures are now required for some Commercial members. You can check member benefits through Availity Self-Service by logging in to Availity, clicking on **Patient Registration** and then **Eligibility and Benefits Inquiry**. If you follow these steps, but can't get the information you need, the system will provide you with a Fast Path ID to contact Provider Service for help. A valid Fast Path ID is required for each patient inquiry.

Billing Accuracy and Cost Control

Please note that an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. Please remember to submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, or the itemized bill doesn't match the total claim, your claims may be denied or returned. If they're returned, you'll need to resubmit them along with the itemized bill.

Tips for Coding Professionals

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

Updates to Front-End Claims Edits for All Institutional Claims

Starting May 1, 2019, we're updating our front-end claims edits for all institutional claims to comply with National Uniform Billing Committee (NUBC) guidelines and ASC X12 standards. These changes relate to the Statement Covers Period and how it differs from the Admission Date.

Here's some information to help you file claims correctly:

- The **Statement Covers Period** (see Form Locator 6) identifies the span of service dates included in a particular bill.
  - The "From" date is the earliest date of service on the bill.
  - If you provide all of your services on the same day, the "From" and "Through" dates should be the same.
- The **Admission Date** (see Form Locator 12) is the date the patient was admitted as an inpatient to the facility (or the start-of-care date for home health and hospice).
  - In some cases, your Admission Date may be the same as your Statement Covers dates.
  - The Admission Date may fall outside the "From" and "Through" dates in the Statement Covers Period.
  - It must be reported on all inpatient claims whether it's an initial, interim or final bill.

Examples of Correct Usage:

1. When patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement. Therefore, the Admission Date and the "From" date will differ. On an initial bill, the "From" date would be prior to the Admission Date.
2. A patient treated in the Emergency Department is subsequently admitted after midnight (the next day). The "From" date and the ED Procedure Date would be the same, but the Admission Date would be the following day.
3. In a longer term stay, you need to issue an initial bill, one or more interim bills, and a final bill. The Admission Date is reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

Please note, the same methodology applies to the 837 Institutional Claim, which has distinct data segments and qualifiers to distinguish Admission Date and Statement Covers Period dates.

For more information on code editing best practices, please see the NUBC UB-04 manual.

Billing Guidelines for Vaginal and Cesarean Section Delivery

Effective May 1, 2019, obstetric providers for BlueCare, TennCare*Select* and CoverKids should only use ICD-10 Procedure Coding System (ICD-10-PCS) code 10E0XZZ "Delivery Products of Conception, External Approach" when billing for a vaginal or cesarean section delivery. Claims containing this code should include the delivery date.

If you file a claim with ICD-10-PCS code 10E0XZZ without a delivery date or for services outside of a vaginal or C-section delivery, the claim will be denied.

BlueCare Tennessee

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

Boost Well-Care Compliance with Alternate and Extended Office Hours

Many times, parents and others caring for children covered by BlueCare Tennessee have jobs that don't allow them to bring their kids in for visits during normal office hours. If you have patients who can't visit your office during the day because of their parents' or caregivers' work schedule, here's something to consider. Some practices have found that offering appointments later in the evening or on weekends helps more kids and teens get preventive care.

If you're interested in providing alternate or extended hours, consider asking your patients which ones are most convenient for them.

Authorization Process Updates for Home Health Services

To help home health agencies reduce administrative time and better serve our members, we're expanding the authorization date span for home health services and private duty nursing (PDN). Effective May 1, 2019, the authorization date span for S (hourly) and T (PDN) codes (S9122/S9123/S9124 and T1000) will increase from 16 weeks to 180 days or six months. Benefit limits and medical necessity determination still apply.

These changes will only apply to initial and ongoing authorization requests submitted on or after May 1, and all requests must follow current rules for submitting provider orders and clinical documents. Additionally, your agency must monitor billed units versus authorized units during the authorized date span and submit a corrected bill if a claim was submitted for a visit that was missed.

Coming Soon: New Forms for PDN and Home Health Services

We're in the process of updating the following forms for private duty nursing (PDN) and home health services based on guidance from the Division of TennCare:

- Home Health Agency Plan of Care Agreement
- Home Health Agency Plan of Care Form
- Home Health Agency Caregiver Training Checklist

These forms will be online soon, and you'll be able to find them on the Provider Forms page of bluecare.bcbst.com under the Patient Authorizations header. At the same location, you'll also have access to a new Division of TennCare form: Agency Caregiver Reauthorization Training Checklist. Moving forward, your agency will need to complete this form with each new authorization to continue or increase PDN and home health services.

If you have questions, please call us at 1-888-423-0131.

Note: These forms don't apply to CoverKids.

Medicare Advantage

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

Screening and Diagnostic Colonoscopy Services

When your patient needs a colonoscopy, the reason for the procedure determines whether it should be a screening or diagnostic service. You're paid regardless of the service, but your patient's cost share changes under Affordable Care Act (ACA) rules. This is why it's important to know which service it falls under when you file your claims.

Here's an example: Your patient comes in for a regular screening colonoscopy (i.e., they don't have any symptoms or complaints, and only have a history of benign polyps removed). During the procedure you find and remove polyps. This procedure is considered a screening, so a member copay won't apply. You'll be paid for removing the polyps, as well as for the screening colonoscopy. The diagnosis and procedure codes filed on the claim determine if the procedure is processed as screening or diagnostic.

If your patient has abdominal pain, weight loss or signs of rectal bleeding, the procedure is considered diagnostic and we'll apply member benefits accordingly. Also, if your patient undergoes Cologuard® testing with a positive result, the follow-up colonoscopy is considered diagnostic because you'll be evaluating the positive test result.

Coding Notes: The following codes are considered screening/preventive regardless of the diagnosis on the claim:

- G0105 colorectal cancer screening; colonoscopy on individual at high risk (which includes a history of benign polyps)
- G0121 colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

The following codes will be treated as preventive if filed with the preventive diagnosis codes (Z0000, Z0001, Z1210, Z1211, Z1212, Z800 and Z8371). However, only 45378 is considered diagnostic by description:

- 45378 colonoscopy, flexible; diagnostic, including collection of specimen by brushing or washing, when performed
- 45380 colonoscopy, flexible; with biopsy, single or multiple
- 45381 colonoscopy, flexible; with directed submucosal injection, any substance
- 45384 colonoscopy, flexible; with removal of tumor, polyp, or other lesion by hot biopsy forceps
- 45385 colonoscopy, flexible; with removal of tumor, polyp, or other lesion by snare technique

Musculoskeletal Web Submissions

All requests for outpatient musculoskeletal procedures and procedures that aren't on the CMS Inpatient Only (IPO) list should be submitted online using the "Outpatient Surgical Procedure" form.

Please use the "Inpatient Confinement" form when submitting requests for procedures that are on the CMS IPO list or for an actual inpatient admission.

Please note that in January 2018, CMS removed total knee arthroplasties from the Medicare IPO list. To request an inpatient diagnosis-related group pre-operatively for knee replacements, you need to provide a compelling medical reason for services that can only be done in an acute inpatient setting. It's also important to note these requests are reviewed by our Plan Medical Director.

Home Health Skilled Nurse Care Administrative Approval Update

If you have a patient who needs to start receiving home health skilled nursing care, authorization approvals will be up to 13 visits during a 30-day timeframe. This helps us make sure claims are paid correctly, based on the initial evaluation and treatment visit.

When you request a start day for service, it should indicate the actual or anticipated evaluation date.

Please note we may initially deny claims for service dates in 2019 if you didn't have authorization for an initial evaluation before March 1, 2019, when our approval process changed. However, we will pay these claims without asking you to request authorization updates.

Quality Care Partnerships

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

Provider Stars Ratings Now Available in Availity

BlueCross' Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement for 4-Star and above Star Quality ratings and coding accuracy completed during the 2018 calendar year. You may now visit Availity to view your final 2018 Stars rating.

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

On April 1, 2019, and after, Star Quality ratings, which are calculated by the previous year's performance, will 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 or ask your Quality Outreach Consultant for additional information.

Quality Care Rewards Changes

The Provider Assessment Form (PAF/PACF) within the Quality Care Rewards tool has been updated to offer easier navigation and a more streamlined assessment.

Attestations in the Quality Care Rewards tool that have been in a pended state for 90 days will be cleared from the queue and must be resubmitted. This change to the QCR tool will go into effect at the end of May. Please check to see if you have attestations in this pending queue.

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Questions? Call 1-800-924-7141.

of Tennessee

MAY 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

We've added a new medical Clinical Practice Guideline for rheumatoid arthritis to our Health Care Practice Recommendations web page.

To request a paper copy of our clinical practice guidelines, please call us at (423) 535-6705.

Updated Taxonomy Codes for Better Provider Specialty Identification

We recently updated our systems to meet a new BlueCross BlueShield Association mandate for all BlueCross Plans to use the National Uniform Claim Committee's (NUCC) taxonomy code list to identify provider specialties. This update took effect for all lines of business April 14, 2019. We don't expect this to impact claims processing or provider payments.

INSIDE THIS ISSUE

Claim Filing Update for Ambulatory Surgical Centers

Ambulatory Service Centers (ASC) should file institutional claims with the CMS-1450/ANSI-837 form (as stated in your BlueCross provider agreement) for services provided to our Commercial (including FEP), BlueCare, TennCare*Select* and CoverKids members. In the past, we've accepted both institutional and professional claims from an ASC. However, starting in May, we can only reimburse an ASC for institutional claims for these members.

If Medicare is the primary carrier on the claim and the explanation of benefits (EOB)/remit advice is included with the submission, we can make an exception to this rule. However in all other cases, we'll return your claim and ask you to resubmit it as an institutional transaction.

Note: We'll only accept paper claims if you have a technical or temporary issue or extenuating circumstances that prevent you from submitting claims online. To report this type of issue, please call our eBusiness Department at (423) 535-5717 or send an email to eBusiness_TechSupport@bcbst.com.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On April 30, 2019, we added the following new-to-market medications to our Provider-Administered Specialty Pharmacy List, which identifies drugs that require prior authorization:

- Gamifant
- Truxima
- Herzuma

You can find information on all the medications that require prior authorization on the Pharmacy Resources & Forms page on our website.

Billing Guidance for Two Specialty Pharmacy Devices

If you have patients with a defective Neulasta Onpro (J2505) injector or Liletta (J7297) hormone-releasing system, please contact the manufacturer to get a replacement or credit rather than billing us.

Here's who you can contact if you have questions or problems with the devices:

- Amgen 1-800-772-6436 (Neulasta Onpro)
- Allergan 1-800- 678-1605 (Liletta)

Updates to the Provider Dispute Resolution Procedure Now on Hold

We recently ran a BlueAlert article about upcoming updates to the Provider Dispute Resolution Procedure. The article stated we'd revised the process so providers could choose to skip the reconsideration step.

However, this update is now on hold until further notice for all lines of business. We apologize for any inconvenience this may have caused. Please stay tuned to BlueAlert for future updates to this procedure.

Behavioral Health in Pediatrics (BeHiP) Chattanooga Training Event May 10

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) will host a training event for pediatricians and other health care providers who want to learn more about screening, assessing and managing patients with emotional, behavioral and substance abuse concerns.

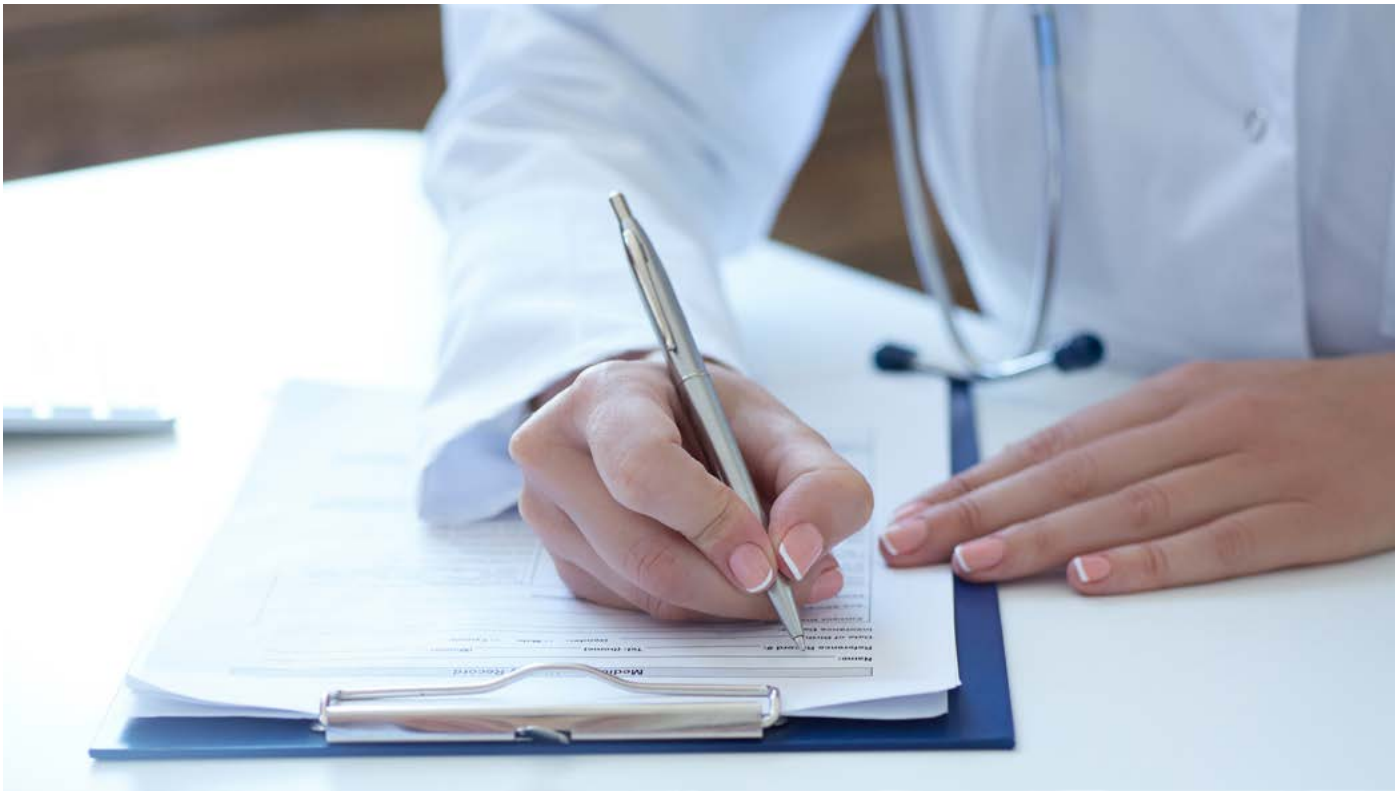
The event takes place Friday, May 10, from 6:00 p.m. to 8:30 p.m. at our office at 1 Cameron Hill Circle in Chattanooga. Dinner will be provided.

Seven years ago, TNAAP began working to improve care for patients with behavioral health concerns because there weren't enough child and adolescent psychiatrists. The BeHiP program is developing a statewide, regionalized system of care that provides better outcomes for children with behavioral health concerns. Pediatric care is critical to its success.

Please visit the BeHiP website to learn more about the upcoming training and register for the event.

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.



Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning July 1, 2019, CPT® codes 81211, 81213 and 81214 will no longer need prior authorization through eviCore's Genetic Testing Program. However, the following codes will now need prior authorization:

81163	81173	81190	81337
81164	81174	81286	81443
81165	81185	81289	81518
81166	81186	81306	81596
81167	81189	81336	

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

You can submit prior authorization requests through Availity.com. You can also submit your requests to eviCore by fax at 1-888-693-3210 or by calling 1-888-693-3211.

Billing Guidelines for Retinal Use of Avastin Change in July

Effective July 1, 2019, we're changing billing guidelines for ophthalmologists and pediatric ophthalmologists caring for Commercial members. You will need to use HCPCS Code J7999 when billing intravitreal Avastin (Bevacizumab) to treat retinal disease – not J9035. We will deny ophthalmology claims submitted with the incorrect code.

For more information about our billing and reimbursement policies for compound medications and compounding services, please see the Provider Administration Manual.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect, and CoverKids℠ plans unless stated otherwise.

Changes to the TennCare℠ Preferred Drug List

Please review notable changes to the Division of TennCare Preferred Drug List (PDL) that may affect your patients' medications.

Effective Jan. 1, 2019

Epclusa was added to the list of preferred hepatitis C antiviral agents, and Mavyret remains a preferred treatment. Providers still need a prior authorization to prescribe hepatitis C antiviral treatment. However, several prior authorization requirements were also changed or lifted.

You can view the full provider notice outlining these changes here: Prescriber Notice for Hepatitis C Antivirals.

Effective April 1, 2019

The following medications are no longer on the list of generic drugs, and requests for these medications will be denied:

- Fosrenol chewable tabs
- Onfi oral suspension

You can transition patients taking Fosrenol chewable tabs to lanthanum carbonate chewable tabs. Patients taking Onfi oral suspension may transition to clobazam oral suspension. Both now have preferred status and are covered for patients with existing prior authorizations.

For more information, please see the Provider Notice for Brand as Generic Removals – Effective 4-1-19.

Note: The TennCare PDL doesn't apply to CoverKids members.

Division of TennCare Medicaid ID Pharmacy Requirements

All pharmacies that dispense medicine to BlueCare, TennCare*Select* and CoverKids members must have a valid Tennessee Medicaid ID. This includes pharmacies that participate in the MagellanRX and Express Scripts pharmacy networks, as well as future pharmacy benefit managers that serve TennCare or CoverKids members.

The Division of TennCare will send one more notice to pharmacies that haven't registered reminding them to do so. Claims submitted by pharmacies that don't register with TennCare after receiving this notice will be denied at the point of sale.

For more information, including directions for registering, please see the TennCare Medicaid ID Required for Pharmacies notice.

Balance Billing Guidelines for Members with Secondary TennCare Coverage

Patients enrolled in BlueCare or TennCare*Select* may also have other insurance. In these cases, TennCare is nearly always considered secondary to other third-party payers, but Division of TennCare billing guidelines still apply.

Excluding copays and special circumstances, providers can't bill BlueCare Tennessee patients for TennCare-covered services. If you know at the point of service that you're treating a patient who has primary insurance and secondary TennCare coverage, you may not bill the patient for balances, fees, etc. that aren't covered by the primary payer if the service is covered by TennCare.

For more information about when you may bill BlueCare Tennessee patients, please see the related TennCare Policy Manual or refer to the BlueCare Tennessee Provider Administration Manual.

Best Practices for Keeping Kids on Track with Preventive Care

During a busy day caring for patients, it's not always easy to find time to contact families and remind them to schedule their children's and teens' well-child checkups. Consider the following best practices for appointment scheduling:

1. Schedule a full year of visits for newborns at their first appointment.
2. Before patients leave your office, schedule their next well-child exam.
3. Make the most of your electronic medical records system patient reminder tools, such as letters, text messages and reports.

Children and teens enrolled in BlueCare Tennessee are eligible for well-care visits on the same schedule recommended by the American Academy of Pediatrics. For more information, please visit our TennCare Kids Tool Kit.

Division of TennCare Offers Annual Episodes Design Feedback Sessions

See the invitation from TennCare below.

TN Division of TennCare | Tennessee Health Care Innovation Initiative

Annual Episodes Design Feedback Session

Tuesday, May 21st, 2019

RSVP HERE

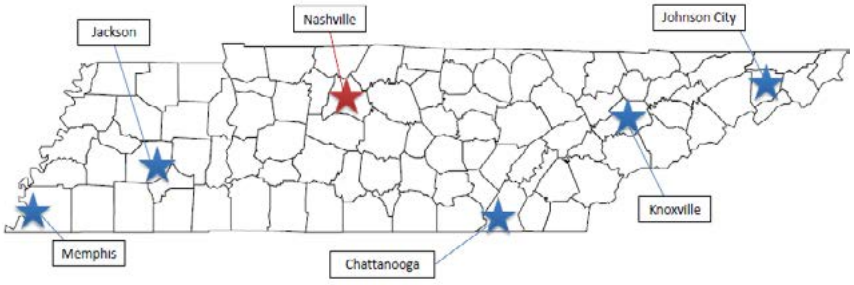
TennCare is hosting our annual episodes feedback session for stakeholders to share successes, ask questions, and recommend changes to improve episode design. The feedback session will be live streamed across the state, and participants may share their feedback at **all 6** locations:

- **Nashville**
- **Johnson City**
- **Jackson**
- **Knoxville**
- **Memphis**
- **Chattanooga**

Submit your feedback before the session using our feedback form

There will be 3 sessions based on episode type:

- **Behavioral Health and Outpatient Episodes**
  - 8:30 am to 10:15 am Central
  - 9:30 am to 11:15 am Eastern
- **Perinatal and Procedural Episodes**
  - 10:30 am to 12:15 pm Central
  - 11:30 am to 1:15 pm Eastern
- **Acute Episodes with Facility Quarterback**
  - 1:15 pm to 3:00 pm Central
  - 2:15 pm to 4:00 pm Eastern



Please send any questions to Payment.Reform@tn.gov. For more information about this event please visit our website: https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

Medicare Advantage

This information applies to BlueAdvantage (PPO)[SM] *plans.*

New Claims Requirement for Patients in Research Studies

Medicare Advantage now requires a National Clinical Trial (NCT) identification number with claims when you provide services to a patient participating in a clinical research study, but only for the services that are part of the study. These include:

- Clinical trials
- Investigational device exemption (IDE)
- Coverage with evidence development (CED)

The NCT is required when a clinical research study claim includes:

- Condition Code 30 (for institutional claims)
- ICD-10 Z00.6 in either the primary or secondary position
- Modifier Q0 and/or Q1

When you submit electronic claims in the 837I or 837P format, please file the eight-digit NCT identifier number in Loop 2300 REF02 (REF01=P4). We won't be able to process claims without this clinical trial number.

Quality Care Rewards

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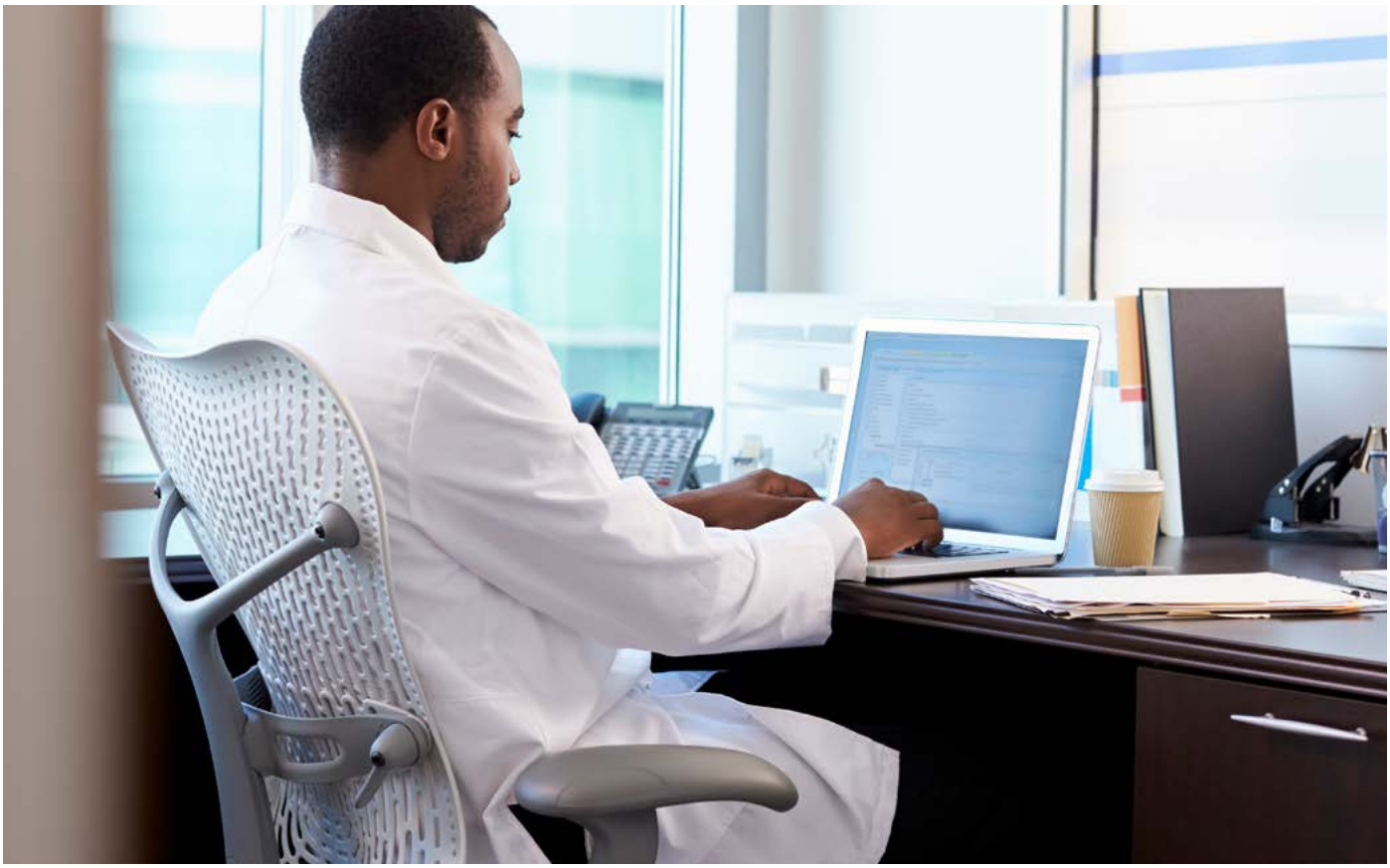

Online Quality Program Educational Sessions

If you'd like to learn about our Medicare Advantage Provider Quality program, join us for an online introduction to its structure and the Provider Assessment Form (PAF) incentive program.

Click on one of the sessions below to learn more:

- Tuesday, May 28, 2019 at 10 a.m. (ET)
- Thursday, May 30, 2019 at 4 p.m. (ET)

THCII Episodes of Care Program

New Quarterly Reports for both Medicaid and Commercial will be available sometime in May to Quarterbacks participating in the Episodes of Care Program. If you're a Quarterback having trouble accessing your Quarterly Report, please contact eBusiness Support (423) 535-5717 and press option 2 or by email at eBusiness_Service@bcbst.com for assistance.

Quality Care Rewards Changes

The Provider Assessment Form (PAF/PACF) within the Quality Care Rewards tool has been updated to offer easier navigation and a more streamlined assessment.

Attestations in the Quality Care Rewards tool that have been in a pended state for 90 days will be cleared from the queue and must be resubmitted. This change to the QCR tool will go into effect the end of May. Please check to see if you have pending attestations.

Tips for Coding Professionals

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

Correct Use of Modifiers for Procedure-to-Procedure Edits

It's important to us that your claims are processed and paid on time, so please be sure to use the correct modifiers with edits. Each National Correct Coding Initiative (NCCI) procedure-to-procedure edit has a modifier indicator of 0, 1 or 9.

- Modifier indicator 0 indicates NCCI-associated modifiers can't 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 can be bypassed by a modifier, and the 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 column one comprehensive codes in some instances, it shouldn't be appended to both codes in the code edit pair. This can delay your claims processing and payment. Please review the NCCI guidelines to prevent claim submission errors.

Starting July 1, 2019, NCCI guidelines will change to allow the modifier on either the column one or column two code, but not both. Although the modifier may be accepted on the comprehensive codes in some situations, it shouldn't be appended to both codes in the code edit pair.

For more information about the upcoming changes, click here.

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCareSelect. For TTY help call 771 and ask for 1-888-418-0008.

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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CAQH Solutions | PROVIEW™

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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
***Select*Community**	1-800-292-8196
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	1-800-924-7141
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Important 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.

of Tennessee

JUNE 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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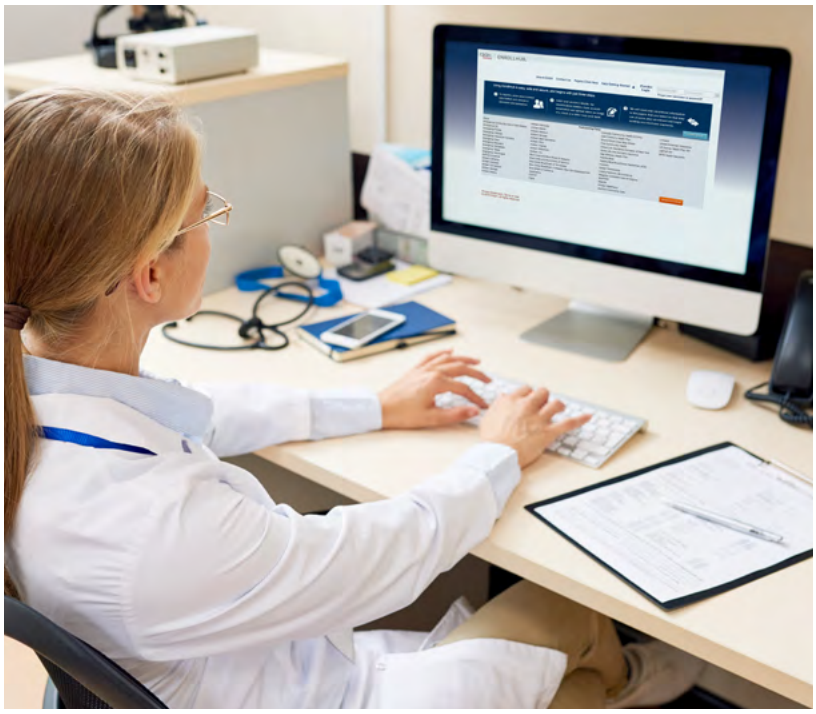


Update to Clinical Practice Guideline for Asthma

We've added a new medical Clinical Practice Guideline for asthma on our Health Care Practice Recommendations web page.

To request a paper copy of our clinical practice guidelines, please call us at (423) 535-6705.

INSIDE THIS ISSUE

How Current CAQH Records Make Recredentialing Easier

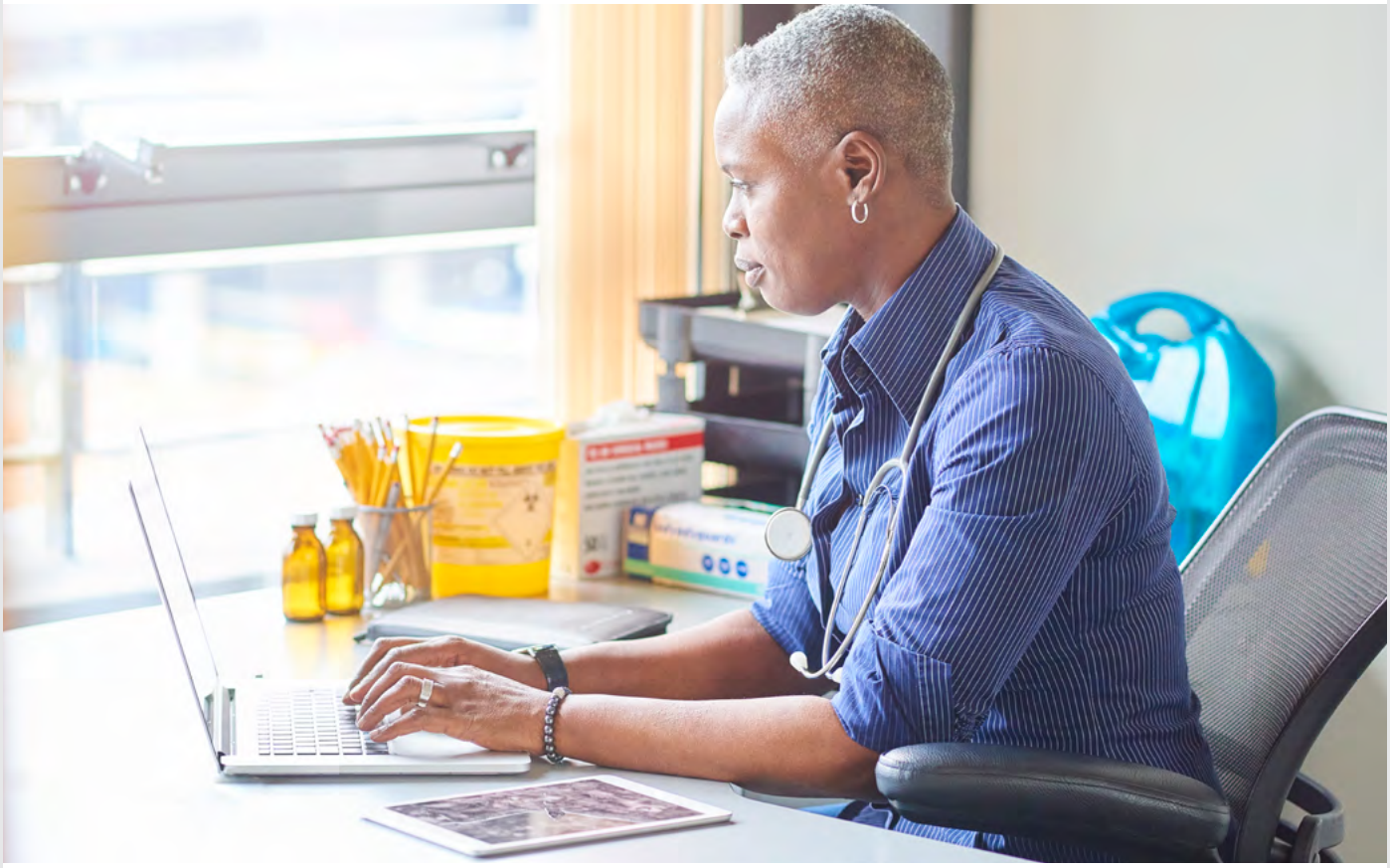
Providers who serve patients in our networks must recredential at least once every three years. We want that process to be easy for you so we use the Council for Affordable Quality HealthCare (CAQH) database for recredentialing. You can easily review and update your information with them at Solutions.CAQH.org. It's important that you keep your information current, because we're also planning to use the CAQH database as the source for more provider information in the near future. This will make the exchange of information easier and more efficient for you and your office.

Claim Filing Update for Ambulatory Surgical Centers

Ambulatory Service Centers (ASC) should file institutional claims with the CMS-1450/ANSI-837 form (as stated in your BlueCross provider agreement) for services provided to our Commercial (including FEP), BlueCare℠, TennCare*Select* and CoverKids℠ members. We've previously accepted both institutional and professional claims from an ASC. However, beginning June 1, 2019, we're only reimbursing an ASC for institutional claims for these members.

If Medicare is the primary carrier on the claim and you include the explanation of benefits (EOB)/remit advice with your submission, we can make an exception to this rule. However, in all other cases, we'll need to return your claim and ask you to resubmit it as an institutional transaction.

Note: We'll only accept paper claims if you have a technical issue or temporary situation that prevents you from submitting claims online. To report this type of issue, please call our eBusiness Department at (423) 535-5717 or send an email to eBusiness_TechSupport@bcbst.com.



Pharmacy

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

National Drug Code Requirement

Since 2014, we've required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications. Starting Sept. 1, 2019, claims without the NDC may be returned unprocessed or denied. You can find more information about this requirement in our Provider Administration Manuals. For details about provider-administered specialty medications that require prior authorization, please visit our website.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

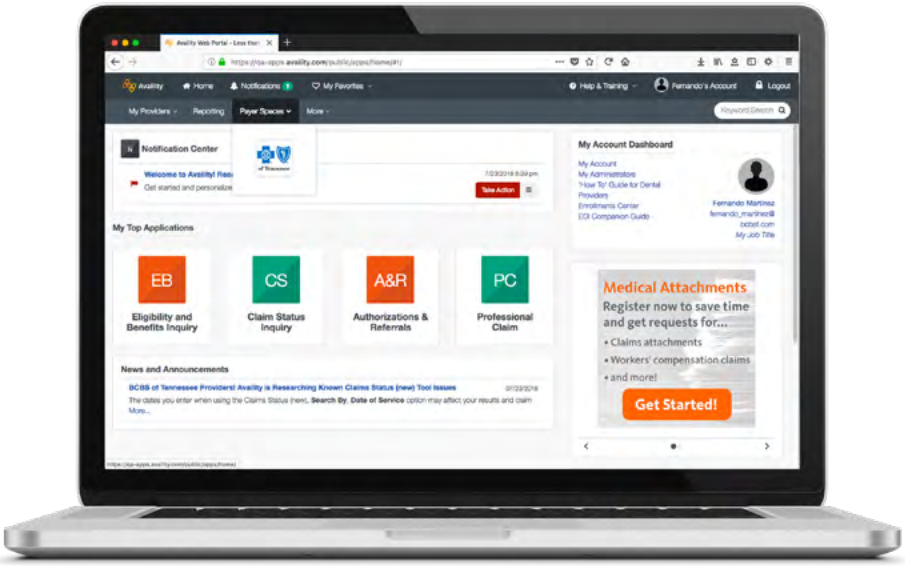
On May 31, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization.

- Asparlas
- Elzonris
- Erwinaze
- Oncaspar
- Ontruzant
- Ultomiris

Please see our website for more information on all provider-administered specialty medications that require prior authorization.

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.



New Eligibility and Benefits Inquiry Enhancement in Availity®

With Availity, you can securely review claim status, check patient benefits and eligibility, see remittance advice, and access our other applications and updates any time.

Now, we've added something new to the BlueCross Payer space. You can now see benefit-specific exclusions in the Eligibility and Benefits Inquiry section.

To get your office started with Availity, please contact your eBusiness Regional Marketing Consultant or visit Availity.com.

For technical questions about Availity, please call them at 1-800-282-4548. You can also contact our eBusiness team at (423) 535-5717, option 2 or by email at ebusiness_techsupport@bcbst.com.

BlueCross Partners with CIOX Health to Collect Medical Records

Federal law requires us to submit medical records to support the Risk Adjustment Data Validation Audit (RADV). To meet the requirement, we're partnering with CIOX Health to help us collect medical records starting in mid-June. As a result, you may receive a letter with a list of requested patient records, along with instructions and options on how to send the medical records to CIOX. Please follow the instructions carefully and contact CIOX with any questions. We appreciate your help with this important audit.

Prior Authorization Changes for Genetic Testing Program Begin Aug. 1

Starting Aug. 1, 2019, CPT® code 0057U will no longer need prior authorization through eviCore's Genetic Testing Program. However, the following codes will need prior authorization:

0084U	0089U	0101U	0104U
0087U	0090U	0102U	
0088U	0094U	0103U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity.com. You can find the information by clicking Patient Registration and then Eligibility and Benefits Inquiry. You can also submit prior authorization requests through Availity.

If you'd rather send these requests directly to eviCore, you can fax them to 1-888-693-3210 or by calling 1-888-693-3211.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect, and CoverKids℠ plans unless stated otherwise.

Team Up for Well-Child Care

The daily schedule of pediatric providers can be unpredictable – even hectic. Most of the time, you're in diagnose-and-treat mode, while your team works to schedule office visits. In the midst of these busy days, it's not easy to pause and see which patients need preventive care and which visits can be converted to well-child checks.

Many offices see benefits from meeting as a team to review daily schedules, either at the beginning or end of each day. That way, they can more easily spot opportunities to deliver preventive care. These team huddles are a great time to:

- Plan ahead for patients who need higher levels of care and may require longer appointments
- Review best practices for coding and documentation
- Discuss visits that can be converted to well-child visits as time allows

With a little extra effort, you may find you're able to save time and effort, while better meeting the health care needs of your patients.

Is it Time to Revalidate Your Medicaid ID?

The Centers for Medicare & Medicaid Services requires all providers to maintain a Medicaid ID to serve in our BlueCare, TennCare*Select* and CoverKids networks. If your Medicaid ID is about to expire, please revalidate it at tn.gov/tenncare/providers/provider-registration.html. Otherwise, we'll have to remove you from these networks and reassign our members to other network providers.

Defining New and Established Patients for Proper Coding

Providers who are contracted to bill claims using CPT® codes need to review for reporting when billing face-to-face services may differ if they're treating a new patient versus an established patient. Here's how they're defined:

- **New patients** haven't received professional services from you – or a physician in your group practicing the same specialty – within the past three years.
- **Established patients** have received professional services from you – or a physician in your group practicing the same specialty – within the past three years.

For more information, please see the BlueCare Tennessee Provider Administration Manual. Coding resources are also available through the American Medical Association.

Include Original Claim Number When Submitting Corrected Bills

When you need to submit corrected claims, please file them electronically using the ANSI-837, version 5010 format. It's important to follow all of the steps, including entering the original claim number found on your electronic remittance advice in the 2300 loop REF segment. If you forget this important step, we may reject or deny your claim.

If you have questions or need help filing the corrected bill, our Electronic Corrected Claim Guidelines flyer contains step-by-step guidance. For more information, please see the BlueCare Tennessee Provider Administration Manual.

Use the Provider Change Form to Update Your Patient Age Criteria

When BlueCare and TennCareSelect members age out of their providers' patient age criteria, we reassign them to a new provider, based on the age criteria we have on file.

If you'd like to continue seeing a patient who's been assigned to another provider because of the patient's age, please update your age criteria by completing the Provider Change Form and emailing it to PNS_GM@bcbst.com.

On page four of the form, you can choose from three age ranges – 0-17, 18 and above, or no age limit. If you treat a different age range, please specify it in the **Other Limitation (Please Specify)** field at the bottom of the first page.

You'll also need to complete a Primary Care Provider Change Request Form for each patient you'd like to keep who's been reassigned to another provider.

Daily Limit Reminders for Home Health and Skilled Nursing Services

The maximum daily limit for Home Health Intermittent Skilled Nursing and Home Health Aide Visits billed with codes G0299, G0300 or G0156 is four units. One unit equals 15 minutes, so home health providers may spend up to one hour in the homes of patients receiving these services each day. For more information, please see below:

TYPE OF SERVICE	DESCRIPTION	REVENUE CODE	PROCEDURE CODE	BILLING UNIT
Home Health Agency Visits (Visits are typically one hour or less.)	Physical Therapy	0421	Not required	1 unit per visit
	Occupational Therapy	0431	Not required	1 unit per visit
	Speech Therapy	0441	Not required	1 unit per visit
	Medical Social Services	0561	Not required	1 unit per visit
Home Health Intermittent Visits (Visits are one hour or less.)	Skilled Nursing Visit (RN)	0551	G0299	1 unit/15 minute
	Skilled Nursing Visit (LPN)	0551	G0300	1 unit/15 minute
	Home Health Aid Visit	0571	G0156	1 unit/15 minute
Home Health Extended Visits (Visits are at least one hour, but no more than eight hours.)	Skilled Nursing Hour (RN)	0552	S9123	1 unit/1 hour
	Skilled Nursing Hour (LPN)	0552	S9124	1 unit/1 hour
	Home Health Aide Hour	0572	S9122	1 unit/1 hour
Private Duty (Visits require constant nursing supervision to support and sustain the use of ventilator equipment or other life-sustaining medical technology.)	Private Duty Nursing	0589	T1000	1 unit/15 minute

Patients may have one Intermittent Skilled Nursing Visit each day. They may have up to two Home Health Aide Visits, as long as the total time spent in the home doesn't exceed one hour.

Please bill extended home health visits that last more than one hour using the applicable S code above. Extended Skilled Nursing and Home Health Aide Visits have a maximum daily limit of eight units (eight hours) and require a prior authorization under the S code for accurate billing.

For more information, please refer to the BlueCare Tennessee Provider Administration Manual.

Note: This information doesn't apply to CoverKids.

New PDN and Home Health Forms Now Available

In the April 2019 BlueAlert, we announced that home health providers would soon have access to several new forms for private duty nursing (PDN) and home health services. These forms are now online at the links below:

- Initial Member/Caregiver Training Checklist
- Private Duty Nursing/Home Health Plan of Care
- Private Duty Nursing Home Plan of Care Agreement
- Recertification Member/Caregiver Training Checklist

We'll be reaching out to you soon to schedule training on how to use the new forms. Please note you won't be required to use them until you've completed this training.

Note: These forms don't apply to CoverKids.

Medicare Advantage

This information applies to our BlueAdvantage plans.

In-Home Bone Density Screenings Available for BlueAdvantage Members

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

We understand it's not always easy for our BlueAdvantage patients to see their physicians for an in-office screening, so we work with our independent health partner, MedXM, to provide in-home bone density screenings. Our members who can't travel may now receive this important test in the privacy of their own homes. Plus, eligible members can receive 50 wellness points through the MyHealthPath® program for getting a bone density test.

If your patients could benefit from this test, they may call BlueCross customer service to make an appointment.

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of Tennessee

JULY 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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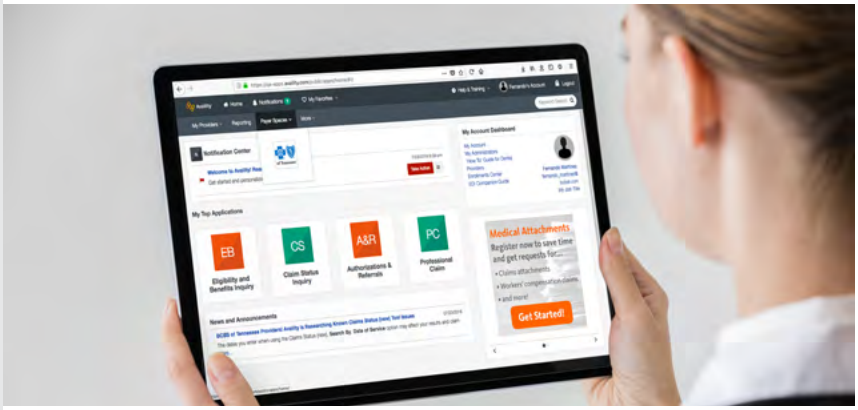

Enhancements Added to Eligibility and Benefits Inquiry in Availity®

With Availity, you can securely review claim status, check patient benefits and eligibility, see remittance advice and access our other applications and updates any time.

Now, we've added something new to the Eligibility and Benefits Inquiry. You can now see additional information for outpatient surgery benefits.

You can find benefit information in multiple categories based on place of service, provider type and member coverage. For additional information on updates and enhancements, please refer to the Availity Knowledge Center.

To get your office started with Availity, please contact your eBusiness Regional Marketing Consultant or visit Availity.com.

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INSIDE THIS ISSUE

Maintaining Provider Information with CAQH Eases Recredentialing Process

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Claim Filing Update for Ambulatory Surgical Centers

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- BlueCare℠
- TennCare*Select*
- CoverKids℠

We've previously accepted both institutional and professional claims from an ASC. However, as of June 1, 2019, we'll only reimburse an ASC for institutional claims for these members.

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Pharmacy

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Changes Related to NDC and J-Codes

Since 2014, we've required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications. Starting Sept. 1, 2019, we'll reject claims submitted without the NDC. Providers should refer to our Provider Administration Manuals for more information.

Coming Soon: New Ways to Request Provider-Administered Specialty Drug Prior Authorizations for Federal Employee Program Members

In October, you'll have two new ways to request prior authorization for provider-administered specialty drugs for Federal Employee Program (FEP) members. Starting Oct. 1, you'll be able to log in to Availity.com or call FEP customer service at 1-800-572-1003 Monday through Friday from 8 a.m. to 6 p.m. ET. When calling, listen for the specialty drug authorization prompt that will connect you directly to MagellanRx, who manages these prior authorizations. Please note that we will no longer accept faxed or mailed prior authorization requests as of Oct. 1, 2019. Look for more details in upcoming issues of BlueAlert.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Document All Seven Parts of a TennCare Kids Checkup

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups have seven key components:

- 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

When your BlueCare Tennessee patients receive their well-child checkups, please document all seven required parts of the exam, as well as assessments of your patients' nutrition and physical activity. Include this documentation in both your patients' electronic medical records and the initial EPSDT record that you send to us.

Additionally, the claim submitted for EPSDT visits must match your patients' medical records and contain codes for all parts of the well visit, including the physical exam, milestone and depression screenings, and vaccines.

For more information about EPSDT coding and medical documentation requirements, please refer to our EPSDT booklet.

Note: This information doesn't apply to CoverKids.

Is it Time to Revalidate Your Medicaid ID?

The Centers for Medicare & Medicaid Services (CMS) requires all providers to maintain a Medicaid ID to serve in our BlueCare, TennCare*Select* and CoverKids℠ networks. If your Medicaid ID expires, we'll have to remove you from these networks and reassign any members assigned to you. If your Medicaid ID expires soon, please revalidate it by visiting the Division of TennCare's website.

Influenza and Tdap Vaccine Reimbursement Update

All children and teens enrolled in TennCare qualify for the Vaccines for Children (VFC) program. Through this program, their providers can receive free vaccine serums through the Tennessee Department of Health. As a result, we've only reimbursed these providers an administration fee for vaccine delivery.

Starting in August, we're making a change to help address the needs of patients under the age of 18 who are pregnant. Since OB/GYNs don't typically participate in the VFC program, they aren't eligible to receive free vaccines from the Department of Health. So effective Aug. 1, 2019, we'll begin covering flu and Tdap vaccines for teens who are pregnant outside of the VFC program. That means if you're an OB/GYN caring for one of these patients, we'll reimburse you for the cost of these vaccines in addition to the administration fee for giving them.

Note: This doesn't apply to CoverKids.

Coming Soon: Updated Process for Submitting the Home Health Missed Visit Form

Soon, home health providers will be able to submit the Home Health Missed Visit Form through Availity.

If you're responsible for delivering home health or private duty nursing services, we'll contact you to schedule training on how to use Availity for this purpose. Please be on the lookout for your training invitation.

Note: This doesn't apply to CoverKids.

Prior Authorization Required for Secondary Claims

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

Begin Using Our New PDN and Home Health Forms Today

As announced in the June BlueAlert, home health providers now have access to four new forms for private duty nursing (PDN) and home health services. The forms are available online at the links below:

- Initial Member/Caregiver Training Checklist
- Private Duty Nursing/Home Health Plan of Care
- Private Duty Nursing Home Plan of Care Agreement
- Recertification Member/Caregiver Training Checklist

Beginning July 1, 2019, please use the new forms to submit the required patient information to us.

If you have questions or would like to view the MCO Collaborative WebEx presentation hosted by the Tennessee Association for Home Care, please reach out to your provider network manager.

Note: These forms don't apply to CoverKids.

BlueCare Plus (HMO SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plan.

New Authorization Requirement for Cosmetic Procedures

Starting Sept. 1, 2019, you'll need prior authorization for procedure codes that may be cosmetic. Prior authorization includes a medical review to determine whether a procedure is medically necessary due to functional impairment, or whether it's considered cosmetic. Cosmetic procedures are not covered by Medicare. Prior authorization will help members know if they'll pay out of pocket before the service is provided.

Medicare Advantage

This information applies to our BlueAdvantage plans.

Provider Assessment Form Changes

We wanted to let you know about some changes we made in May to the Provider Assessment Form (PAF) in the Quality Care Rewards tool:

- Your date of service needs to be within 30 days of the current date to submit the PAF.
- PAFs that remain in the "In Progress" or "Pending" status for 90 days will be voided from the system, and you'll need to create a new PAF.
- You won't be able to submit a PAF with a date of service after the current date.

These changes comply with CMS' expectation that the PAF is completed when you have a face-to-face evaluation with your patient.

New Authorization Requirement for Cosmetic Procedures

Starting Sept. 1, 2019, you'll need prior authorization for procedure codes that may be cosmetic. Prior authorization includes a medical review to determine whether a procedure is medically necessary due to functional impairment, or whether it's considered cosmetic. Cosmetic procedures are not covered by Medicare. Prior authorization will help members know if they'll pay out of pocket before the service is provided.

Quality Care Rewards

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

THCII Episodes of Care Program Final Performance Reports Coming Soon

Quarterbacks participating in the Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program will have their Quarterly Reports, including 2018 Final Performance Reports for Medicaid and Commercial lines of business available in August. We'll release these reports in Availity.

If you have trouble accessing your quarterly report, please call eBusiness Support at (423) 535-5717, option 2, or email eBusiness_Service@bcbst.com.

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not 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 1-888-418-0008.

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.

Archived editions of BlueAlert are available online.

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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

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
***Select*Community**	1-800-292-8196
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	1-800-924-7141
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)	

Important 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.

of Tennessee

AUGUST 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

New Enhancements in Availity®

As a reminder, providers are required to verify benefits through Availity. With Availity, you can securely review claim status, check patient benefits and eligibility, see remittance advice, and access our other applications and updates any time.

Multi-Payer Updates

We've added something new to the Eligibility and Benefits Inquiry. You can now see additional benefit information for the following:

- Consolidated Durable Medical Equipment category
- Hearing Aid benefits located under the Audiology Exam category
- Benefit reset date will now be reflected throughout member benefits where applicable (deductible, limitations, etc.)

Benefit information may be found in multiple sections depending upon place of service, provider type and member coverage. Please see the Availity Knowledge Center for more on updates and enhancements.

Feature Announcements

To make sure you are receiving announcements on enhancements that apply to you, look for updates under the News & Announcements and Notification Center sections of the Availity Portal.

To get your office started with Availity, please contact your eBusiness Regional Marketing Consultant or visit Availity.com.

INSIDE THIS ISSUE

Claim Filing Update for Ambulatory Surgical Centers

Ambulatory Surgical Centers (ASC) should file institutional claims with the CMS-1450/ANSI-837 form (as stated in your BlueCross provider agreement) for services provided to our members enrolled in these plans:

- Commercial (including FEP)
- BlueCare℠
- TennCare*Select*
- CoverKids℠

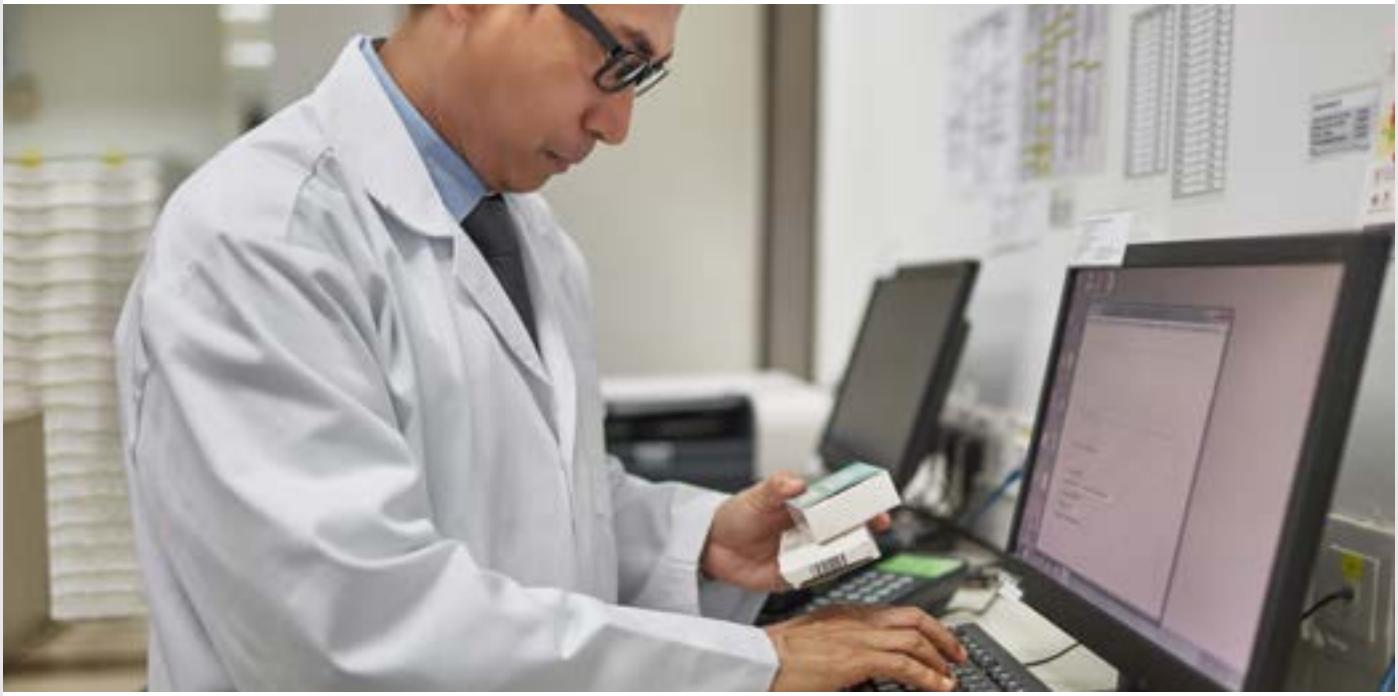
We've previously accepted both institutional and professional claims from an ASC. However, as of June 1, 2019, we'll only reimburse an ASC for institutional claims for these members.

If Medicare is the primary carrier on the claim and you include the explanation of benefits (EOB)/remit advice with your submission, we can make an exception to this rule. However, in all other cases we'll need to return your claim and ask you to resubmit it as an institutional transaction.

Note: We'll only accept paper claims if you have a technical issue or temporary situation that prevents you from submitting claims online. To report this type of issue, please call our eBusiness Department at (423) 535-5717, option 2, or send an email to eBusiness_TechSupport@bcbst.com.

Pharmacy

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



Changes Related to NDC and J-Codes

Since 2014, we've required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications. Starting Sept. 1, 2019, we'll reject claims submitted without a valid NDC. Please be sure to include the full 11-digit NDC code on the claim, including any leading zeroes. You may refer to our Provider Administration Manuals for more information.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On July 31, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization for all lines of business:

- Trazimera
- Herceptin-Hylecta

Please see our website for more information on all provider-administered specialty medications that require prior authorization.

Coming Soon: New Ways to Request Provider-Administered Specialty Drug Prior Authorizations for Federal Employee Program Members

In October, you'll have two new ways to request prior authorization for provider-administered specialty drugs for Federal Employee Program (FEP) members. Starting Oct. 1, you'll be able to log in to Availity.com or call FEP customer service at 1-800-572-1003, Monday through Friday, from 8 a.m. to 6 p.m. ET. When calling, listen for the specialty drug authorization prompt to connect directly to MagellanRx, who manages these prior authorizations. Please note that we'll no longer accept faxed or mailed prior authorization requests as of Oct. 1, 2019. Look for more details in upcoming issues of BlueAlert.

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Tips to Streamline the Utilization Management (UM) Reconsiderations and Appeals Process

We want to handle your Commercial UM Reconsiderations and Appeals requests as quickly as possible, so here are some ways to speed the process:

Denied Authorizations

If you didn't initially submit clinical information or additional details we requested, you may submit it for reconsideration by calling us at 1-800-924-7141, faxing it to 1-866-558-0789 or submitting it through Availity.com. If a reconsideration won't help resolve the denial, please complete the Commercial Utilization Management Appeal Form and fax it to (423) 591-9451. Be sure to include any additional clinical information to support your appeal.

Denied Claims

If you're requesting a claim reconsideration due to a denied claim, please complete the Provider Reconsideration Form and fax it to (423) 535-1959.

Submit Prior Authorizations through Availity

You can submit prior authorization requests 24 hours a day, seven days a week through Availity. If you have an urgent request, please contact the Provider Service line at 1-800-924-7141 and follow the prompts to authorization. Voicemail options are also available after business hours and on weekends and holidays

BlueCare Tennessee

*This information applies to BlueCare℠, TennCare*Select* and CoverKids℠ plans unless stated otherwise.*

Submit Home Health Missed Visit Forms in Availity

In the July 2019 BlueAlert, we announced that home health providers for BlueCare and TennCare*Select* plans would soon be able to submit the Home Health Missed Visit Form through Availity. That function is now available, and we encourage you to enter details about missed visits into Availity instead of printing and faxing the form to us.

We're currently conducting training on how to use Availity for this purpose. Please email the eBusiness Consultant for your region to schedule your agency's training:

- **East Tennessee**
  Faith Daniel, Faith_Daniel@bcbst.com
- **Middle Tennessee**
  Faye Mangold, Faye_Mangold@bcbst.com
- **West Tennessee**
  Debbie Angner, Debbie_Angner@bcbst.com

You can also find directions for using Availity in our Quick Reference Guide. To view the guide online, log in to Availity.com, select **Resources** and choose **Quick Reference Guide**.

Note: This doesn't apply to CoverKids.

Prior Authorization Required for Secondary Claims

Please remember that prior authorization requirements apply when you submit claims for secondary payment from BlueCare Tennessee plans. Prior authorization is not necessary if the primary carrier provided benefits and there are no plans to file a secondary claim.

Help Your Patients Get Ready for a Healthy School Year

The beginning of every school year is a great time to check in with your patients to make sure they've had their yearly Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkup and are up to date on preventive care, including immunizations they'll need for school.

You can view and print a detailed list of BlueCare Tennessee patients who need preventive care in the Quality Care Rewards section of the Availity provider portal. Once you've logged in to the QCR tool:

- Select **All Gaps** to view a list of your patients who need preventive care.
- Click on **Non-Compliant Members** to find a detailed record of your patients who are past due for their EPSDT checkup. This list is updated monthly and includes the date of each patient's last wellness check, as well as the number of missed visits.

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

Note: This doesn't apply to CoverKids.

Medicare Advantage

This information applies to our BlueAdvantage plans.

90-Day Prescriptions Available for 30-Day Copay

Your patients who order a 90-day supply for maintenance medications are more likely to stick to their prescribed treatment over those who don't. Remind them they can get a 90-day supply of generic medications for chronic conditions like diabetes, hypertension and dyslipidemia for only $1 through our preferred network pharmacies. This includes mail order delivery.

BlueCare Plus (HMO SNP)SM and Medicare Advantage

This information applies to our Medicare and Medicaid, dual-eligible special needs plan and our BlueAdvantage plans.

New Authorization Requirement for Cosmetic Procedures

Starting Sept. 1, 2019, you'll need prior authorization for procedure codes that may apply to cosmetic services. Prior authorization includes a medical review to determine whether a procedure is medically necessary due to functional impairment, or whether it's considered cosmetic. Medicare doesn't cover cosmetic procedures, so prior authorization will help members know if they'll pay out of pocket before they receive services.

Quality Care Rewards

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

THCII Episodes of Care Program Reports Coming This Month

The 2018 Final Performance Reports for Medicaid and Commercial lines of business will be available in August to Quarterbacks participating in the Episodes of Care Program.

If you're a Quarterback who's having trouble accessing your Quarterly Report in Availity, please contact eBusiness Support at (423) 535-5717, option 2, or by email at eBusiness_Service@bcbst.com for assistance.

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ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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Email:	eBusiness_service@bcbst.com
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Important Note:

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

- Email a completed Provider Change Form and any attachments to us at PNS_GM@bcbst.com. Update your provider profile on the CAQH Proview™ website.
- Questions? Call 1-800-924-7141.

of Tennessee

SEPTEMBER 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

New Enhancements in Availity®

As a reminder, providers are required to verify benefits through Availity. With Availity, you can securely review claim status, check patient benefits and eligibility, see remittance advice, and access our other applications and updates any time.

Multi-Payer Updates

We're constantly adding new features to the Eligibility and Benefits Inquiry.

Benefit information may be found in multiple sections depending upon place of service, provider type and member coverage. Please see the Availity Knowledge Center for more on updates and enhancements.

Feature Announcements

We've made updates to Contact Preferences that include improved usability, notification if we've had issues with your email address, and the ability to opt out of receiving emails. Please check your contact preferences to make sure you're receiving important contracting messages and announcements that apply to you. Look for updates under the News & Announcements and Notification Center sections of the Availity Portal.

To get your office started with Availity, please contact your eBusiness Regional Marketing Consultant or visit Availity.com.

INSIDE THIS ISSUE

Shared Decision-Making Tools in Availity

Shared decision-making (SDM) is a model of two-way communication that involves providers and patients working together to make health care decisions. It helps make sure that all health care decisions are made with evidence-based information, your knowledge and experience, and your patient's values and preferences.

We've uploaded four certified SDM aids to the Availity portal that may be helpful for orthopedic and OB/GYN providers. They're designed to help patients with joint pain or a higher risk of complications during childbirth better understand their options for care:

- Hip Osteoarthritis: Is it Time to Think About Surgery?
- Knee Osteoarthritis: Is it Time to Think About Surgery?
- Pregnancy: Your Birth Options After Cesarean
- Pregnancy: Birth Options if Your Baby is Getting Too Big

To use these resources, simply log in to Availity and go to the BlueCross Payer Space. From there, choose the Resources tab and click the link to show all resources. Select the SDM tool you want to view, and it will open in a new browser tab.

If you have questions about using the Availity portal, please call your eBusiness Regional Marketing Consultant.

More Information About Code Editing Guidelines on our Website

Over the past several years, we've implemented payment policies to process claims efficiently and deliver payments to providers with more accuracy. We've aligned our payment policies with National Correct Coding Initiative (NCCI) edits, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards. We use these guidelines for professional (including durable medical equipment, medical supplies, prosthetics, orthotics and home infusion therapy services) and institutional claims during claims processing or claims adjustment.

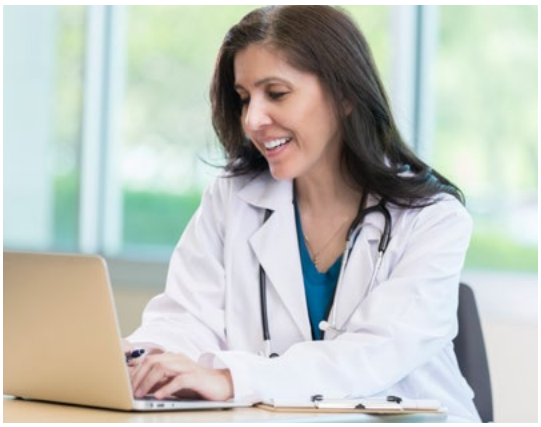
Medically Unlikely Edit (MUE) is an example of an NCCI edit. MUE is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service for a HCPCS/CPT® code. All HCPCS/CPT® codes do not have a MUE.

BlueCross reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records, etc.) to determine appropriate application of our code editing rules.

You can find more information about our code editing guidelines and upcoming code edits by visiting our **Code Editing** section at bcbst.com/providers.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.



Improving Health in Tennessee

Good health outcomes start in the communities where your patients live, work and play. The Division of TennCare wants to learn more about the challenges your patients face in their communities to help you improve your patients' health.

Starting Sept. 20, please take a few minutes to complete the provider survey at tn.gov. Your name will not be tied to your survey answers, but combined with information from all provider surveys to better understand community needs.

Save the Date for a Tennessee Healthcare Symposium Near You

The Tennessee Medical Association (TMA) is hosting four Tennessee Healthcare Symposiums for providers across the state next month. During these one-day events, you'll have an opportunity to:

- Attend sessions on relevant health care topics, including TennCare updates and coding and documentation
- Meet with vendors and exhibitors to learn more about new health care products and services
- Schedule one-on-one time with payers to ask questions about claims, prior authorizations and more

Events will be held in Memphis, Nashville, Knoxville and Chattanooga. Please see below for dates and locations:

Oct. 8, 2019 Memphis	Oct. 9, 2019 Nashville	Oct. 10, 2019 Knoxville	Oct. 11, 2019 Chattanooga
The Fogelman Center 3675 Central Avenue Memphis, TN 38152	**Wilson County Expo Center** 945 Baddour Parkway Lebanon, TN 37087	**Rothchild Conference Center** 8807 Kingston Pike Knoxville, TN 37923	**Chattanooga Convention Center** 1150 Carter Street Chattanooga, TN 37402

For more information or to sign up for an event near you, please visit the TMA's Tennessee Healthcare Symposium event page.

Reminder: Updated Guidelines for Allergen Immunotherapy*

Several changes to allergen immunotherapy guidelines and limits took effect July 1, 2019. Please see below for a summary of notable changes that apply to your BlueCare, TennCare*Select* and CoverKids contracts:

1. **CPT® Code 95165 – Preparation and Provision of Antigen for Allergen Immunotherapy**
   Your patients can receive 150 doses of antigen (one dose of antigen is defined as 1 cc aliquot) per calendar year without a prior authorization. You must have a prior authorization from us to bill more than 150 units using code 95165. We can reimburse up to a three-month supply (approximately 37 doses/units) at one time.

2. **CPT® Code 95115 and 95117 – Allergy Injections**
   Please report ICD-10 codes on the claim(s) to support the injection code billed.
   - For 95115 (single injection), the claim should include at least one allergy-related diagnosis code.
   - For 95117 (multiple injections), the claim should include two or more allergy-related diagnosis codes.

3. **Home Administration**
   Evidence-based guidelines don't support giving patients a self-injectable allergy serum they can use at home. If you make an exception, please discuss the anaphylactic risks of self-injection and make sure your patient can safely administer the serum before they leave your office. Also, please include a signed informed consent in the patient's medical record. When filing claims for at-home immunotherapy administration, bill Modifier 32 with CPT® code 95165.

   In addition to the above guidelines and limits, providers caring for patients covered by BlueCare and TennCare*Select* should continue to bill claims for initial allergen immunotherapy treatment with a –GD modifier. Please see the Division of TennCare budget reduction changes memo that went into effect on Oct. 1, 2016, for more information.

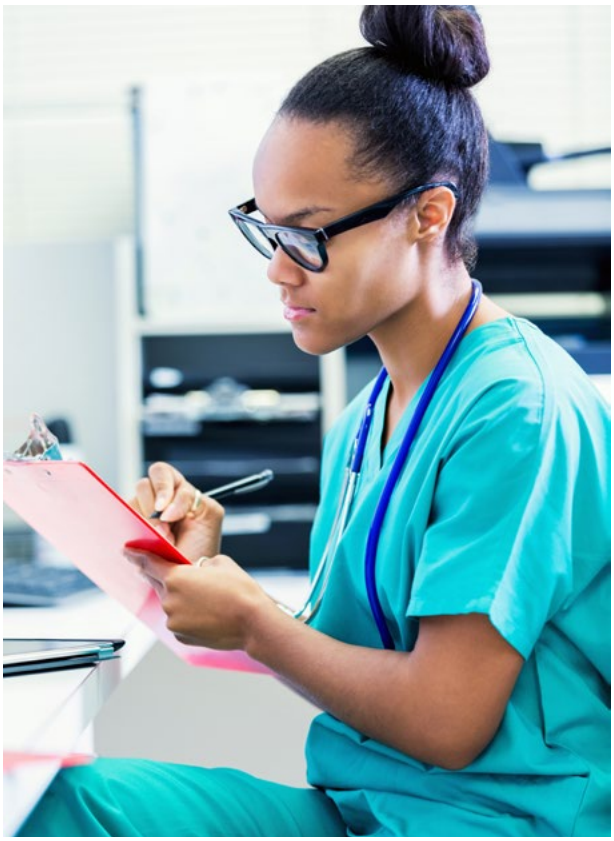
   We're updating the BlueCare Tennessee Provider Administration Manual on Sept. 30, 2019, to reflect these changes. Please refer to the manual for more information.

Coordinating Behavioral Health Services for Your School-Age Patients*

We recently updated the requirements for medically necessary behavioral health services delivered in a school setting. You no longer have to include covered behavioral health services in students' individualized education program (IEP). Previously, we required children and young adults receiving in-school behavioral health services to have an IEP that included those services. We're updating the BlueCare Tennessee Provider Administration Manual to reflect this change.

Please note this update only applies to behavioral health services. Students receiving other medically necessary, school-based services (including physical, occupational and speech therapies) must still have an IEP including that service. Also, this update only impacts IEP requirements. To receive school-based, medically necessary services, including behavioral health, children and young adults must have a doctor's order for the service and a signed parental consent form. For more information about school-based services and related requirements, please see the third quarter update to the Provider Administration Manual.

Note: This doesn't apply to CoverKids members.



Tips for Combining Well-Child Checkups with Sick Visits

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

TennCare Kids' screening guidelines allow you to receive reimbursement 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 (TNAAP), 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 workup of a normal preventive visit. Please attach a Modifier -25 to the code for the additional E/M service when applicable when submitting the claim.
- 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 TennCare Kids Tool Kit. You can also find free TNAAP EPSDT and coding resources at TNAAP.org.

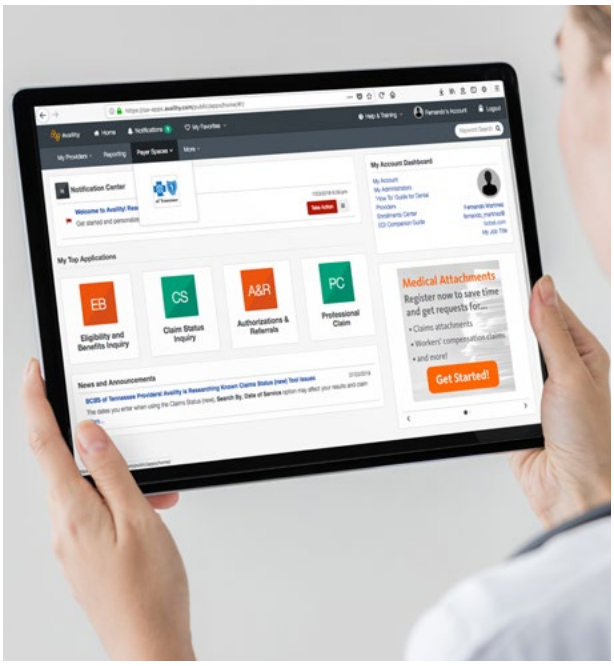
Note: This information doesn't apply to CoverKids.

Regional EPSDT Training Scheduled for Oct. 2

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) is hosting a regional EPSDT training event at Le Bonheur Children's Outpatient Center—Jackson on Wednesday, Oct. 2. Providers and local health departments serving children in Jackson and surrounding counties, including Chester, Hardeman, McNairy, Hardin, Decatur, Perry and Henderson counties, are welcome to attend.

For more information, please contact Janet Sutton, TNAAP ESPDT and Coding Program Manager, at **(615) 447-3264** or janet.sutton@tnaap.org.

Note: TennCare Kids EPSDT exams don't apply to CoverKids.



BlueCare Tennessee Maternity Assessments Must be Submitted Through Availity

Effective Oct. 1, 2019, you must submit your maternity assessments (OB risk assessments) online through the Availity payer spaces application. Fax forms will no longer be available after this date.

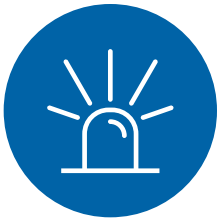
For more information or to schedule an on-site or webinar-based Availity training for your team, please contact your eBusiness Regional Marketing Consultant.

New Prior Authorization Requirement for Removable Foot Inserts

Starting Oct. 1, 2019, you'll need a prior authorization for foot inserts coded using HCPCS L3000. This requirement will apply to all patients with BlueCare, TennCare*Select* and CoverKids coverage.

Prior Authorization Required for Secondary Claims

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



Correction: Influenza and Tdap Vaccine Reimbursement Update

In August 2019, we began covering flu and Tdap vaccines for teens who are pregnant outside of the Vaccines for Children (VFC) program. The July BlueAlert incorrectly stated that we'd cover these vaccines for eligible teens under the age of 18. **We cover these vaccines until teens turn 19**.

If you're an OB/GYN caring for a pregnant teen who's under the age of 19 and covered by BlueCare or TennCare*Select*, we'll reimburse you for the cost of these vaccines in addition to the administration fee for giving them.

We apologize for any inconvenience this error may have caused.

Sterilization Consent Form Instructions Update

The Division of TennCare has revised the Sterilization Consent Form Instructions on its website to align with the Title 42 Code of Federal Regulations. Please find a summary of notable changes below:

- A claim denial should only occur if the form isn't completed and signed properly.
- The form becomes invalid if it's altered.
- An expiration date on the form isn't required for it to be considered valid.

To view the updated instructions and download versions of the consent form in English and Spanish, please visit the Miscellaneous Provider Forms page of tn.gov/tenncare.

Medicare Advantage

This information applies to our (PPO)[SM] BlueAdvantage plans.

Free Behavioral Health Services Available for Qualified Medicare Advantage Members

BlueCross has partnered with AbleTo to provide telephonic counseling and outreach for common behavioral health issues and emotional stress support to our Medicare Advantage members.

The program offers 16 telephonic sessions with a licensed therapist and a behavioral health coach during an eight-week course at no cost to the member. After enrolling in the program, members can access these services 24 hours a day, seven days a week.

To enroll, you or your patients may call **1-866-287-1802** between 8 a.m. and 10 p.m. Monday through Friday, or 10 a.m. to 6 p.m. on Saturday. AbleTo's clinical team will do an initial consultation to see if the member's condition is within their program's scope. Any program updates will be communicated with our member's PCP.

This program doesn't limit any other behavioral health services your patients have through their Medicare Advantage plan.

Online Provider Strategy September WebEx Opportunities

If you'd like to learn more about our Medicare Advantage provider quality program, please join us for an online presentation that offers an introductory look at the program structure and Provider Assessment Form (PAF) incentive program. For your convenience, we're offering two one-hour sessions – click on the date that works best for you:

- Sep. 19, 2019 at 10 a.m. (ET)
- Sept. 24, 2019 at 4 p.m. (ET)

Eye Exam Copays

Routine eye exam copays for BlueAdvantage members are referenced under the vision copay on the member's ID card. Routine eye exam claims for BlueAdvantage members should be filed to EyeMed. However, non-routine, medically related eye exams such as services performed by an ophthalmologist apply the specialist copay that's also listed on the member's ID card. Please bill these services to BlueCross' BlueAdvantage. You'll also need to collect the appropriate copay based on the type of care you perform.

Coding for Annual Wellness Visits and Provider Assessment Forms

Chronic conditions and health status codes should be assessed, documented and coded at least annually, using the highest level of specificity. While the Z00.xx diagnosis code may be appropriate for both the Annual Wellness Visit (AWV) and Provider Assessment Form (PAF), we encourage you to include any chronic conditions assessed or treated during the visit. Any condition that's been treated in the past and no longer exists can be coded using the appropriate history codes.

Our Medicare Advantage members are eligible to receive a wellness visit each calendar year. This offers an opportunity for your patient to receive a comprehensive preventive medicine evaluation and management focused visit. The PAF is an important tool for collecting information on your patient's current health status and may be completed during the wellness visit. It's a great opportunity to evaluate, treat and document your patient's chronic conditions and health status.

Pharmacy

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

Changes to the TennCare℠ Preferred Drug List

Please review notable changes to the TennCare Preferred Drug List (PDL) that may affect your patients' medications.

Effective July 1, 2019

On July 1, 2019, the Division of TennCare updated the Provider Notice for Partial Fill Requirements that went into effect Jan. 1, 2019. This notice outlines the process for submitting partially filled controlled substance prescriptions to Magellan. To review the updated notice, please see the Provider Notice for Partial Fillable Forms – Effective 1-1-19 (Updated 7-1-19) announcement on the News & Manuals Provider page of bluecare.bcbst.com.

Effective Aug. 1, 2019

The below medications have been moved to non-preferred status and removed from the list of branded agents classified as generics, and requests for these medications will be denied:

- Canasa
- Gleevec
- Pataday
- Tamiflu capsules

You can transition patients taking one of these drugs to the following generic medications. These medicines now have preferred status:

- Mesalamine suppository
- Imitanib
- Olopatadine drops
- Oseltamivir capsules

The following medications have also been removed from the list of branded medications classified as generic drugs. Requests for these brand names will require a new prior authorization:

- Flector
- Forfivo XL
- Adcirca
- Albenza

Effective Aug. 1, 2019 (continued)

To avoid delays at the pharmacy, you can transition patients to these generic drugs, which have all been moved to preferred status and will pay at the point of sale for patients with existing prior authorizations:

- Diclofenac patch (generic for Flector)
- Bupropion XL (generic for Forfivo XL)
- Tadalafil (generic for Adcirca)
- Albendazole (generic for Albenza)

For more information, please see the Provider Notice for Brand as Generic Removals – Effective 8-1-19, which is also available on the News & Manuals Provider page of bluecare.bcbst.com.

Note: The TennCare PDL doesn't apply to CoverKids members.

Changes Related to NDC and J-Codes

We've required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications since 2014. As of Sept. 1, 2019, we're now rejecting claims submitted without a valid NDC. Please be sure to include the full 11-digit NDC code on the claim, including any leading zeroes. You may refer to our Provider Administration Manuals for more information.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On Aug. 30, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization for all lines of business.

- Ogivri
- Mvasi

Please see our website for more information on all provider-administered specialty medications that require prior authorization.

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not 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 1-888-418-0008.

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.

Archived editions of BlueAlert are available online.

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CAQH Solutions | PROVIEW™

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

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

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
***Select*Community**	1-800-292-8196
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	1-800-924-7141
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)	

Important Note:

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

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

Questions? Call 1-800-924-7141.

of Tennessee

OCTOBER 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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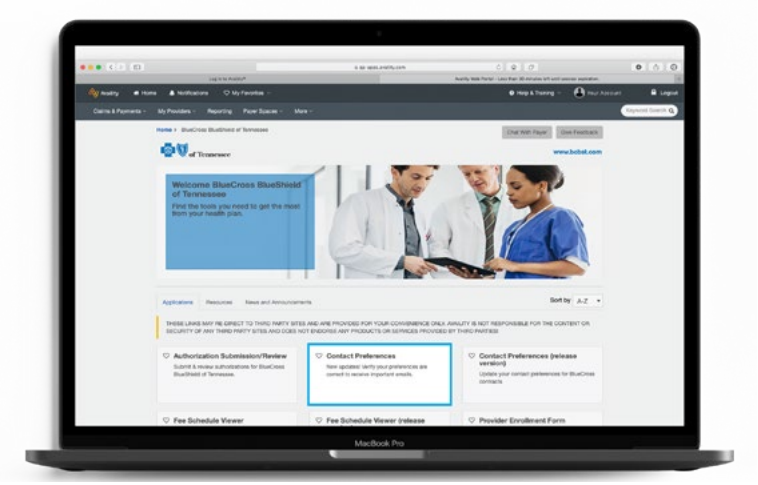


Enhancements in Availity®

We're constantly updating Availity to improve how you do business with us. To meet Provider Stability Act requirements, we're offering you more ways to get messages from us. By updating your **Contact Preferences**, you can opt-in to make email your preferred communication method. We're also adding new **Contact Types** and, starting in October, you can select how you want to receive **General Correspondence** and Operational information.

We've made updates to **Contact Preferences** to improve usability. We've added a notification to let you know if we've had issues with your email address. You can also now tell us if you wish to opt-out of receiving emails. Be sure to check your contact preferences to make sure you're getting important contracting messages and announcements that apply to you. Please continue to look for updates under the **News & Announcements** and **Notification Center** sections of Availity.

INSIDE THIS ISSUE

Multi-Payer Updates

We've made a recent update to the **Eligibility and Benefits Inquiry**, which lets you see more information for the following benefits:

- Colonoscopy
- Hearing Aid
- Contraceptive Benefits
- Pulmonary Rehab

You can find benefit information in multiple sections depending upon place of service, provider type and member coverage. Please see the **Availity Knowledge Center** for more on updates and enhancements.

Feature Announcements

With Availity, you can securely review claim status, check patient benefits and eligibility, see remittance advice, view Commercial fee schedules and access our other applications and updates any time.

When viewing Commercial fee schedules, you'll notice that we've simplified the Network ID and Network Name by adding an agreement description. BlueCare Fee Schedules are currently not available in Availity. If you have questions about your fee schedule, please call the Provider Service Line at 1-800-924-7141 or contact your local Network Manager.

Need Help?

To get your office started with Availity, please contact your eBusiness Regional Marketing Consultant or visit Availity.com.

Look for Major Improvements to the Provider Change Submission Process in Late 2019

Many changes are on the way for the Provider Change Form in late 2019, starting with a slight name revision. We'll begin referring to the change submission process as the **Provider Change Request** because it will no longer be a form. We're replacing the long PDF form currently on bcbst.com with an easier format you can access in our section of Availity.com.

Please continue to use CAQH Proview® to update your provider profile as we move toward using the CAQH database as the source for more of our provider information.

Enrollment Process Improvements Coming for Nurse Practitioners and Physician Assistants in late October

Starting Oct. 19, 2019, Nurse Practitioners and Physician Assistants who enroll with BlueCross will no longer have to submit a Supervising Physician Form. We're making the process easier by replacing the extra paperwork and required signature with a fillable field where you can simply enter the Supervising Physician's name. This update will apply for all Nurse Practitioners and Physician Assistants when they enroll using the Provider Enrollment Form at bcbst.com.

Redesigned Provider Web Pages to Launch Later this Year

We're redesigning our provider website to make it easier for you to find the information you need. Please look for more information about our website redesign in future issues of BlueAlert.

Get Ready for Flu Season

Fall signals the beginning of flu season in Tennessee. Consider offering these reminders to prepare your team – and your patients.

- Schedule patients' flu vaccines in advance and send appointment reminders. The Centers for Disease Control and Prevention recommends patients age 6 months and older get their flu shots by the end of October.
- Talk with your patients about why vaccination is important. Discuss the serious complications flu can cause, especially in young children, older adults and other at-risk patients.
- If you have young patients who will turn 6 months old toward the end of flu season, don't forget to order extra doses of the vaccine. The vaccine is often in short supply in February, March and April.

Help Improve Chlamydia Screening Compliance with Urine-Based Testing

Young women between ages 16 and 24 who are sexually active need a chlamydia screening every year. Your patients are considered sexually active if they use any form of contraception — regardless of the contraception's purpose.

If you're looking for a quick and accurate alternative to traditional screening, you may want to consider urine-based DNA testing. It's an easier test and may be preferable for younger patients.

The following recommendation from the Centers for Disease Control and Prevention outlines the preferred methods for screening:

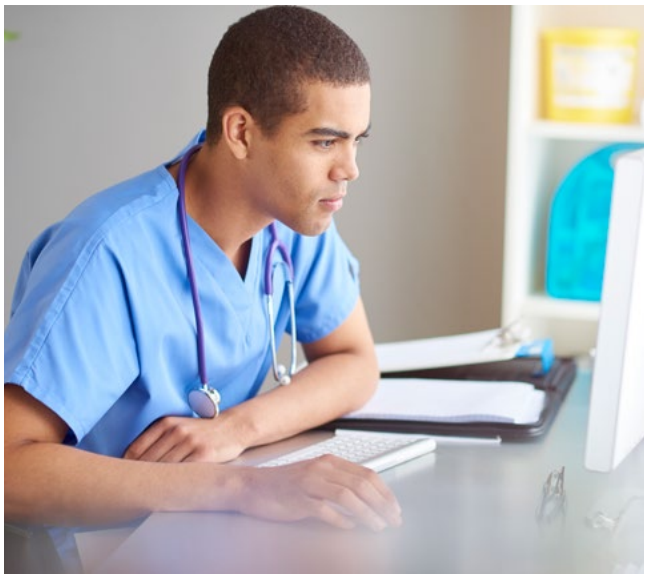
"*Chlamydia trachomatis* urogenital infection can be diagnosed in women by testing first-catch urine or collecting swab specimens from the endocervix or vagina. NAATs (non-nucleic acid DNA amplification tests) are the most sensitive tests for these specimens and therefore are recommended for detecting C. trachomatis infection. NAATs that are FDA-cleared for use with vaginal swab specimens can be collected by a provider or self-collected in a clinical setting".[1]

For more information about chlamydia screening and other preventive care recommendations, please see our Commercial or BlueCare Tennessee quality measures guides.

Reference:

[1]2015 CDC STD Treatment Guidelines

Billing Guidelines for Retinal Use of Avastin (bevacizumab)



Starting Dec. 1, 2019, ophthalmologists and pediatric ophthalmologists must bill HCPCS code J9035 for Avastin (bevacizumab) for intravitreal use. We will deny ophthalmology claims submitted for Avastin (bevacizumab) with any code other than J9035. Please note that this is a change from the last notification we sent in May 2019.

At this time, we will only reimburse one unit of bevacizumab per eye treated on a unique date of service, with a maximum of two units if both eyes are treated. Your claim must show the eye or eyes treated with the appropriate modifier.

Since June 1, 2018, this code hasn't required 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. Please refer to our provider administration manuals for additional HCPCS billing guidelines.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Boost Practice Efficiency by Assigning Staff Members to Deliver Well-Child Care

The daily schedule of a pediatric practice can be unpredictable. Some groups have found that they can improve practice efficiency by assigning team members or using floating staff to handle TennCare Kids checkups.

Designated or floating team members can focus on tasks that are essential to making sure children get needed preventive care, including:

- Reviewing patient records
- Contacting patients who are overdue for their Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exam
- Triaging sick visits that can be combined with well-care checkups

This frees up staff to handle other types of appointments and needs, ensuring all kids and teens get the care they need.

For more tips and best practices for delivering preventive care, please see our TennCare Kids Tool Kit.

Improving Health Outcomes in Tennessee

Good health outcomes start in the communities where your patients live, work and play. The Division of TennCare wants to learn more about the challenges your patients face in their communities to help you improve your patients' health.

Please take a few minutes to complete the Provider CARES survey at tn.gov. Your name will not be tied to your survey answers, but combined with information from all provider surveys to better understand community needs.

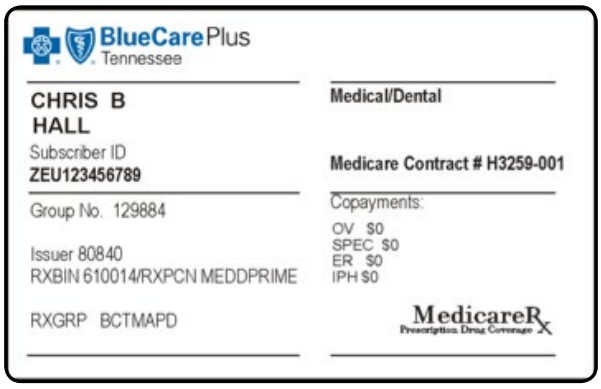
BlueCare Plus (HMO SNP)SM

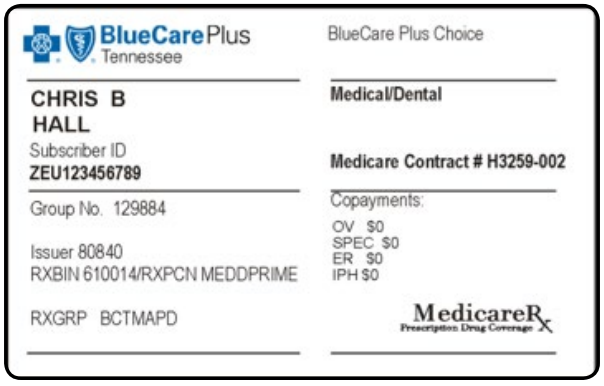
This information applies to our Medicare and Medicaid, dual-eligible special needs plan.

Introducing a New BlueCare Plus Tennessee Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan Option

Starting Jan. 1, 2020, BlueCare Plus Choice (BCPC) will be available for our Medicare and Medicaid CHOICES eligible members. BCPC members will be able to use their new BCPC ID card for all medical and pharmacy services, which eliminates the need for multiple cards. You'll only need to submit one claim – BCPC will process both Medicare and Medicaid benefits on one remittance advice, which can help reduce paperwork. BCPC will provide member incentives to help encourage provider engagement and offer reimbursements for requirements outlined in the BCP Model of Care. If you have questions about this new plan, please call the BlueCare Plus Provider Service line.

Sample ID Cards





BlueCare Plus Model of Care Training Due Soon

The BlueCare Plus Model of Care is designed to serve the unique individual needs of the dual-eligible Medicaid and Medicare population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs.

BlueCare Plus providers are contractually required to complete Model of Care Training after initial contracting and annually thereafter. This training is offered through self-study and attestation on the BlueCare Plus website: Model of Care Training.

The last date to be compliant by completing the training for 2019 is Dec. 31, 2019. All physicians are strongly encouraged to complete the training before the end of the year.

Medicare Advantage

This information applies to our BlueAdvantage plans.

BlueCross Inter-Plan Medicare Advantage Program Helps Coordinate Care

All BlueCross Medicare Advantage plans across the country, including ours, are now part of the Blue Cross Blue Shield Association's Inter-Plan Medicare Advantage Program.

This new plan-to-plan arrangement enhances the way Blue Plans support Medicare Advantage group accounts and their members who live outside their home plan service areas. This newly designed collaborative model connects these members with existing BlueCross BlueShield of Tennessee programs to better support Star scores, ensure appropriate risk adjustment and increase effectiveness in member care coordination.

The inter-plan program will help health insurance companies and providers coordinate between Blue Plans across state lines to close gaps in care. For example, if a member lives in Tennessee but is a member of another Blue Plan, they'll be part of our provider outreach efforts. Look for more details in upcoming issue of BlueAlert.

Changes Coming Soon to Quality Care Rewards (QCR) Tool Icons

To create consistency and improve the user experience, we'll soon be updating icons in the QCR tool. If you have questions or concerns about the updated icons, please call your Medicare Advantage Quality Outreach Consultant or the eBusiness team at (423) 535-5717 (Option 2) or email ebusiness_service@bcbst.com.

Provider Strategy October WebEx Opportunities

Would you like additional information about our Medicare Advantage Provider Quality program? Join us for an online look at the quality measures in the Medicare Advantage Provider Quality program and the Quality Care Rewards tool located within Availity. Select one of the two sessions below to learn more:

- Oct. 22, 2019 at 10 a.m. (ET)
- Oct. 30, 2019 at 11 a.m. (ET)

Pharmacy

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

2020 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 on the Pharmacy Resources & Forms page to view the 2020 Formulary changes

- 2020 Preferred Formulary Changes
- 2020 CoverKids Formulary Changes
- 2020 Essential Formulary Changes

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On Sept. 30, 2019, we added the following specialty medications to our Provider-Administered Specialty Pharmacy lists. They now require prior authorization for all lines of business.

- Asceniv
- Cutaquig
- Evenity
- Infugem

Please see our website for more information on all provider-administered specialty medications that require prior authorization.

BlueCare Tennessee Billing Update for Specialty Pharmacy Drugs*

Beginning Jan. 1, 2020, all BlueCare, TennCare*Select* and CoverKids claims for specialty pharmacy drugs must be submitted by specialty pharmacy providers. Claims for specialty drugs submitted by other providers will be denied.

If you administer a specialty drug, you may bill and receive reimbursement for an administration code, but a specialty pharmacy must bill for the cost of the drug. When administering a specialty drug at the same time as other services, please use the appropriate modifier on your claim for the office visit to receive reimbursement for the administration code.

Coding Tips for Specialty Pharmacy Providers

Specialty pharmacy providers should use each specialty drugs' assigned HCPCS codes on claims. Please only submit a miscellaneous HCPCS code if no assigned code exists. In these cases, include the following supplemental information on the claim:

- Drug name
- Dosage
- Amount supplied
- Valid NDC number

Please note this change doesn't replace other billing policies. Guidelines for timely filing, authorization requirements, coordination of benefits, etc. still apply.

To view a complete list of BlueCare Tennessee specialty pharmacy medications, please click here. To find an in-network specialty pharmacy, please see our Specialty Pharmacy Network reference document.

Changes Related to NDC and J-Codes

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of Tennessee

NOVEMBER 2019

BlueAlert℠

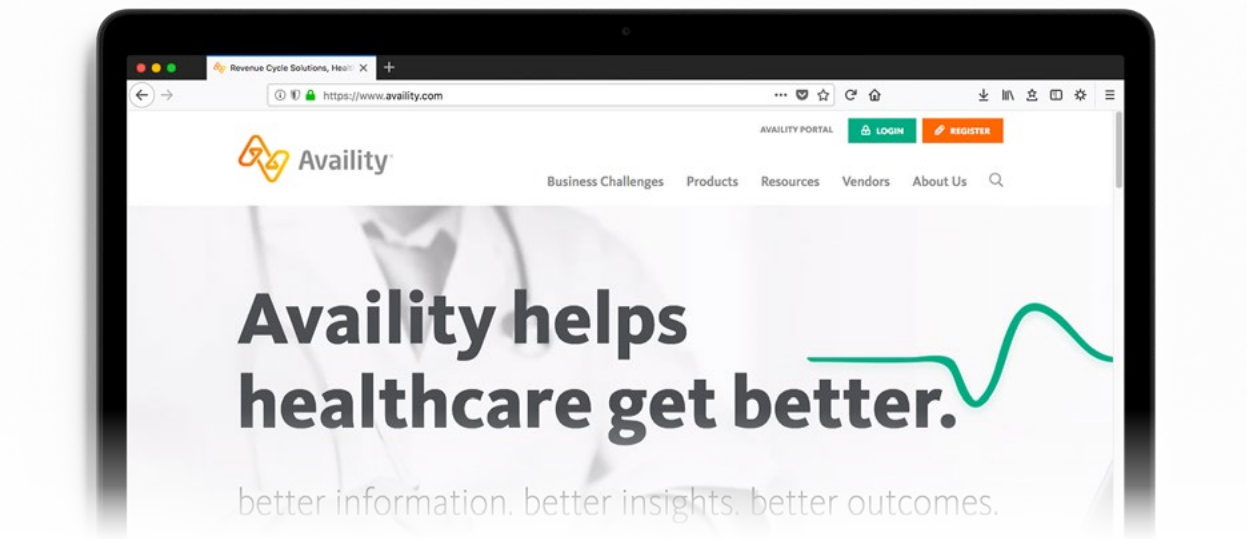
BlueCross BlueShield of Tennessee, Inc.

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

Redesigned Provider Web Pages Set to Launch Later this Year

We're redesigning our provider website to make it easier for you to find the information you need. We're also working to move more transactional documents behind Availity®. As part of this transition, the "Contact Us" link on our website will move to another area of our site. You can always find Provider Service Contact information in our BlueAlert newsletters as we move through the redesign.

INSIDE THIS ISSUE



Upcoming Changes in Availity Payer Spaces

We hope you've enjoyed the convenience of using Availity as a single place to interact with us online. If you send emails to customer service via **Send A Message** on Availity Payer Spaces, we'll soon start replying to the email address you've provided instead of your existing secure inbox under **View Messages**.

Since this process engages direct email-to-email contact, we're working to remove the **View Messages** Inbox from the Availity system at the end of the year. If you have messages saved there, please archive them before the inbox is retired. We'll send more information before that happens, but you may want to start reviewing messages now.

How to Find Announcements about Changes to Fee Schedules, Code Updates and Medical Policies

As part of the Provider Stability Act, we've taken special measures to make sure you know about changes to fee schedules, code updates and medical policies. In addition to sending you news about these changes in advance, we've stored all of these messages in the Contact Preference/Communication Viewer tile in Availity Payer Spaces. Be sure to verify your contact preference information to get these important communications.

Have questions or need help with Availity? Please visit Availity.com or contact eBusiness Service at **(423) 535-5717**, **option 2**.

Look for Major Improvements to the Provider Change Submission Process in Late 2019

Later this year, we're replacing the Provider Change Form that's posted on our website with an easier format that will be posted on Availity. We'll include more about these updates in future issues of BlueAlert.

In the meantime, please continue using the CAQH Proview® website to update your profile as we move toward using the CAQH database as the source for more of our provider information.

Enrollment Process Improvements Coming for Nurse Practitioners and Physician Assistants

Nurse Practitioners and Physician Assistants who enroll with BlueCross no longer have to submit a Supervising Physician Form. As of Oct. 19, 2019, you only need to enter the supervising physician's name in a fillable field. This update will apply for all Nurse Practitioners and Physician Assistants when they enroll using the Provider Enrollment Form at bcbst.com.

All Blue Workshops to be Paperless in 2020

Mark your calendar for next year's All Blue Workshops. For 2020, we're going paperless and will post the presentation on bcbst.com ahead of time. That way you can print your materials before the meeting or access them online during the event. Be sure to keep an eye out for more details in upcoming BlueAlerts.

March 5, 2020 – Chattanooga
Embassy Suites Chattanooga
2321 Lifestyle Way, Chattanooga, TN 37421

March 23, 2020 – Memphis
Holiday Inn University of Memphis
330 Innovation Drive, Memphis, TN 38152

March 24, 2020 – Jackson
DoubleTree Jackson
1770 Highway 45 Bypass, Jackson, TN 38305

April 8, 2020 – Nashville
Cool Springs Marriott
700 Cool Springs Drive, Franklin, TN 37214

April 14, 2020 – Kingsport
MeadowView Marriott
1901 Meadowview Parkway, Kingsport, TN 37660

April 15, 2020 – Knoxville
Hilton Knoxville
501 Church Avenue, Knoxville, TN 37902

Behavioral Health in Pediatrics (BeHiP) Training to be Held in Chattanooga

BeHiP is offering provider training, sponsored by BlueCross and TNAAP, to introduce you to the Chattanooga Learning Collaborative. It will be on Saturday, Nov. 2, 2019, at the Erlanger Medical Center Campus in Chattanooga, Tennessee. The training is designed to help you provide more comprehensive care for your pediatric patients with behavioral health issues.

Learn how you can:

- Connect with regional behavioral health resources.
- Get online access to child/adolescent psychiatrists and psychologists.
- Develop relationships with your local DCS office
- Bill more efficiently for these services.

Additionally, you can get CME credit for this training and reimbursement for your time.

For more information or to register, please visit the BeHiP website.

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Additional Provider Directory Designations Coming Soon

Starting at the end of January 2020, we're making a change to the online provider directory to help our members make more informed health care decisions.
As you may be aware, our directory already includes patient ratings of network providers. In late January we'll also include a BlueCross rating for our Commercial Primary Care Providers (PCPs).

While this is a common practice among health care payers, rating systems vary. That's why we'd like to provide details of our rating system to you in advance. By late-November, we'll send all practices with PCPs who participate in Blue Network P and Blue Network S more information, including:

- The BlueCross ratings for the practice's individual PCPs
- How the ratings are calculated
- Who to contact with questions
- How to provide additional information or comments

We appreciate your assistance and look forward to working together to improve the effectiveness of our provider directory.

Upcoming Non-Compliance Updates in the Commercial Provider Administration Manual*

Effective Jan. 1, 2020, you'll see the following changes related to non-compliance:

- The timeframe for submitting emergency admission authorization will change from 24 hours to two business days for the Commercial line of business.
- Emergency admissions will require authorization within two business days after services have started or within one business day after conversion from observation to inpatient status.
- Concurrent reviews should be requested before approval expiration or within one business day of the last day approved.
- When prior authorization is required for elective procedures, you must obtain authorization before any scheduled services.
- Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved. If you don't comply within specified authorization timeframes, benefits will be denied or reduced from non-compliance. As a reminder, we BlueCross BlueShield of Tennessee Providers can't bill members for covered services denied due to non-compliance.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Jan. 1, 2020, CPT® codes 0113U, 86152 and 86153 will require authorization through the Genetic Testing Program administered by eviCore.

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

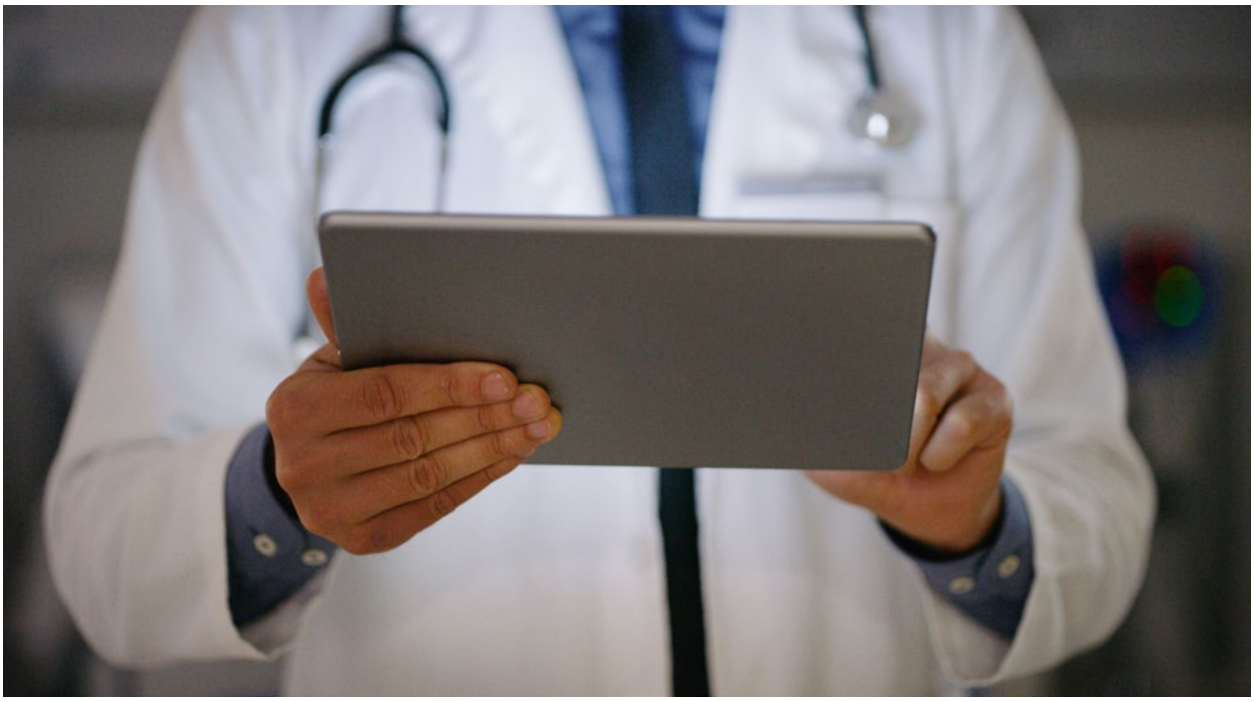
Prior authorization requests can be submitted through Availity. You may also fax them to eviCore at 1-888-693-3210 or call them at 1-888-693-3211.

Billing Accuracy and Cost Control

As a reminder, an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. Please remember to submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, or the itemized bill doesn't match the total claim, your claims may be denied or returned. If they're returned, you'll need to resubmit them along with the itemized bill.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.



Opioid Risk Reports Offer Insight into Patients' Opioid Use

We're committed to promoting the appropriate use of opioids and keeping our members safe. That's why we're working with axialHealthcare to give providers in the BlueCare and TennCare*Select* networks a new tool to support the health and safety of their patients who use opioids.

The opioid risk report provides member-level data about patients' opioid use and factors that may put their health at risk. To view a sample report, please click here.

If you care for patients who use opioids — especially if they receive opioids from more than one provider or use opioids in combination with other medications, such as benzodiazepines – you may receive one of these reports. They'll come directly from axialHealthcare, and you can choose to get them by email, fax or electronic health record direct messaging.

If you have questions about your reports or would like to request a consultation on pain management and opioid therapy, please contact the axialHealthcare team at providersupport@axialhealthcare.com.

Note: This doesn't apply to CoverKids.

Transportation Services Available for BlueCare Tennessee Members

If your patients can't get to appointments for covered services, like Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups, please let them know they have an option. BlueCare Tennessee has contracted with Southeastrans to provide certain transportation services for BlueCare and TennCare*Select* plan members. They can use Southeastrans to get to and from covered medical services including pharmacies at no charge.†

Southeastrans offers three types of transportation:

- Shared rides
- Bus passes
- Mileage reimbursement

When your patients call to schedule their transportation, Southeastrans will help them choose the best option for them.

If they need to travel less than 90 miles, your patients can book their ride online at southeastrans.com or by calling the phone number for their plan and region below:

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

If your patients need to travel more than 90 miles to visit your office, please ask them to call us at the appropriate Customer Service line:

- **BlueCare — 1-800-468-9698**
- **TennCare*Select* — 1-800-263-5479**

In most cases, your patients must schedule their transportation at least 72 hours before their health care visit to guarantee a ride. Exceptions to this 72-hour requirement include:

- Non-emergency transportation to health care services that must happen on the day of the request or to same-day appointments with outpatient behavioral health providers
- Transportation home after a hospital or crisis stabilization unit discharge

For more information, please visit bluecare.bcbst.com/members and select **Get a Ride**.

Note: The information in this article doesn't apply to CoverKids members.

† Transportation services are limited to those included as benefits under BlueCare and TennCare*Select*.

Improving Health Outcomes in Tennessee

Good health outcomes start in the communities where your patients live, work and play. The Division of TennCare wants to learn more about the challenges your patients face in their communities to help you improve your patients' health.

Please take a few minutes to complete the Provider CARES survey at tn.gov. While your name will not be tied to your survey answers, your answers will be combined with information from all provider surveys to better understand community needs.

Prior Authorization Required for Secondary Claims

Please remember that prior authorization requirements apply when you submit claims for secondary payment from BlueCare or TennCare*Select*. Prior authorization is not necessary if the primary carrier is Medicare and the services provided are covered by Medicare, hospice services where Medicare is primary, or if the primary carrier provided benefits and there are no plans to file a secondary claim. Services not covered by Medicare, or where Medicare benefits are exhausted require prior authorization as outlined in the Provider Administration Manual.

Note: Retrospective review can be requested for members with Medicare when Medicare fails to provide benefits for services typically covered.

BlueCare Plus (HMO SNP)SM

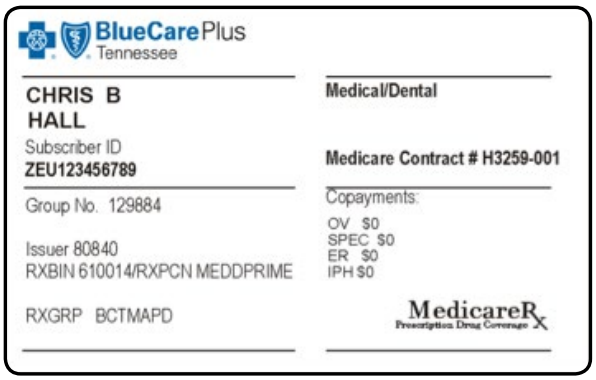
This information applies to our Medicare and Medicaid, dual-eligible special needs plan.

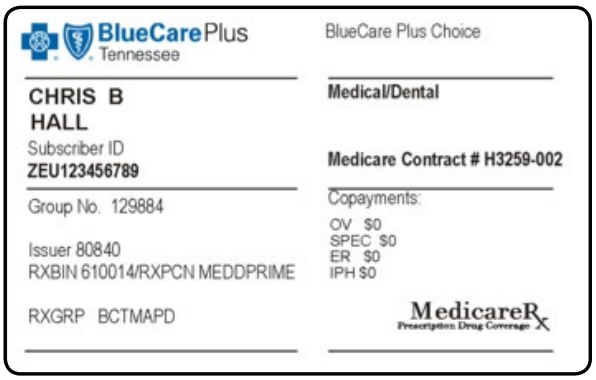
Introducing a New BlueCare Plus Tennessee Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan Option*

Starting Jan. 1, 2020, BlueCare Plus Choice (BCPC) will be available for our Medicare and Medicaid CHOICES-eligible members. BCPC members will use one identification card for all medical and pharmacy services, keeping their current BlueCare Plus, BlueCare and CHOICES benefits. You'll only need to submit one claim – BCPC will process both Medicare and Medicaid benefits on one remittance advice, which can help reduce paperwork. BCPC will help encourage provider engagement and offer provider reimbursements for completion of requirements outlined in the BCP Model of Care. To support this initiative, we'll also give member incentives if they engage with these providers.

If you have questions about this new plan, please call the BlueCare Plus Provider Service line.

Sample ID Cards





BlueCare Plus Model of Care Training Due Soon

The BlueCare Plus Model of Care serves the unique needs of the dual-eligible Medicaid and Medicare population by promoting high-quality, cost-effective care. A large part of this centers on the coordination of care for members with complex, chronic or catastrophic conditions.

BlueCare Plus providers are contractually required to complete Model of Care Training after initial contracting and annually thereafter. This training is offered through self-study and attestation on the BlueCare Plus website at Model of Care Training.

Prior Authorization Requirements for BlueCare Plus Choice Plan Members

Effective Jan. 1, 2020, prior authorization requirements for coverage and medical necessity for **BlueCare Plus Choice plan** members will include services that currently require prior authorization for BlueCare Plus:

- All acute care facility, skilled nursing facility (one day prior hospital stay required), and rehabilitation facility inpatient admissions
- Mental health acute inpatient admissions
- Substance abuse inpatient admissions
- Select musculoskeletal surgical procedures
- Part B and specialty pharmacy medications
- Durable medical equipment rentals
- Durable medical equipment purchases if the price is more than $500
- Orthotics and prosthetics purchases if the price is more than $200
- Home health services to include all therapies, nursing visits and psychiatric visits
- Outpatient speech, occupational and physical therapy
- High-tech imaging
- Non-emergent out-of-network services
- Non-preferred brands of diabetic testing supplies
- Non-emergency ambulance transportation
- Home ventilator devices
- Wearable defibrillator devices
- Mental health partial hospitalization program (PHP) (excludes substance abuse partial hospitalization, which no longer requires prior authorization)
- Electroconvulsive therapy (both inpatient and outpatient)
- Neuropsychological testing and psychological testing
- Transcranial magnetic services

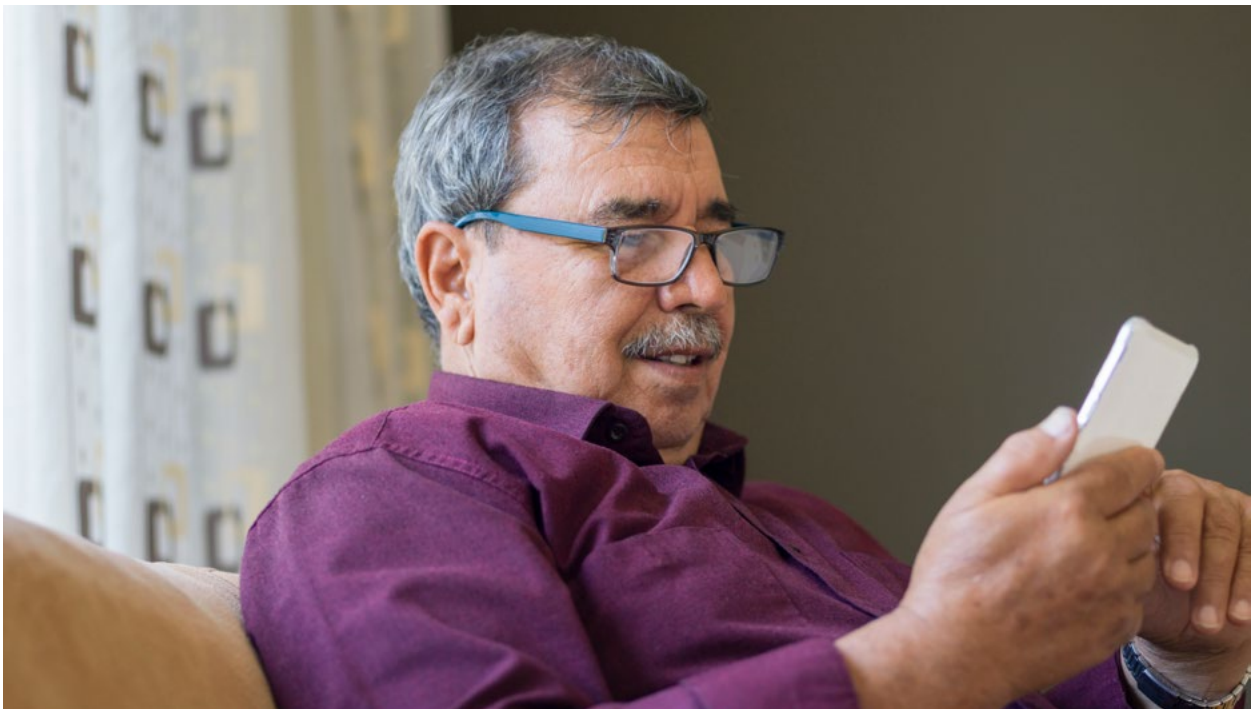
Observation stays require you to notify our utilization management to support required TennCare reporting and start the transition of care process.

Additional prior authorization requirements for **BlueCare Plus Choice members** only include:

- Private duty nursing if a member:
  - Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy); or
  - Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day to avoid or delay tracheostomy (requires medical review); or
  - Has a functioning tracheostomy that requires suctioning and needs other specified types of nursing
- Home health aide visits and services
- Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) if considered medically necessary. Surgery on the non-diseased breast to establish symmetry between the two breasts.
- Arthroscopy
- Nerve conduction studies
- Epidural steroid injections
- All services performed by a plastic specialist, including but not limited to:
  - Abdominoplasty/panniculectomy
  - Blepharoplasty
  - Breast reduction
  - Reconstructive repair pectus excavatum
  - Vein ligation
- All hyperbaric oxygen therapy
- All bariatric surgeries
- All food supplements and substitutes, including formulas taken by mouth
- Incontinence diaper supplies (more than 200 per member per month)

Medicare Advantage

This information applies to our BlueAdvantage MA PPO plans.



Free Behavioral Health Services Available for Qualified Medicare Advantage Members

BlueCross has contracted with AbleTo to provide telephonic counseling to BlueAdvantage MA PPO plan members who need help with common behavioral health issues and emotional stress support.

The program offers 16 telephonic sessions with a licensed therapist and a behavioral health coach during an eight-week course at no cost to the member. After enrolling in the program, members can access these services 24 hours a day, seven days a week.

To enroll, you or your patients may call **1-866-287-1802** between 8 a.m. and 10 p.m. Monday through Friday, or 10 a.m. to 6 p.m. on Saturday. AbleTo's clinical team will do an initial consultation to see if the member's condition is within their program's scope.

This program doesn't limit any other behavioral health services your patients have through their Medicare Advantage plan.

BlueCross Inter-Plan Medicare Advantage Program Helps Coordinate Care

All BlueCross Medicare Advantage plans across the country, including ours, are now part of the Blue Cross Blue Shield Association's Inter-Plan Medicare Advantage Program.

This new plan-to-plan arrangement enhances the way Blue Plans support Medicare Advantage group accounts and their members who live outside their home plan service areas. This newly designed collaborative model connects these members with existing BlueCross BlueShield of Tennessee programs to better support Star scores, ensure appropriate risk adjustment and increase effectiveness in member care coordination.

The inter-plan program will help health insurance companies and providers coordinate between Blue Plans across state lines to close gaps in care. For example, if a member lives in Tennessee but is a member of another Blue Plan, they'll be part of our provider outreach efforts. Look for more details in an upcoming issue of BlueAlert.

Pharmacy

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

Formulary Information Now on Commercial Member ID Cards

Most of our members use their prescription drug coverage more than any other benefit. Our new Commercial member ID cards, printed Oct. 1, 2019 or later, now display which formulary each member's health plan includes. We're not reissuing existing cards for this change, so members who don't get new cards can log in to BlueAccess℠ and download a digital copy that shows their formulary. Individual on- and off-Marketplace plan members' cards already show formularies.

Please note that this information won't appear on ID cards for members who don't have our prescription coverage. Click here to see an image of this information displayed on Member ID cards.

Changes to the TennCare℠ Preferred Drug List

Please review notable changes to the TennCare Preferred Drug List (PDL) that may affect your patients' medications.

Effective Oct. 1, 2019

The PDL status changed for certain drugs in the anti-infective, central nervous system, and oncologic, immunologic and ophthalmic agents covered drug classes. Additionally, the following drugs were removed from the list of branded agents classified as generics. Future requests for these medications will require a new prior authorization:

- Ranexa
- Advair Diskus

You can transition your patients to the following generic medications, which are now covered for patients with existing prior authorizations:

- Ranolazine ER (generic for Ranexa)
- Fluticasone/salmeterol (generic for Advair Diskus)

To view the full provider notices outlining these PDL changes, please see the Provider Notice for 10.01.19 PDL Changes and Provider Notice for Brand as Generic Removals – Effective 10.01.19 in the News and Manuals Provider section of bluecare.bcbst.com.

Note: The TennCare PDL doesn't apply to CoverKids members.

BlueCare Tennessee Billing Update for Specialty Pharmacy Drugs*

Beginning Jan. 1, 2020, all BlueCare, TennCare*Select* and CoverKids claims for specialty pharmacy drugs must be submitted by specialty pharmacy providers. Claims for specialty drugs submitted by other providers will be denied.

If you administer a specialty drug, you may bill and receive reimbursement for an administration code, but a specialty pharmacy must bill for the cost of the drug. When administering a specialty drug at the same time as other services, please use the appropriate modifier on your claim for the office visit to receive reimbursement for the administration code.

Coding Tips for Specialty Pharmacy Providers

Specialty pharmacy providers should use each specialty drug's assigned HCPCS codes on claims. Please only submit a miscellaneous HCPCS code if no assigned code exists. In these cases, include the following supplemental information on the claim:

- Drug name
- Dosage
- Amount supplied
- Valid NDC number

Please note this change doesn't replace other billing policies. Guidelines for timely filing, authorization requirements, coordination of benefits, etc. still apply.

To view a complete list of BlueCare Tennessee specialty pharmacy medications, please click here. To find an in-network specialty pharmacy, please see our Specialty Pharmacy Network reference document.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On Oct. 31, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization for all lines of business.

- Kanjinti
- Polivy
- Triluron
- Zirabev
- Zolgensma

Starting Nov. 30, 2019, the following specialty medications will be added to the Provider-Administered Specialty Pharmacy lists and require prior authorization for all lines of business:

- Belrapzo
- Ruxience
- Xembify

Please see our website for more information on all provider-administered specialty medications that require prior authorization.

Step Therapy for Additional Medicare Part B Drugs

Beginning Jan. 1, 2020, BlueAdvantage, BlueCare Plus and BlueEssential will implement step therapy for additional Part B drugs. According to CMS guidelines, Part B drug step therapy applies only when a Medicare Advantage plan member receives a new prescription for one of the medications include. Prior authorization and step therapy will be required for the following Part B drugs: Aloxi/Sustol, Fusilev, Prolia/Xgeva, Eylea, Lucentis, Macugen, Khapzory, Hemlibra, Cerezyme, Signifor LAR, and Renflexis. You can view our online medical policies by clicking here.

Quality Care Rewards

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

Quality Care Rewards Updates Go Live This Month

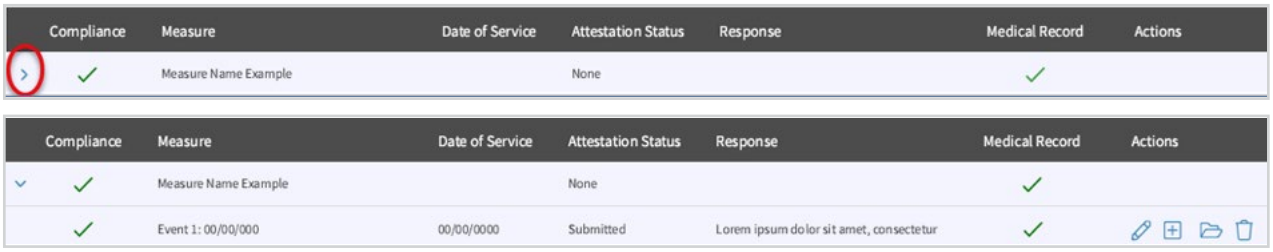
We've made some changes to the Quality Care Rewards (QCR) application that we hope you'll find helpful. Please see below for a summary of notable upcoming updates, which will go live at the end of November.

1. Single HEDIS® Measure Event Dates

You'll be able to view the Single Measure Event Dates for the following measures:

- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment & Effective Continuation Phase
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Chlamydia Screening in Women
- Osteoporosis Management in Women Who Had a Fracture (OMW) and OMW 2020

To view the event date and your options for attesting to the measure, click the expand arrow that will be located next to each measure.

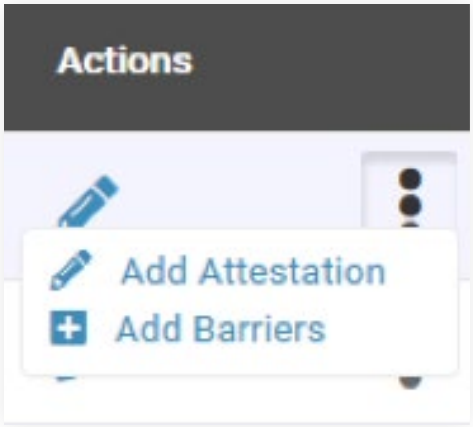
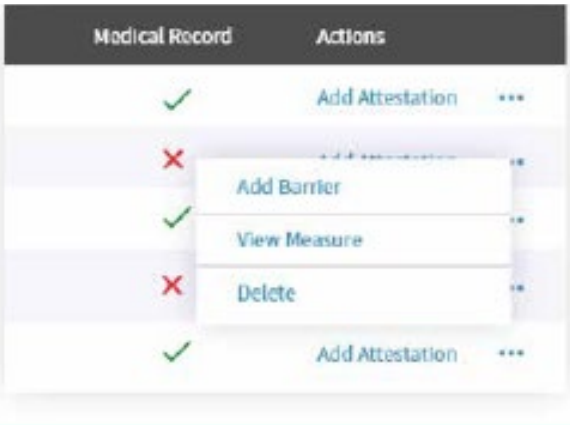


2. Reopen Flag

You'll soon see a flag when an attestation doesn't close a measure or if the measure is no longer compliant after a QCR refresh.

3. **Icon Updates**

The Measure Action Icons on the Member page will be updated as shown below. The pencil will be removed and replaced with **Add Attestation**.

Before	After
	

4. **Delete Practice Notes**

You'll be able to delete your practice notes. If you're unable to delete the notes, please call **(423)535-5717**, **option 2**, and submit a request to have them removed.

If you have questions about these new features, please contact your eBusiness Regional Consultant.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). See www.ncqa.org.

BlueCross BlueShield of Tennessee, Inc. complies with the applicable federal and state laws, rules and regulations and does not 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 1-888-418-0008.

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, Inc. or any of its licensed affiliates. 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.

Archived editions of BlueAlert are available online.

*Changes will be included in the next provider administration manual update as applicable.

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

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
***Select*Community**	1-800-292-8196
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	1-800-924-7141
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)	

Important Note:

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

- Email a completed Provider Change Form and any attachments to us at PNS_GM@bcbst.com.
- Update your provider profile on the CAQH Proview™ website.

Questions? Call 1-800-924-7141.

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of Tennessee

DECEMBER 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Upcoming Changes in Availity®

When you send emails to customer service via **Send a Message** on Availity Payer Spaces, we'll reply to the email address you've provided instead of your existing secure inbox under **View Messages**. We're planning to remove the **View Messages** Inbox from the Availity system at the end of the year. Message history in the **View Messages** inbox will no longer be available.

Multi-Payer Updates

We updated the **Eligibility** and **Benefits Inquiry**, which lets you see more information for the following benefits:

- Specialty Pharmacy
- Colonoscopy under Diagnostic Medical

You can find benefit information in multiple sections depending upon place of service, provider type and member coverage. Please see the **Availity Knowledge Center** for more on updates and enhancements.

INSIDE THIS ISSUE

Find a Doctor Tool Now Using CAQH as Provider Data Source

We continue to increase the use of CAQH as our source for provider data, which now includes our **Find a Doctor** tool. Now, members searching for doctors in our online directory will see the most current provider information.

As part of this process, we'll load the data from our provider directory to CAQH Direct Assure. This may trigger a notice in CAQH Proview® asking you to confirm additional practice location details for data you've reported to us, but isn't currently shown in CAQH Proview.

By confirming your data, you can help us avoid sending out lengthy paper Data Verification Forms each quarter. We'll soon have a much shorter form that will cover only things not captured in the CAQH Proview Portal.

If you have any questions about this process, please contact Provider Service at **1-800-924-7141**.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses. If you're not sure when it's time to renew your license, please take a look. A current license tops our list of required provider credentials and we're obligated to terminate providers from our network when their licenses expire. Providers who want to rejoin the network will have to reapply and go through the credentialing process again. It's also important to note that we don't cover claims during the period of the lapsed license.

New Prior Authorization Requirement for Proton Beam Therapy

BlueAdvantage PPO℠ members and BlueCare℠, TennCare*Select* and CoverKids℠ members age 21 and over will require a prior authorization for proton beam therapy beginning Jan. 1, 2020.

To request prior authorization for proton beam therapy:

- **For BlueCare, TennCare*Select* or CoverKids –** Complete the Prior Authorization Request Form and fax it to **1-800-292-5311**.
- **For BlueAdvantage –** Complete the PPO Services Authorization Request Form and fax it to **1-888-535-5243**.

All Blue Workshops to be Paperless in 2020

Mark your calendar for next year's All Blue Workshops. For 2020, we're going paperless. We'll post the materials on bcbst.com before the meeting, so you can print them ahead of time or access them online during the event. Keep an eye out for more details in upcoming BlueAlert newsletters.

March 5, 2020 – Chattanooga
Embassy Suites Chattanooga
2321 Lifestyle Way, Chattanooga, TN 37421

March 24, 2020 – Memphis
Holiday Inn University of Memphis
330 Innovation Drive, Memphis, TN 38152

March 25, 2020 – Jackson
DoubleTree Jackson
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April 8, 2020 – Nashville
Cool Springs Marriott
700 Cool Springs Drive, Franklin, TN 37214

April 14, 2020 – Kingsport
MeadowView Marriott
1901 Meadowview Parkway, Kingsport, TN 37660

April 15, 2020 – Knoxville
Hilton Knoxville
501 Church Avenue, Knoxville, TN 37902

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

BlueCross Marketplace Plans Available in Nashville and Memphis in 2020

For the first time since 2016, we're offering on- and off-Marketplace plans in every county across the state. These plans will become effective Jan. 1, 2020. This means that Nashville and Memphis providers participating in Blue Network S will start seeing patients with these plans. Please note that you'll be reimbursed for services rendered based on your existing Blue Network S rates. For more information, please contact your network manager.

Billing Accuracy and Cost Control

An itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. Please remember to submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, or the itemized bill doesn't match the total claim, your claims may be denied or returned. If they're returned, you'll need to resubmit them along with the itemized bill.

Please be sure to clearly identify all the services and/or supplies you've provided on your itemized bill, either by description or the valid corresponding CPT®/HCPSCS code(s). If we can't identify all of these services or supplies, we may not be able to reimburse you for them.

Review Updated Guidelines for Authorization Non-Compliance in the Upcoming Commercial Provider Administration Manual*

Please review important changes to our Provider Administration Manual regarding non-compliance with prior authorization requirements that become effective Jan. 1, 2020.

- The timeframe for submitting emergency admission authorization will change from 24 hours to two business days.
- Emergency admissions will require authorization within two business days after services have started or within one business day after conversion from observation to inpatient status.
- You'll need to request concurrent reviews before approval expiration or within one business day of the last day approved.
- When prior authorization is required for elective procedures, you must obtain authorization before any scheduled services.
- Prior authorization compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved. Coverage can be reduced or denied for services that don't comply within specified authorization timeframes. Network providers can't bill members for covered services denied due to non-compliance.

Behavioral Health Program Changes for AT&T Members

Starting **Jan. 1, 2020**, Blue Cross and Blue Shield of Illinois will administer behavioral health benefits for our members enrolled in an AT&T health plan. This change replaces Beacon Health Option as AT&T's current behavioral health administrator.

Please submit claims for **dates of service on or after Jan. 1, 2020** to your local Blue Plan.

AT&T members have the three-character prefix **PAS or VXV** on their member ID cards, which they were notified about in October 2019. If you or your patients have questions about benefits and eligibility, please contact the number on the member's ID card.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Clarification for Billing School-Based Behavioral Health Services

When community mental health centers provide school-based services covered by TennCare, they must be reimbursed by TennCare managed care organizations (MCOs) if the services are medically necessary and billed appropriately. Since behavioral health services are no longer required to be in Individual Education Programs (IEPs), MCOs can't recoup claim payments simply because the services weren't listed in the IEP.

In contrast, school districts that are reimbursed as providers must include the behavioral health service in the IEP. Under some circumstances, school districts may contract with MCOs. That process would be the same as treatment given by any other MCO-contracted provider.

Please note that all TennCare-covered, medically necessary services provided on school grounds must be billed with the place of service code 03, which CMS defines as any facility whose primary purpose is education. If you have questions, please contact your Behavioral Health Network Manager.

BlueCare Tennessee Resources to Support Your Success

We want to make it easy for you to find the information you need to perform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams.

You can find the following resources on the Provider pages of bluecare.bcbst.com:

BlueCare Tennessee Provider Administration Manual (PAM) – This manual, which is updated every quarter, features comprehensive information about your patients' benefits.

TennCare Kids Tool Kit – Our TennCare Kids Tool Kit contains best practices for delivering and coding EPSDT exams, along with information about patients' transportation benefit and reference materials for publicizing community outreach events.

One other technique is to host a well-child community outreach event at your practice, so your patients have another easy way to get preventive care. We're happy to help you host one of these events. For more information, simply call us at 1-800-771-0217 or fill out our Community Outreach Provider/Agency Referral Fax Form and fax it to (423) 591-9165.

Note: EPSDT exams don't apply to CoverKids members.

Helping Your BlueCare Patients Get a Ride Just Got Easier

No matter where your patients covered by BlueCare live in Tennessee, they can now call **1-855-735-4660** to schedule a ride to covered medical services.

The number for TennCare*Select* isn't changing, so your patients with this coverage should continue to call **1-866-473-7565** to schedule their transportation.

To learn more about your patients' transportation benefit, please visit bluecare.bcbst.com/members and select **Get a Ride**.

Note: This information doesn't apply to CoverKids members.

BlueCare Plus (HMO SNP)SM and Medicare Advantage

This information applies to our Medicare and Medicaid, dual-eligible special needs plan.

Billing for Multiple Places of Service

BlueAdvantage and BlueCare Plus can't accept claims billed with multiple places of service on the same claim when the services are paid under the Medicare Physician Fee Schedule or anesthesia fee schedule. We'll return claims billed this way, so providers are able to file a corrected claim.

Please refer to CMS guidance for more information about this billing requirement.

Medicare Advantage

This information applies to our BlueAdvantage MA PPO plans.

New Prior Authorization Fax Forms Available Jan. 1, 2020

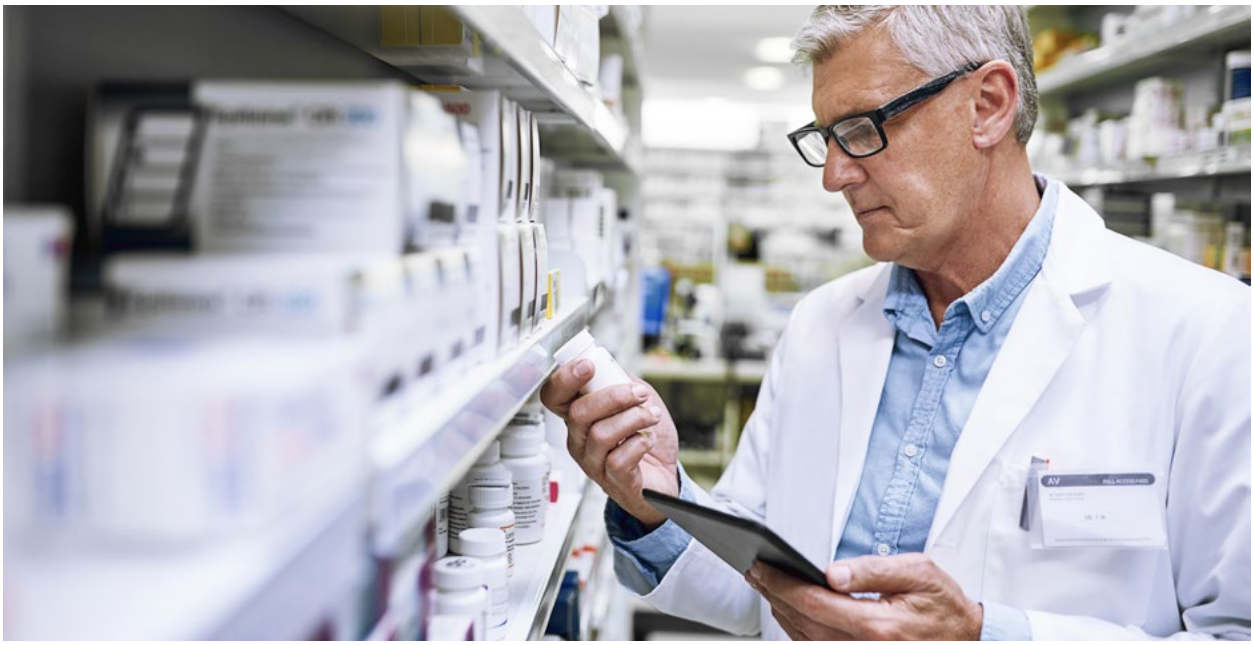
Starting Jan. 1, 2020, new prior authorization fax forms will be under the Medicare Advantage forms section on our provider page at bcbst.com.

More specific custom forms will include:

- Inpatient/outpatient admission/surgery request
- Predeterminations
- Home Health Services
- DME Requests
- Outpatient Therapies
- Provider Appeals (post service medical necessity appeals)

Pharmacy

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



New Prior Authorization Requirement for Provider-Administered Specialty Medications

On Nov. 30, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization for all lines of business.

- Belrapzo
- Ruxience
- Xembify

Please see our website for more information on all provider-administered specialty medications that require prior authorization.

Requesting Provider-Administered Specialty Drug Prior Authorizations for Federal Employee Program Members

You now have two ways to request prior authorization for provider-administered specialty drugs for Federal Employee Program (FEP) Commercial members:

- Log in to Availity.com anytime
- Call FEP customer service at 1-800-572-1003 (Monday through Friday, from 8 a.m. to 6 p.m. ET)

When calling, listen for the specialty drug authorization prompt that will connect you directly to MagellanRx, which manages these prior authorizations. Please note we no longer accept faxed or mailed prior authorization requests.

Changes Related to NDC and J-Codes

We've required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications since 2014. As of Sept. 1, 2019, claims received without a valid NDC will be rejected. Please be sure to include the full 11-digit NDC code on the claim, including any leading zeroes. You may refer to our Provider Administration Manuals for more information.

Quality Care Rewards

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

Tennessee Health Care Innovation Initiative (THCII) Delivery System Transformation Success

TennCare has announced positive results from ambitious changes it made to influence the way health care is paid for and delivered in Tennessee. The Division published a report that discusses the success of its Delivery System Transformation programs: Tennessee Health Link, Patient-Centered Medical Home, and Episodes of Care. The report provides the most up-to-date picture of how the state's innovative programs are improving care for TennCare members while also delivering significant savings for Tennessee taxpayers.

For more information including TennCare's press release and program analytics reports, please visit https://www.tn.gov/tenncare/health-care-innovation.html.

THCII Episodes of Care Program Payments and Recoupments Coming This Month

The 2018 Final Performance Reports for both Medicaid and Commercial providers were released in August to Quarterbacks participating in the Episodes of Care Program. Quarterbacks receiving either a Gain Share Payment or Risk Share Recoupment for the 2018 performance period will receive a letter about their performance in December. Please contact your provider network manager if you have any questions.

Simple Tips to Improve Quality Care for Patients

When patients are trying to understand medical conditions and recommended treatments, they can sometimes feel overwhelmed by the information they're receiving. This can sometimes affect whether their treatment is successful. Here are some easy tips that can help you make sure your patients are getting the information they need.

1. **Explain things in ways that are easy to understand.** When talking with patients about a medical condition or treatment plan, try to avoid medical jargon. Consider using shared decision-making tools to help patients learn more about their conditions and options for treatment.
2. **Make eye contact with your patients, and spend time listening carefully to them.** Ask your patients or their caregivers if they have concerns, as well as questions. The National Institutes of Health (NIH) recommends asking open-ended questions that require patients to reveal more than a simple yes or no. Additionally, talk with them about the care they receive from other providers to make sure they understand all of the information they're receiving about their treatment plan.
3. **Be as respectful as possible about patients' thoughts and beliefs, and try to continue conversations at the next visit if they refuse care.** For example, if parents don't want their child to receive a needed vaccination, work with them to find one action item that you can agree upon, like scheduling a follow-up appointment.
4. **Use the teach-back method, which involves asking patients to explain what they need to do in their own words.** According to the NIH, this technique lets you see if patients need additional information or if they understand the information you presented.

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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, Inc. or any of its licensed affiliates. 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.

Archived editions of BlueAlert are available online.

*Changes will be included in the next provider administration manual update as applicable.

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

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
***Select*Community**	1-800-292-8196
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	1-800-924-7141
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)	

Important Note:

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

- Email a completed Provider Change Form and any attachments to us at PNS_GM@bcbst.com.
- Update your provider profile on the CAQH Proview™ website.

Questions? Call 1-800-924-7141.

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