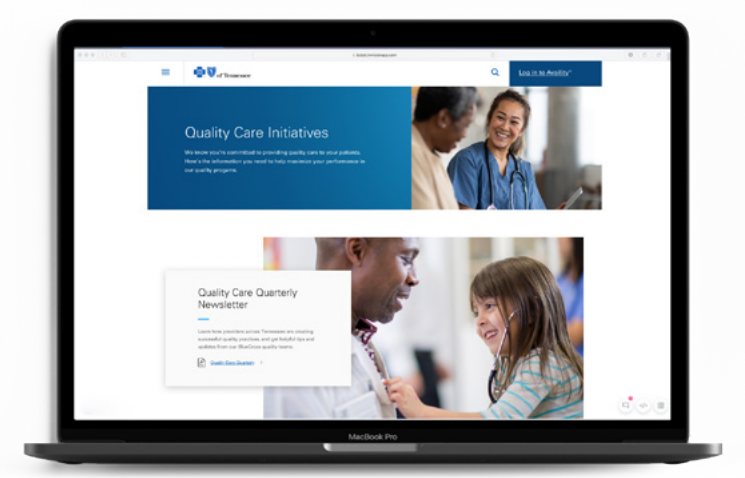
of Tennessee

JANUARY 2020

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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



Redesigned Provider Web Pages Set to Launch Early Next Year

We're redesigning our provider website to make it easier for you to navigate our pages and find the information you need from us fast. Look for more information about our website redesign in future issues of BlueAlert.

INSIDE THIS ISSUE

Code/Modifer Requirement Updates

Effective March 1, 2020, we'll reject and/or return claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus (HMO SNP℠) lines of business. You can resubmit the claim for reimbursement after correcting it with valid combinations. Any BlueCare℠, TennCare*Select* and CoverKids℠ claims submitted with invalid procedure code and modifier combinations will be denied.

You can find more information about billing modifiers in the Provider Administration Manual on the provider page at bcbst.com, or in the National Correct Coding Initiative (NCCI) policy manual at cms.gov. Or you can call our Provider Service Line at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. ET. For BlueCare, please call **1-800-468-9736** and for TennCare*Select*, the number is **1-800-276-1978**.

Understanding Member's Rights and Responsibilities

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.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so if you're not sure when 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 if their licenses expire. Providers who want to rejoin the network following termination due to license expiration will have to reapply and go through the credentialing process again. It's also important to note that any claims submitted by an unlicensed provider will be denied.

Register for the 2020 All Blue Workshops

Register now for the 2020 All Blue Workshop near you by clicking one of the events listed below. After Jan. 15, you can also register by visiting the All Blue Workshops page in the provider section of bcbst.com.

For 2020, we're going paperless. We'll post the materials on the All Blues page before the meeting, so you can print them ahead of time or access them online during the event.

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
1770 Highway 45 Bypass, Jackson, TN 38305

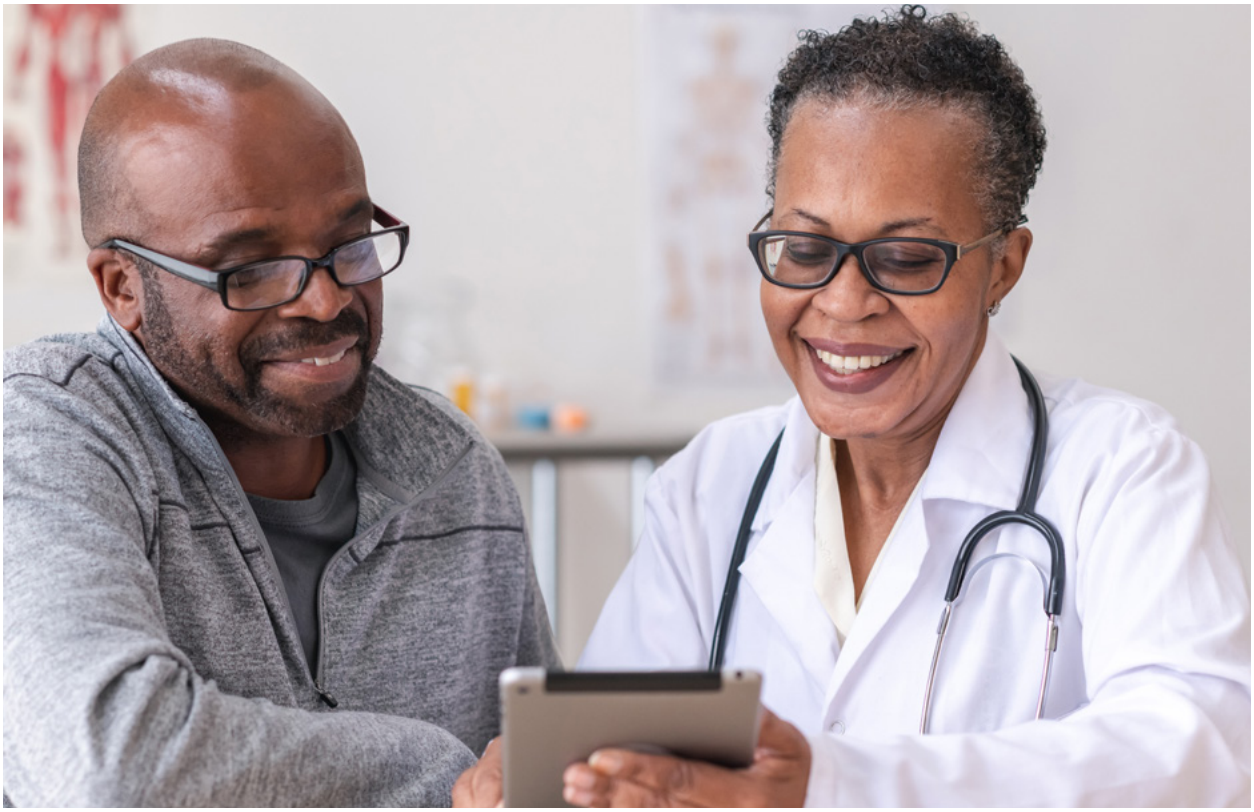
April 8, 2020 – Nashville
Cool Springs Marriott
700 Cool Springs Drive, Franklin, TN 37214

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

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

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 became effective Jan. 1, 2020. This means that Nashville and Memphis providers participating in Blue Network S will start seeing members with these plans. Please note that payment for covered services rendered to these members will be 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 with the valid corresponding CPT®/HCPSCS code(s). If we can't identify all of these services or supplies, we may not be able to pay for them.

BlueCare Tennessee

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

Every Visit is an Opportunity for Well-Child Care

When patients visit your office this winter due to coughs, colds and the flu, consider checking their medical records to see if they're up to date on preventive care before their appointment. Sometimes, the only chance you have to perform a well-child exam is when patients visit your office because of an illness or other need. So TennCare Kids' screening guidelines allow you to be reimbursed for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups performed at the same time as other types of 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 significant problem on the same day as 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 submitting the claim.
- Your documentation for the visit reflects the extra work done during the appointment for the problem. 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.

Get Up to Date on Medicaid ID Re-validation Requirements

The Division of TennCare℠ requires providers in our BlueCare, TennCare*Select* and CoverKids networks to re-validate their registration information every three years. This ensures our state meets CMS revalidation requirements.

The steps to complete re-validation are different for individual providers, groups and entities:

- Individual providers must keep the information in their Council for Affordable Quality Healthcare (CAQH) profiles current. To help make sure these profiles are up to date, CAQH requires providers review their information and re-attest to their data at regular intervals. To review your CAQH profile, please visit proview.caqh.org/Login.
- Groups, entities and atypical providers should use the Division of TennCare's provider portal to verify their data:
  - Simply log in to pdms.tenncare.tn.gov/Account/Login and verify the data on each screen.
  - Click the **Submit to TennCare** button to submit your revalidation for review.

If a provider, group or entity doesn't complete their re-validation within the required timeframe, the Division of TennCare will terminate their TennCare Medicaid ID. If this happens, the provider's BlueCare, TennCare*Select* and CoverKids contracts may also be terminated, and they'll need to re-credential before they can care for patients with BlueCare Tennessee coverage.

If you have questions about the re-validation process, please email Provider.Registration@tn.gov or call the TennCare Provider Services Call Center at 1-800-342-3145 between 8 a.m. and 3 p.m. CT, Monday through Friday. You can also find additional information on the Division of TennCare's Provider Registration page.

Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

Medicare Advantage Routine Foot Care

As a reminder, our Medicare Advantage plans covers routine foot care according to CMS's Local Coverage Determination (LCD) L37643. The appropriate CPT®/HCPCS codes (11055-11057, 11719-21, and G0127) and modifier usage (Q7, Q8, Q9) are explained in this LCD and in the associated Local Coverage Article (A56680 – Billing and Coding: Routine Foot Care). Reviewing this information ensures proper billing and coverage determinations when treating Medicare Advantage plan members.

Changes to Medicare Inpatient Only List

CMS has made its annual changes to the Medicare Inpatient Only List. These changes impact how authorization requests are reviewed starting in 2020 for our Medicare Advantage plan hospital inpatient DRG approvals. This is because there must be a specific medical need for inpatient services pre-operatively to get acute inpatient DRG coverage.

New Prior Authorization Forms Available Jan. 1, 2020

More specific prior authorization forms are now available in the Medicare Advantage section of the provider website under Utilization Management. The new custom forms include:

- Inpatient/outpatient admission/surgery request
- Pre-determination
- Home health services
- DME requests
- Outpatient therapies
- Provider appeal (post service medical necessity appeals)

We'll accept existing and new forms until Feb. 29, 2020. After that date, we'll only accept the new forms.

Reminder: Radiation Therapy Including Proton Beam Therapy Requires Prior Authorization

As a reminder, our Medicare Advantage plans require prior authorization for proton beam therapy, as well as for other types of radiation therapy. To avoid claim payment denials, please be sure to get prior authorization before starting these types of services for our Medicare Advantage plan members.

Provider Assessment Form Reimbursement for 2020

In 2020, you'll again be eligible to get paid for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueEssential members.

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

- $225 for dates of service between Jan. 1 and June 30, 2020
- $175 for dates of service between July 1 and Dec. 31, 2020

To be reimbursed, please submit the completed form through Availity or fax a completed form to 1-877-922-2963. The form should also be included in your patient's chart as part of their permanent record. For directions on uploading the PAF, see the Quality Care Rewards section of this newsletter.You don't need to wait 365 days between PAF submissions as the benefit is each calendar year. For additional information about the PAF, please visit the Quality section on our provider website.

Criteria for Medicare Advantage Medical Necessity Provider Appeals

Per the Provider Administration Manual, please send medical necessity provider appeals through the postal service. You also may fax your submissions. To qualify as a provider appeal, the service must have already been rendered and denied.

Your information must:

- Indicate that it's a provider appeal and not a reconsideration
- Be legible
- Be submitted within 60 days of the date the original claim was denied (the date the denial letter was sent)
- Have pages in chronological order
- Clearly state what is being appealed

We prefer this documentation:

- Physician orders
- Daily physician progress notes from all specialties, including consultations
- Pertinent lab results if not found in physician progress notes
- Procedure notes and diagnostic test results, if not found in progress notes
- Discharge summary
- History and physical
- PT/OT/ST notes
- Case management notes that specifically address discharge needs and disposition

Documents that aren't needed for medical necessity provider appeals.*

- Face sheet
- Billing information
- Coding summary
- Nursing assessments
- Entire medication administration record (MAR)

**Normally we don't need these unless there is something found in these sources not found in the physician documentation.*

Pharmacy

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

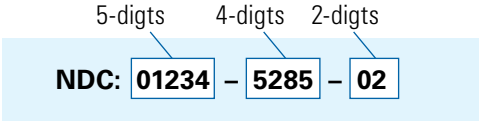
Coding Updates for Provider-Administered Drugs

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 started rejecting these types of claims if they were submitted with the wrong procedure code and NDC combination. This applies to all lines of business except BlueCare, TennCare*Select* and CoverKids.

To make sure your claims get paid correctly, we've provided additional information about NDCs and how best to process your claims.

About NDCs:

An NDC is a unique number assigned to every drug available for purchase in the United States and should always follow a **5-4-2 digit format**:



The first set of digits represents the manufacturer/distributer. The second set describes the medication's dosage form and formulation. The last set of numbers represents the package size.

Tips for billing with NDCs:

- NDCs are found on the drug packaging and on the vials. If the NDCs on the box and vial don't match, use the NDC on the vial.
- NDCs always follow the same format: 5 digits – 4 digits – 2 digits. On the drug label, they may only have 10 digits, but they must have 11 digits to be billed properly.
- To create an 11-digit NDC, just add a leading zero to the front of the section that doesn't have enough digits.
- For example, if the NDC on the bottle reads 1234-5285-02, add 0 to the front of the first section so the NDC becomes 01234-5285-02.
- The 11-digit NDC is what should be included in the claim.

Tips for billing with NDCs (continued):

PACKAGE NDC	ADDED ZEROES (LEADING 0S)	11 DIGIT NDC	EXPLANATION
1234-1234-12	01234-1234-12	0123123412	The first section should have 5 digits, so we added a 0 to the front.
12345-123-12	12345-0123-12	12345012312	The second section should have 4 digits, sowe added a 0 to the front of the second section.
2-22-2	00002-0022-02	00002002202	The first section needs 5 digits, so we added four 0s, the second section needs 4 digits, so we added two 0s, the last section needs 2 digits, so we added one zero.

You can find more information in the Provider Administration Manual on the provider page at bcbst.com. You can also visit cms.gov, the Centers for Medicare and Medicaid Services (CMS) website. If you have additional questions, please contact your local network manager.

Medication Therapy Management for Our Medicare Advantage Plan Members

Many of your patients enrolled in our Medicare Advantage plans may be eligible for the free Medication Therapy Management (MTM) Program. Those eligible for the program must have multiple chronic conditions, take multiple medications and spend more on Part D than a CMS-designated threshold. The MTM program empowers people to manage their chronic conditions through a better understanding of their medication regimen. This year, we're concentrating with CSS Health pharmacists to provide the MTM program for our members. This program is often underutilized but can be a huge benefit to your eligible patients, especially those in vulnerable populations. For more information, please visit the MTM page on our website.

Update: BlueCare Tennessee Specialty Pharmacy Billing Change Delayed

In the October and November 2019 BlueAlert newsletters, we announced that starting Jan. 1, 2020, we would only accept BlueCare, TennCare*Select* and CoverKids claims for provider-administered specialty pharmacy drugs from specialty pharmacy providers. However, we've delayed the implementation date for this change. Providers who administer specialty pharmacy drugs may continue to bill us for the costs of the drugs, in addition to receiving reimbursement for administration.

We do plan to make some changes to our billing process for specialty pharmacy drugs in the future. When we finalize our plans, we'll be sure to notify you ahead of time.

Our relationship with you is important to us, so we apologize for any confusion this may cause. If you have any questions, please contact your provider network manager.

New Pharmacy Benefits Manager for BlueCare and TennCare*Select* Members

On Jan. 1, 2020, the Division of TennCare's pharmacy benefits manager changed from Magellan Health Services to Optum Rx. Please note this change doesn't affect your patients' pharmacy benefits – it only impacts the company that manages the TennCare Pharmacy Program and processes the TennCare pharmacy claims.

The Division of TennCare notified your patients covered by BlueCare Tennessee about this change and sent them new pharmacy cards. If your patients haven't received their ID cards yet, please let them know they can still fill their prescriptions at the pharmacy.

If you have questions about your patients' pharmacy benefits or a prior authorization, please call Optum Rx at the appropriate number below:

- **Optum Rx Technical Call Center (Pharmacy Help Desk)** – 1-866-434-5520
- **Optum Rx Clinical Call Center (Prior Authorizations)** – 1-866-434-5524

For more information about the TennCare Pharmacy Program, please visit the Division of TennCare's Pharmacy page.

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

Quality Care Rewards

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

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.

Quality Care Rewards Application UPDATES: End of January 2020 Provider Assessment Form (PAF)/ Patient Assessment and Care Planning Form (PACF) Upload

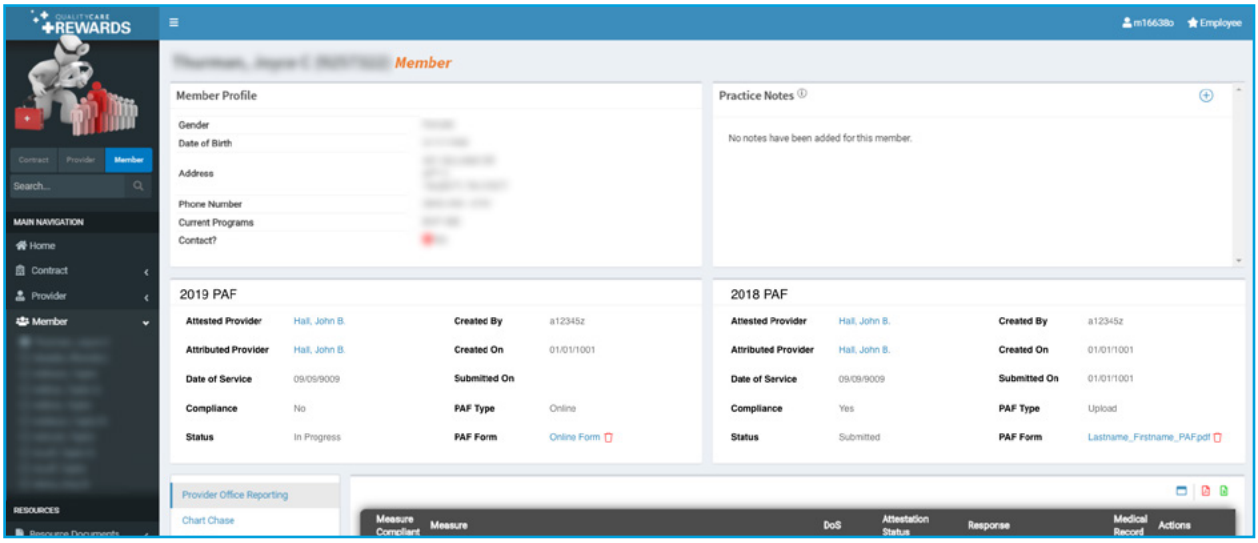
The PAF and PACF upload functionality for Medicare Advantage and BlueCare Plus value-based contracting (VBC) will now allow you to upload an assessment that you normally would have faxed.

Users with access to these programs can now follow the steps below to upload these forms.

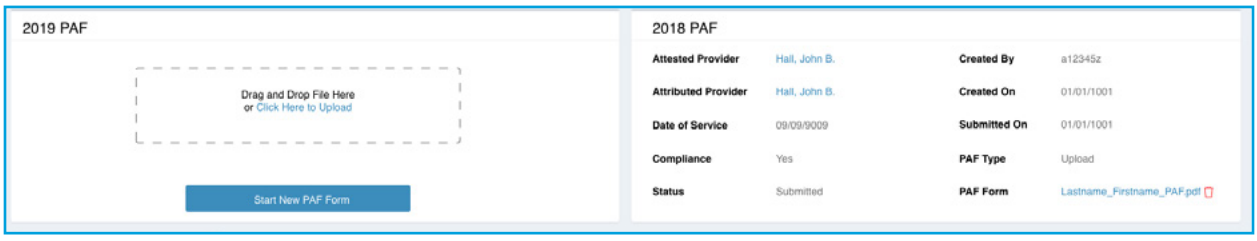
Note: the screens shown are still in development. The final version could be different.

Because we're making this change, we've removed the PAF/PACF Tab on the Member Page. As well, please note that if a member is in the Medicare Advantage or BlueCare Plus VBC program, there will be two frames for their prior year and current year assessments.

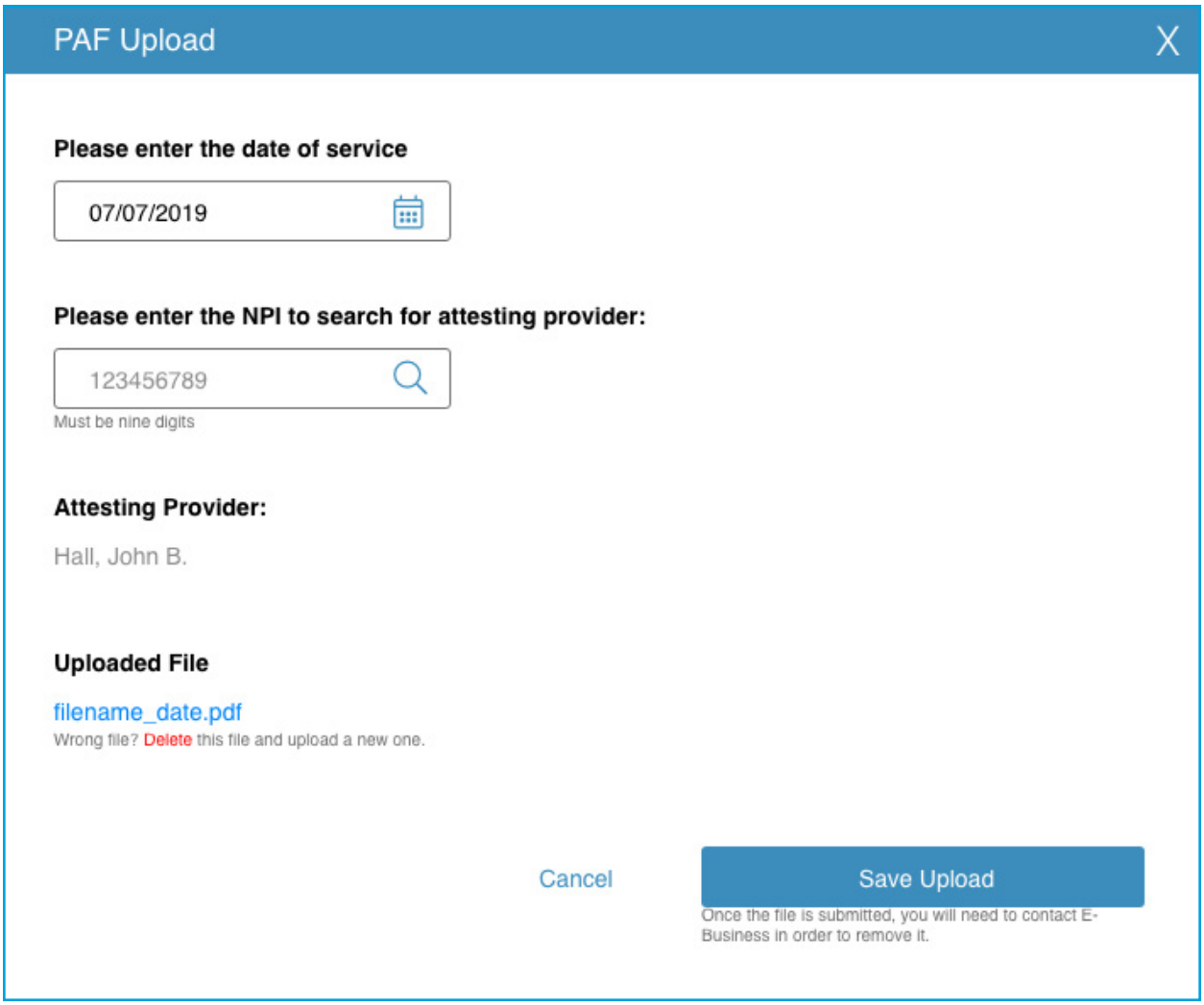
1. **Go to the Member Page**



2. **To upload, drag and drop the file into the box for the measurement year pictured below or click the link to browse. The file type can be a PDF, rich text file (rtf) or Word document. The maximum file size should be 2MB.**



3. **Next, please do the following:**
   - Enter Date of Service – assessment completed with member
   - Enter Attesting provider NPI
   - Display Provider Name
   - Check the file name to make sure it's correct. If it isn't, you can delete it and start over.
   - Click Cancel or Save Upload



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.

19PED725067 (1/20)

of Tennessee

FEBRUARY 2020

BlueAlert℠

BlueCross BlueShield of Tennessee

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

Redesigned Provider Website Set to Launch Later this Month

We've created a new, dedicated provider website to help you easily find the information you need from us faster. The new site will go live in mid-February, and the layout will have a format similar to the recently redesigned bcbst.com. The new provider site will have a dedicated URL so you can access it directly at provider.bcbst.com, plus you'll still be able to get to the new site from bcbst.com.

Among the many additions and improvements to the site are redesigned pages that are easier to navigate, quick access to every section of the site using the main drop down menu and all forms and documents you use in one convenient place.

Review and Update Provider Information in CAQH

BlueCross has steadily increased the use of CAQH ProView® as our source for provider data, which now includes our Find a Doctor tool. Please continue to review and update your information in CAQH regularly. Your confirmation of this data will help us move away from 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 CAQH. Items not captured in the CAQH ProView, such as Patient Acceptance for our networks, will still require your review. For those items, we'll send you a notice so you can verify them in Availity®. Ancillaries and facilities will continue to receive the Data Verification Form via paper until we're able to migrate all providers to this new process.

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

INSIDE THIS ISSUE

Code/Modifer Requirement Updates

Effective March 1, 2020, we'll reject and/or return claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus lines of business. You can resubmit the claim for reimbursement after correcting it with valid combinations. Any BlueCare℠, TennCare*Select* and CoverKids℠ claims submitted with invalid procedure code and modifier combinations will be denied.

You can find more information about billing modifiers in the Provider Administration Manual on the provider page at **bcbst.com**, or in the National Correct Coding Initiative (NCCI) policy manual at **cms.gov**. Or you can call our Provider Service Line at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. ET. For BlueCare, please call **1-800-468-9736** and for TennCare*Select*, the number is **1-800-276-1978**.

Applied Behavioral Analysis (ABA) Services Update

Beginning March 3, 2020, we'll adopt MCG Health's 23rd Edition Care Guideline for ABA services for all lines of business. The only exception will be for BlueCare Tennessee members. We'll modify the guideline to allow diagnoses related to Intellectual/Developmental Disabilities and Traumatic Brain Injury, as well as Autism Spectrum Disorder.

You can find more information on our website at Utilization Management Guidelines or contact your Network Manager:

East Region - Knoxville

Brenda Simmons
Network Manager
(865) 588-4631
Brenda_Simmons@bcbst.com

East Region - Chattanooga

Michael Burks
Network Manager
(615) 557-6791
Michael_Burks@bcbst.com

Middle Region

Jennifer Ramsden
Network Manager
(423) 535-3807
Jennifer_Ramsden@bcbst.com

East Region - Northeast

Catherine Overstreet
Network Manager
(423) 535-6013
Cathy_Overstreet@bcbst.com

West Region

Tory Moon
Network Manager
(901) 544-2323
Tory_Moon@bcbst.com

Middle Region

Lee Green
Network Manager
(615) 483-7886
Lee_Green@bcbst.com

Register for the 2020 All Blue Workshops

Register now for the 2020 All Blue Workshop near you by clicking one of the events listed below. After Jan. 15, you can also register by visiting the All Blue Workshops page in the provider section of bcbst.com.

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

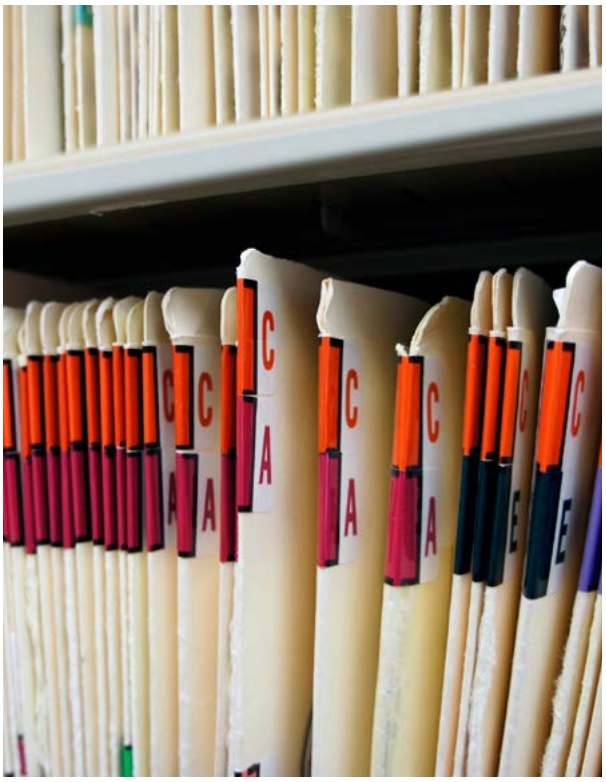
March 25, 2020 – Jackson
DoubleTree Jackson
1770 Highway 45 Bypass, Jackson, TN 38305

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

For 2020, we're going paperless. We'll post the materials on the All Blues page before the meeting, so you can print them ahead of time or access them online during the event.



2020 HEDIS® Medical Record Requests to Begin Soon

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

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

If you need help submitting your records using any of the following methods, please call us at **(423) 535-3187**.

- Remote access into your electronic medical records
- Secure email
- Fax
- On-site collection
- Our web-based portal

HEDIS® is a registered trademark of NCQA.

Commercial

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

Prior Authorization Changes Scheduled for April

The following prior authorization changes will be effective on April 1, 2020.

Musculoskeletal Program

CPT® codes 0375T and 27360 will no longer need prior authorization. However, code C9757 will require prior authorization.

You may submit prior authorization requests through Availity.com. You can also call TurningPoint at **1-866-747-0587** or fax your request to **1-866-747-0587**.

Genetic Testing and High-Tech Imaging

CPT® code 0081U for genetic testing will no longer need prior authorization. However, the following codes will need prior authorization:

0153U	0159U	81277	81542
0156U	0160U	81307	81552
0157U	0161U	81308	
0158U	0162U	81522	

The following CPT® codes for high-tech imaging will require prior authorization:

78429	78432	78830
78430	78433	78831
78431	78434	78832

You may submit prior authorization requests for genetic testing and high-tech imaging through Availity.com. You can also fax your requests to eviCore at **1-888-693-3210** or submit them by phone at **1-888-693-3211**.

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

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 became effective Jan. 1, 2020. This means that Nashville and Memphis providers participating in Blue Network S will start seeing members with these plans. Please note that payment for covered services rendered to these members will be 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 of the services and/or supplies you've provided on your itemized bill, either by description or with the valid corresponding CPT®/HCPSCS code(s). If we can't identify all of these services or supplies, we may not be able to pay for them.

BlueCare Tennessee

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

Document Each Required Part of a TennCare Kids Exam

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 visit your office for their well-child checkup, please document all seven required parts of the exam, as well as assessments of their nutrition and physical activity.

If you're unable to complete a checkup because a patient is uncooperative, deferred or refused the exam, please be sure to include this information in the patient's medical record.

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.

Coordinating Care for School-Based Health Services

School districts play an important role in helping families access health information and medical and behavioral services. They also help children with special needs who are covered by BlueCare Tennessee receive medically necessary, school-based, health-related services that support their ability to participate in their education.

We need your help to make sure children receive the care they need at school. To receive reimbursement for medically necessary, health-related services, school districts must meet certain requirements. These include getting a physician's order for services from the child's primary care provider or another provider in our network. If a school district or their third-party billing administrator contacts you about a treatment request, please respond as soon as possible. With your help, we can make sure children have timely access to the in-school, medically necessary services they need.

Note: This doesn't apply to CoverKids.

Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

Expanded Dental Benefits for BlueAdvantage and BlueEssential Dental Members

We've enhanced our dental benefits for 2020, so you can provide more preventive and comprehensive services to BlueAdvantage and BlueEssential members.

Here's a list of the services our 2020 plans cover:

- Standard diagnostic exam (up to two per year)
- Emergency diagnostic exam (one per year)
- Cleanings (up to two per year)
- Bitewing X-ray (one per year)
- Panoramic X-ray (one set of full mouth x-rays in any 36-month period)
- Fillings (one per tooth surface per year)
- Crowns (one per tooth every five years)
- Extractions
- Bridges (one every five years)
- Dentures (one every five years)

Please refer to your provider agreement and applicable Preferred Dental Maximum Allowable Fee Schedule. This outlines payment amounts for dental services provided through our Medicare Advantage network. 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.

You can find dental benefits and plan maximums in Availity. If you'd like more information, please call our Provider Service line at **1-800-924-7141**, Monday through Friday from 8 a.m. to 6 p.m. ET.

Please note: If you formally opted out of the Medicare program, any dental services you provide aren't covered or payable by the plan.

Review CMS Guidelines for Coverage and Billing of Routine Foot Care

Our Medicare Advantage plans cover routine foot care according to CMS's Local Coverage Determination (LCD) L37643. The appropriate CPT®/HCPCS codes (11055-11057, 11719-21 and G0127) and modifier usage (Q7, Q8, Q9) are explained in this LCD and in the associated Local Coverage Article (A56680 – Billing and Coding: Routine Foot Care). This information outlines proper billing and coverage determinations when treating Medicare Advantage plan members.

Receive Payment for Submitting Provider Assessment Forms

Payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueEssential members are available again in 2020.

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

- $225 for dates of service between Jan. 1 and June 30, 2020
- $175 for dates of service between July 1 and Dec. 31, 2020

Please submit the completed PAF form through Availity or by fax to **1-877-922-2963**. Your patient's medical chart should include a copy of the form as part of their permanent record. For directions on uploading the PAF, please see the Quality Care Rewards section of this newsletter. You may submit a completed PAF for a particular member once per calendar year (you do not need to wait 365 days) and receive the above noted payment. For additional information about the PAF, please visit the Quality section on our provider website.

New Prior Authorization Forms Required Starting in March

You can find new BlueAdvantage and BlueEssential prior authorization forms that are more specific and easier to understand in the forms section under Medicare Advantage on our website. The new custom forms include:

- Inpatient/outpatient admission/surgery request
- Pre-determination
- Home health services
- DME requests
- Outpatient therapies
- Provider appeal (post service medical necessity appeals)

Please note, we'll accept new and existing forms until Feb. 29, 2020. After that date, we'll only accept the new forms.

Guidelines for Submitting Medical Necessity Provider Appeals

Here are a few reminders for submitting a provider appeal based on medical necessity.

Your appeal must be:

- Delivered to us by mail or fax
- Clear that it's a provider appeal and not a reconsideration
- For a service that's been rendered and denied
- Submitted within 60 days of the date the original claim was denied (the date the denial letter was sent)
- In chronological order
- Specific about what's being appealed

Please submit associated clinical records with your appeal, including, but not limited to:

- Physician orders
- Daily physician progress notes from all specialties, including consultations
- Pertinent lab results (if not part of physician progress notes)
- Procedure notes and diagnostic test results (if not part of progress notes)
- Discharge summary
- History and physical
- PT/OT/ST notes
- Case management notes that specifically address discharge needs and disposition

Documents that may be necessary, though not required*

- Face/cover sheet
- Billing information
- Coding summary
- Nursing assessments

Entire medication administration record

*Normally we don't need these unless there is something found in these sources not found in the physician documentation.

BlueCare Plus (HMO SNP)SM

This information applies to our BlueCare Plus Medicare Advantage, dual-eligible special needs plans.

Understanding BlueCare Plus Benefits and Billing

BlueCare Plus is a Medicare Advantage HMO Special Needs Plan (SNP) for individuals eligible for benefits under Medicare and Medicaid. BlueCare Plus plan options include supplemental benefits for dental, vision, and hearing services.

Claims for covered dental services should be filed with BlueCross BlueShield of Tennessee like any other dental claim. Benefits can be verified through Availity. Please call BlueCare Plus Provider Service at **1-800-299-1407** if you have questions about benefits or your network participation status.

Proton Beam Therapy Will Soon Need Prior Authorization

Starting March 1, 2020, proton beam therapy for BlueCare Plus members age 21 and over will require prior authorization. Before requesting prior authorization, please verify member benefits and eligibility at Availity.com by clicking **Patient Registration**, then **Eligibility and Benefits Inquiry**. You can also use Availity to submit your prior authorization request.

Pharmacy

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

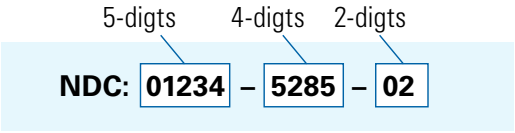
Coding Updates for Provider-Administered Drugs

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 started rejecting these types of claims if they were submitted with the wrong procedure code and NDC combination. This applies to all lines of business except BlueCare, TennCare*Select* and CoverKids.

To make sure your claims get paid correctly, we've provided additional information about NDCs and how best to process your claims.

About NDCs:

An NDC is a unique number assigned to every drug available for purchase in the United States and should always follow a **5-4-2 digit format**:



The first set of digits represents the manufacturer/distributer. The second set describes the medication's dosage form and formulation. The last set of numbers represents the package size.

Tips for billing with NDCs:

- NDCs are found on the drug packaging and on the vials. If the NDCs on the box and vial don't match, use the NDC on the vial.
- NDCs always follow the same format: 5 digits – 4 digits – 2 digits. On the drug label, they may only have 10 digits, but they must have 11 digits to be billed properly.
- To create an 11-digit NDC, just add a leading zero to the front of the section that doesn't have enough digits.
- For example, if the NDC on the bottle reads 1234-5285-02, add 0 to the front of the first section so the NDC becomes 01234-5285-02.
- The 11-digit NDC is what should be included in the claim.

PACKAGE NDC	ADDED ZEROES (LEADING 0S)	11 DIGIT NDC	EXPLANATION
1234-1234-12	01234-1234-12	0123123412	The first section should have 5 digits, so we added a 0 to the front.
12345-123-12	12345-0123-12	12345012312	The second section should have 4 digits, sowe added a 0 to the front of the second section.
2-22-2	00002-0022-02	00002002202	The first section needs 5 digits, so we added four 0s, the second section needs 4 digits, so we added two 0s, the last section needs 2 digits, so we added one zero.

You can find more information in the Provider Administration Manual on the provider page at **bcbst.com**. You can also visit **cms.gov**, the Centers for Medicare and Medicaid Services (CMS) website. If you have additional questions, please contact your local network manager.

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.

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.

20PED738554 (1/20)

of Tennessee

MARCH 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee

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

BlueCross Monitoring Coronavirus Disease (COVID-19) Developments

As Tennessee's leading health insurer, we actively monitor health concerns that could pose a threat to our communities, including the spread of flu and other viruses.

In keeping with this practice, we're watching developments related to the 2019 novel coronavirus, or the virus responsible for COVID-19, that was recently identified as a global emergency by the World Health Organization. The number of confirmed cases in the U.S. is currently extremely low. But we want you to know we're preparing for the unlikely event the virus becomes more widespread.

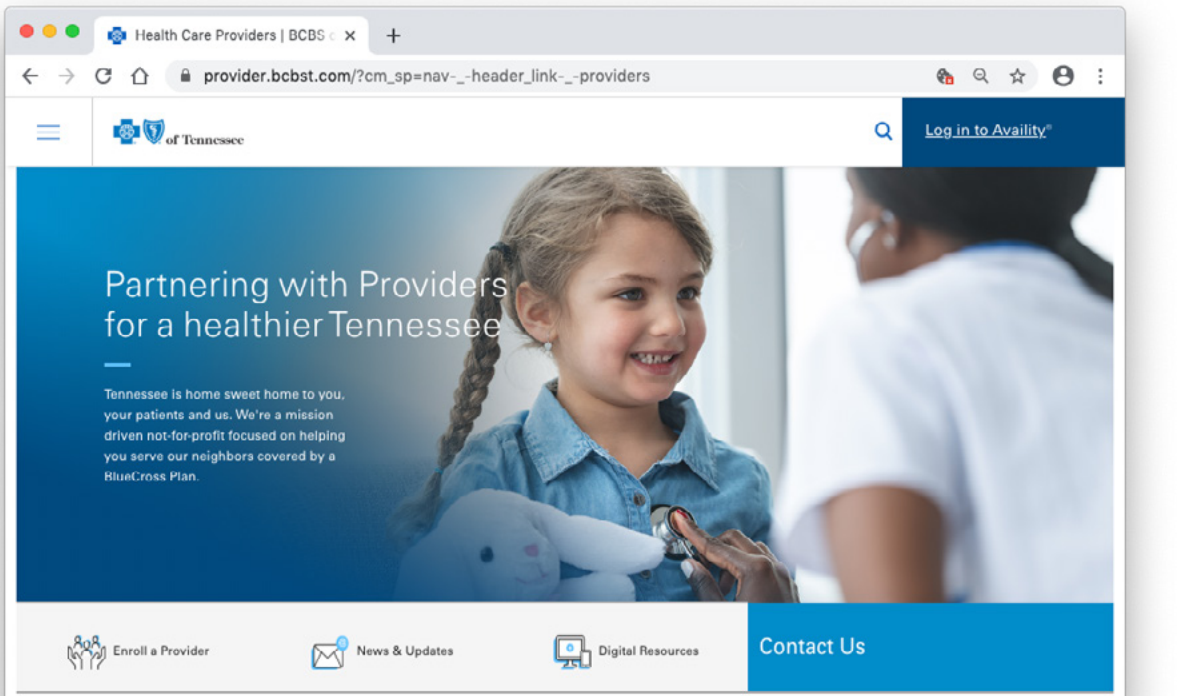
This virus causes respiratory illness and spreads from person-to-person although it's not clear how easily this happens. The CDC also believes the risk of becoming sick after coming in casual contact with someone who is infected is low. They expect the virus will infect more because it is contagious before symptoms appear, usually in as few as two days or as long as 14 after exposure.

Although there's no specific antiviral treatment or vaccine for 2019-nCoV, those with 2019-nCov can seek medical care to help relieve symptoms. The best way to prevent infection is to avoid being exposed to the virus. Standard hygiene protocols like hand washing, covering the mouth and nose when coughing and sneezing can limit exposure.

Please visit our News Center for more information.

INSIDE THIS ISSUE

Provider.BCBST.com: A Redesigned, Easier-to-Use Experience Dedicated to Providers



Check out our new provider-dedicated website that was completely redesigned to make it easier for your office to work with us. Every element of the site was created with input from the people who use it most, including providers like you. Frequently accessed information, like forms, news and provider enrollment, is now right up front on the home page. We also added a main drop-down menu to help you quickly navigate to items like the latest coding updates, provider manuals or details about prior authorizations.

We've optimized everything to work as well on your mobile devices as it does on your computer. Our new site is now live on the provider page at bcbst.com.

How We're Managing the January 2020 CAQH® EnrollHub™ Delay

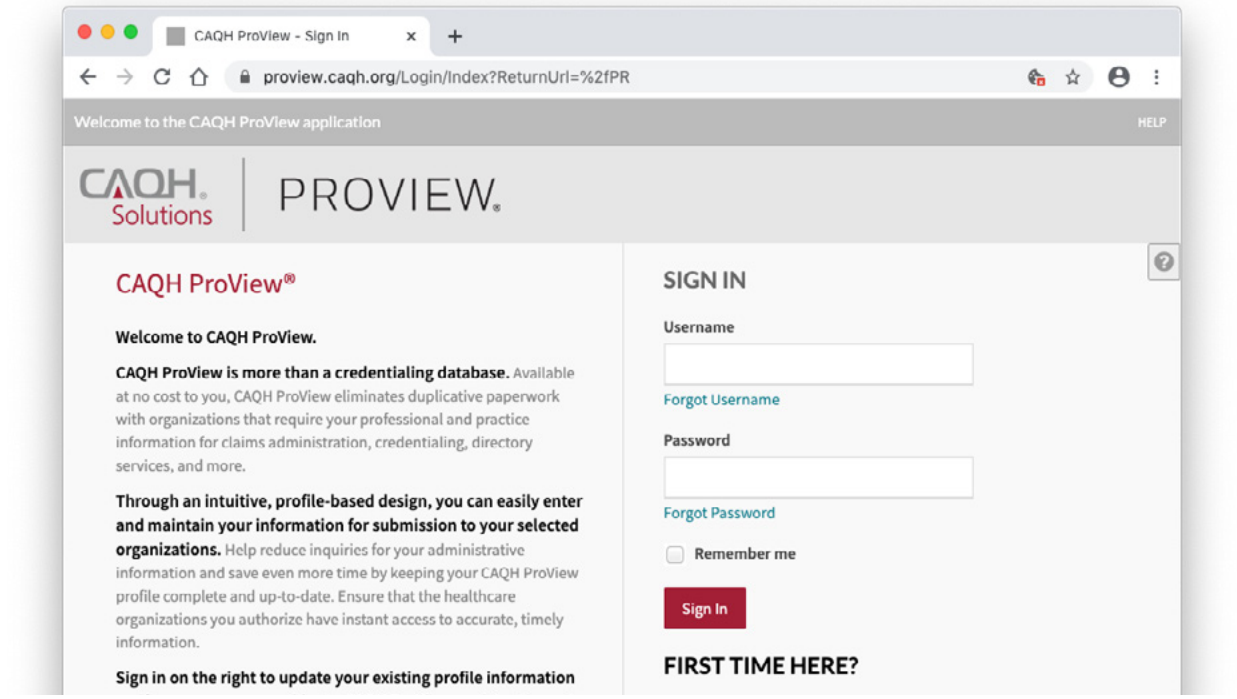
EnrollHub is a web-based tool from the Council for Affordable Quality Healthcare (CAQH) that gives healthcare providers a single source to enter Electronic Funds Transfer (EFT) enrollment information and submit it to the payers of their choice.

Unfortunately, the EnrollHub application was unavailable to our staff and provider community from Jan. 1 through Jan. 27, 2020. This caused delays in our enrollment process since EFT is a network participation requirement.

To avoid additional enrollment delays, we made an EnrollHub exception for new providers until March 1, 2020. We've also given these providers an additional 180 days to complete their EFT information with EnrollHub. These providers will be paid by paper checks until their EnrollHub applications are complete and validated by CAQH.

If you have questions about your EnrollHub enrollment, please contact our Provider Service line at **1-800-924-7141** and follow the prompts for Network Contracts or Credentialing or email GM, Contract Requests.

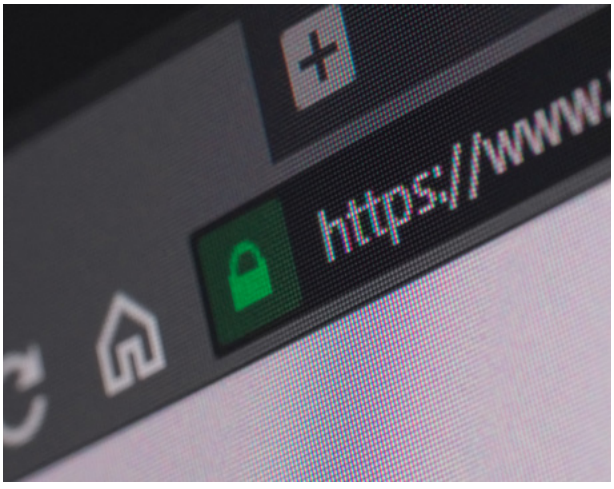
Review and Update Provider Information in CAQH



BlueCross has steadily increased the use of CAQH ProView® as our source for provider data, which now includes our Find a Doctor tool. Please continue to review and update your information in CAQH regularly. Your confirmation of this data will help us move away from 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 CAQH. Items not captured in the CAQH ProView, such as Patient Acceptance for our networks, will still require your review. For those, we'll send you a notice so you can verify them in Availity. Ancillaries and other facilities will continue to receive the Data Verification Form via paper until we're able to migrate all providers to this new process.

If you have any questions about this process contact Provider Network Services at **1-800-924-7141**.



Updating Security for Our Websites

From scrolling around web pages, downloading files or email, security is essential. That's why we're updating all our websites and secure systems to require Transport Layer Security (TLSv1.2) to comply with industry security standards. These security updates may affect electronic claim filing and other electronic transactions. Please have your IT administrators verify system compatibility to avoid disruption. You can call eBusiness Technical Support at **(423) 535-5717** and select option 2 or email eBusiness_service@bcbst.com with any questions about this upgrade.

Register for the 2020 All Blue Workshops

Registration is open for the 2020 All Blue Workshop near you. Just click on one of the events listed below or visit the All Blue Workshops page in the provider section of bcbst.com.

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
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

We're going paperless for the 2020 workshops. We've posted the materials on the All Blues page so you can print them ahead of time or access them online during the event.

Code/Modifier Requirement Updates

Effective March 16, 2020, we'll reject and/or return claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus lines of business. You can resubmit the claim for reimbursement after correcting it with valid combinations. Any BlueCare℠, TennCare*Select* and CoverKids℠ claims submitted with invalid procedure code and modifier combinations will be denied.

You can find more information about billing modifiers in the Provider Administration Manual on the provider page at bcbst.com, or in the National Correct Coding Initiative (NCCI) policy manual at cms.gov. Or you can call our Provider Service Line at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. ET. For BlueCare, please call **1-800-468-9736** and for TennCare*Select*, the number is **1-800-276-1978**.

Please note: The March 16, 2020 date is an update from the original March 1, 2020 date we shared in the Jan. and Feb. BlueAlerts.

Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plans are contractually required to complete our Model of Care Training after initial contracting, then every year afterwards. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking here.

Applied Behavioral Analysis (ABA) Services Update

Beginning March 3, 2020, we'll adopt the MCG 23rd Edition's Applied Behavioral Analysis (ABA) guideline for all lines of business. The only exception will be for BlueCare Tennessee members. We'll modify the guideline to allow for diagnoses related to Intellectual/Developmental Disabilities and Traumatic Brain Injury, as well as Autism Spectrum Disorder.

You can find more information on our provider website under Manuals, Policies and Guidelines or contact your Network Manager:

East Region - Knoxville
Brenda Simmons
Network Manager
(865) 588-4631
Brenda_Simmons@bcbst.com

East Region - Chattanooga
Preston Edmondson
Network Manager
(423) 535-5996
Preston_Edmondson@bcbst.com

Middle Region
Jennifer Ramsden
Network Manager
(423) 535-3807
Jennifer_Ramsden@bcbst.com

East Region - Northeast
Catherine Overstreet
Network Manager
(423) 535-6013
Cathy_Overstreet@bcbst.com

West Region
Tory Moon
Network Manager
(901) 544-2323
Tory_Moon@bcbst.com

Middle Region
Lee Green
Network Manager
(615) 483-7886
Lee_Green@bcbst.com

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 May 1, 2020, the following CPT® codes will be added and will need prior authorization:

- 0169U
- 0170U
- 0171U

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, by fax to eviCore at **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.

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

TennCare Kids' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have different reporting criteria and eligibility requirements than the well-child visit performance measures included in the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS®). Here's some information to help you brush up on the basics for each.

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 determine if 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. Children must be enrolled in their health plan for the entire calendar year to count among a primary care provider's patient population. However, the measures allow one gap in coverage of up to 45 days.

The stand-alone 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 Tool Kit.

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

Updated Billing Guidelines for Allergen Immunotherapy

The Division of TennCare recently revised requirements for allergen immunotherapy billing that have been in place since Oct. 1, 2016. Effective Jan. 1, 2020, please bill claims for initial allergen immunotherapy treatment with modifier–U1. The –GD modifier is no longer valid, as of Jan. 1.

Note: This doesn't apply to CoverKids.

New LTSS Removal of Services Form Available Online

Long-Term Services and Supports (LTSS) providers who no longer perform certain services can now have them removed from their provider agreement outside of the annual credentialing period. To remove these services from your CHOICES or Employment and Community First CHOICES provider agreement, simply download the new form, follow the instructions and email the completed form to CHOICESProviderRelations@bcbst.com.

When filling out the form, please make sure to select a termination date for services. This will be the last date you'll be paid for the services you remove.

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

Quest Diagnostics Laboratory Billing Guidelines

All outpatient laboratory testing for BlueCare Tennessee and CoverKids members must be referred to Quest Diagnostics with these limited exceptions:

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

Please note our arrangement with Quest Diagnostics is not all-inclusive. Please review the BlueCare Tennessee Lab Exclusion List to find a detailed list of tests and corresponding CPT® codes that are excluded from the arrangement.

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

Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

Implantable Infusion Pain Pump Coverage

All Medicare Advantage and SNP products cover compounded medication in implantable infusion pain pumps as an "incident to" service when billed by the provider who's refilling and managing the infusion pump. However, providers may not bill for any additional cost when a third-party pharmacy compounds the medication.

These medications must meet the medical necessity guidelines of Medicare medical policy. Whether a single agent or a combination of agents is used, the compounded medication must be submitted with HCPCS code J7999-KD, even though the compound is similar to or includes a drug with a specific HCPCS code (e.g., HCPCS code J2274 for preservative free morphine).

You can find more details concerning the proper coding and use of modifiers for implantable infusion pain pumps by referencing Tennessee Local Coverage Determination (L33461) and Local Coverage Article (A56695) – Billing and Coding: Implantable Infusion Pump V4 (Rev. Eff. 07/11/2019) along with Chapter 15 of the Medicare Benefit Manual.

Tips for Coding Professionals

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

Code Reminder for Medroxyprogesterone Acetate (Depo Provera)

Effective April 1, 2020, providers should use HCPCS code J1050 when submitting claims for all forms of medroxyprogesterone acetate. We've updated NDC editing software to allow submission of all dosages of this drug with HCPCS code J1050 Injection, medroxyprogesterone acetate.

Please note, the Code J1050 is specific for 1 mg and providers should submit units based on the dosage administered. After this date, we'll deny charges for this medication when billed with HCPCS code J3490.

Quality Care Rewards

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

THCII Episodes of Care Performance and Preview Reports Now Available

The 2019 Interim Performance and Preview Reports for Medicaid and Commercial were released in February 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.

Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement to providers who achieved quality scores of 4-Stars and above with coding accuracy during the 2019 measurement period (Jan. 1 – Dec. 31, 2019).

Stars ratings, based on last year's performance, will affect each provider's reimbursement rates starting April 1, 2020. Participating providers will receive a rebasing rate notification letter and a rate attachment with the new fee schedule by April 1. Your contract amendment will include information about your base rate, the quality escalator and total earning potential.

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.

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.

20PED772726 (2/20)

of Tennessee

APRIL 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

COVID-19 Updates

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

During this state of emergency, we're making changes to help our members and providers stay safe.

Please visit the Provider FAQs at bcbstupdates.com for up-to-the minute guidelines on treating our members.

COVID-19 Coverage

With the recent spread of COVID-19, or novel coronavirus, in Tennessee, we want to make you aware of some changes to our coverage. Updates include:

- Telehealth consultations:
  - From now until April 30, you can use CPT® codes 99441–99443 for telephonic provider-to-member consultation. This applies to all lines of business' PCP or specialist benefits.
  - You can also bill for virtual and telephonic consults with your patients by using E&M codes 99201–99215 from now through April 30.
  - For behavioral health consultations, use codes 90791, 90792, 90832, 90834 and 90837. Please use place of service 02 for all of these options.
  - Pricing for these services would be consistent with your BlueCross fee schedule.
- We'll cover our members' copay and waive their cost-share for any appropriate FDA-approved tests and those currently pending FDA approval at this time.
- We'll also cover any vaccines developed and approved to treat COVID-19 once they're available.

For more information, please see the FAQs at provider.bcbst.com or contact your Network Manager.

COVID-19 Testing and Reimbursement

From now until Dec. 31, we'll reimburse at 100% of the Centers for Medicare and Medicaid Services (CMS) fee schedule for both professional and facility claims for COVID-19 FDA-approved tests. This also includes tests that are currently pending FDA approval. The following codes are billable for all labs and providers across all BlueCross BlueShield of Tennessee product lines*:

- U0001 - (CDC)
- U0002 - (Commercial Labs)
- CPT® code (87635) to be priced at the U0002 payment or the lesser of billed charges once physicians can do their own testing.

We'll also cover our members' swabs and test results in a drive-thru setting as part of the lab payment. Please note

continued

COVID-19 Testing and Reimbursement *continued*

that the test code includes both the swab and the results. You should use place of service code 99 when billing drive-thru testing. All reimbursement will be based on the testing code. Please note that we will only reimburse for our member's COVID-19 swabs and test results, not screenings, in drive-thru testing. This information will be published in the 2nd Quarter BlueCross and BlueCare Tennessee Provider Administration Manuals.

*Codes are included on the preferred lab exclusion list for BlueCare℠, TennCare *Select* and CoverKids℠.

COVID-19 Response: TennCare Pharmacy Program and CoverRx Updates

The Division of TennCare recently made several temporary changes to the TennCare Pharmacy Program and CoverRx in response to the coronavirus (COVID-19) pandemic. Effective March 16, 2020, TennCare will temporarily:

- Allow out-of-network pharmacy and provider fills
- Waive copays for medications on the Attestation and Auto-Exempt lists
- Suspend refill-too-soon edits for most medications, excluding opioids and other controlled medications. To request an exception review for your patient, please call the Pharmacy Support Center at **1-866-434-5520**.
- Override pharmacy lock-in location changes, where applicable

For more information, please review the TennCare notice outlining these changes.

INSIDE THIS ISSUE

BlueCross BlueShield of Tennessee, Inc.

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

New Contact Types in Availity® will Give Providers More Message Delivery Options

Soon, you'll have more choices about how you receive messages from us. This is because we've added three new options to Availity's Contact Preferences section. The new contact types are:

- **Credentialing** – Information about your credentialing status
- **Network Operations** – Updates about network enrollment and your listing in the BlueCross Provider Directory
- **Network Updates** – General business announcements, newsletter updates and surveys

You can update your contact preferences with your email address for each of these communication types. Be sure to check your contact preferences to make sure you're getting important messages and announcements that apply to you. Also, please continue to look for updates under the News & Announcements and Notification Center sections of Availity.

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

Individual Providers May Get Group Contract

New providers joining a practice that has one or more providers under a group NPI may soon receive a group contract – even if the other affiliated providers have individual contracts. By consolidating the contracts of providers who practice together, we're able to improve efficiency for provider offices and BlueCross. This is because we're able to deliver consistent reimbursement rates and reporting requirements to each provider in the practice. It also helps make sure providers all participate in the same networks, which is important for your group's patients.

If you have questions about your new group contract or this group contracting initiative, please contact your local provider network representative.

Beware: Phishing Scams Threaten Your Practice's Identity and Finances

Phishing attacks illegally trick people or businesses into giving up credit card information, Social Security numbers, passwords or other personal data to steal identities and empty financial accounts. Phishing attempts may come in the form of an email, phone call or text from criminals who often pose as legitimate companies.

Trust your feelings if something seems suspicious. Some schemes are easy to spot, while others are cleverly disguised. Phishing outreach often includes unique information about you, and can appear as either a reply to an email you didn't send, or as an urgent request.

Here are few other things to look for:

- Misspelled words, grammatical mistakes or an inappropriate tone
- Emails from a business or person you don't recognize
- Requests that ask you to download a file unrelated to the subject or click a link with an unfamiliar web address

If you receive an unusual email or phone call that appears to be from BlueCross, you can always call our Provider Service line at **1-800-924-7141** to confirm the request.

Code/Modifier Requirement Reminder

Effective March 16, 2020, we began rejecting and/or returning claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus lines of business. You can resubmit these claims for reimbursement after correcting them with valid combinations.

Also effective March 16, 2020, we began denying claims with invalid procedure code and modifier combinations for the BlueCare, TennCare*Select* and CoverKids lines of business. Once you correct the claims, you can resend them for reimbursement review.

You can find more information about billing modifiers in the Provider Administration Manual on the **provider page at bcbst.com**, or in the National Correct Coding Initiative (NCCI) policy manual at **cms.gov**. You can also call our Provider Service Line at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. ET. For BlueCare, please call **1-800-468-9736** and for TennCare*Select*, the number is **1-800-276-1978**.

Please note: We announced the March 16 effective date in our March BlueAlert newsletter. The effective date had previously been listed as March 1, 2020 in the Jan. and Feb. issues.

Change of Schedule for All Blue Workshops

Due to the recent spread of COVID-19, or novel coronavirus, to Tennessee, we've decided to reschedule our All Blue Workshop events. Once we have the new dates and locations, we'll share the news through our BlueAlert newsletter. While we apologize for the inconvenience, we want you to know we take the health of our members, providers and employees very seriously. We had to take this important measure to make sure we could monitor the possible ongoing spread in Tennessee.

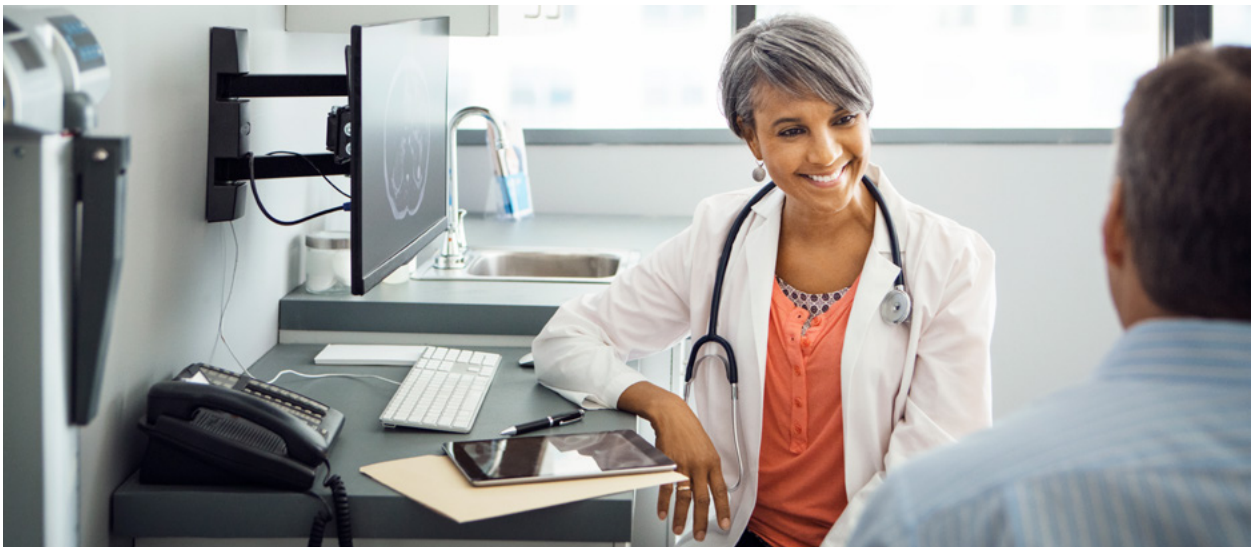
Please look for updates in the BlueAlert newsletter and on the All Blue Workshops page in the provider section of bcbst.com. You can also preview and print the workshop presentation from that web page. If you have questions, please contact your network manager.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so please take a look at your license if you're not sure when to renew it. A current license tops our list of required provider credentials and we're required to terminate providers from our network when their licenses expire. Providers who want to rejoin the network (following termination due to license expiration) will have to reapply and go through the credentialing process again. It's also important to know that we'll deny claims submitted by an unlicensed provider.

Commercial

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



Guidelines for Submitting Urgent and Elective Authorization Requests

You can get behavioral health utilization reviews for emergency services 24-hours-a-day, seven days a week. Emergency behavioral health services should be authorized at the time of admission or within two days. Non-urgent services must be authorized at least one business day before admission and no later than one business day after.

BlueCare Tennessee

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

Top Tips for Recording Well-Child Care

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child checkups have seven key components. When patients visit your office for their well-child exams, please document all seven components, as well as assessments of their weight and physical activity.

Your patients' medical records and the initial EPSDT records that you send to us should include all care administered during the exam, including seasonal flu shots. If you're unable to complete all or part of an exam because a patient deferred or refused the exam, please note this.

Additionally, claims submitted for EPSDT visits must match your patients' medical records and contain codes for all parts, including the physical exam, vaccines, lab tests, and hearing, vision and milestone and depression screenings.

For more information about the components of the EPSDT exams and documentation and billing requirements, please see our TennCare Kids Tool Kit.

Note: This article doesn't apply to CoverKids.

Credentialing and Claims Filing Requirements for Nurse Practitioners and Physician Assistants

Since Jan. 1, 2017, we've required nurse practitioners and physician assistants who care for our members to be credentialed and re-credentialed every three years. We also require provider offices to list these professionals as rendering providers on claims when they care for patients.

When we put these requirements in place, we told providers we would begin denying claims submitted by non-credentialed nurse practitioners and physician assistants starting May 1, 2017. However, in the May 2017 BlueAlert, we announced we would postpone the claims denial until further notice. We're still working through system logistics, which is why we haven't provided an update. We're sorry if this has caused any confusion.

While we aren't denying claims at this time, we do need to remind providers that we may recover payment if we learn through routine monitoring and post-payment auditing efforts that billing and credentialing guidelines haven't been followed. We'll also refer providers who don't meet these guidelines to the applicable state agency as required by our contractor risk agreement.

If you have questions about these policies, please contact your provider network manager.

BlueCare Tennessee Reimbursement Policy for CPT® Category III Codes*

Beginning May 1, 2020, the BlueCare, TennCare*Select* and CoverKids reimbursement rate for CPT® Category III codes will be $0.00. These codes are used to track the use of emerging technologies, services and procedures, and they don't establish a service or procedure as safe, effective or medically necessary.

We're introducing this policy based on Medicare guidelines established by the Centers for Medicare and Medicaid Services' National Coverage Policy. If Medicare develops a price for a CPT® Category III code, we may allow payment. We may also allow payment if the service is approved through an initiative, such as telehealth or telemedicine, or one of our medical directors approves payment for a specific case following a medical review.

We're updating the BlueCare Tennessee Provider Administration Manual to include this information. If you have questions, please contact the Provider Service line for your patient's plan.

Claims Guidelines for Patients with Primary and Secondary Coverage

As you know, some patients have more than one insurer. For example, patients who are dual eligible have Medicaid and Medicare. Other patients may have Medicaid and a Commercial plan.

BlueCare Tennessee is the payer of last resort and considered secondary to Medicare and Commercial plans. To make sure you receive the appropriate payment, please file claims with Medicare or a patient's Commercial insurer before billing BlueCare Tennessee. Billing us first may cause improper payments and result in the recoupment of payments.

We've recently updated our utilization management approval letters to include this reminder. If you have questions, please call Provider Service at **1-800-468-9736** for BlueCare and **1-800-276-1978** for TennCare*Select*.

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

Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

Extension on Provider Assessment Form Rate Through July 31

As a reminder, providers are able to bill CPT® code 96160 for a Provider Assessment Form (PAF) annually for all BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ members. The reimbursement for these forms is $225 for dates of service between January 1 and June 30 and $175 for dates of service between July 1 and December 31. Because of the potential risk for most Medicare-aged members to seek routine care with the novel coronavirus presence, we are extending our $225 level reimbursement for these forms through **July 31, 2020** in order to avoid these members having to come to your office in the next 30 days for Wellness Exams and PAF completion. Please contact your Medicare Advantage Quality Outreach Consultant with questions.

High Tech Imaging Authorization Vendors Differ by Coverage

As a reminder, the Medicare Advantage and DSNP plans use the Magellan Healthcare National Imaging Associates (NIA) radiology benefit management program for authorization review for non-emergent outpatient advanced imaging and cardiac imaging. This is a different clinical business partner than what is used by our Commercial and BlueCare plans for the same service.

Emergency room, observation and inpatient imaging procedures do not require prior authorization from NIA. If an urgent/emergent clinical situation exists outside of a hospital emergency room, please call **1-888-258-3864** to initiate an urgent request.

You can send requests for advanced imaging and cardiac imaging prior authorizations to NIA through Availity.com or by calling **1-888-258-3864**. NIA does not accept authorization requests via fax.

Medicare Advantage Medical Record Request for Risk Adjustment

Medicare requires us to provide annual documentation to show the presence of some acute and many chronic conditions in Medicare Advantage populations through risk adjustment. Although we get a lot of this information from member claims data, we still need to get more details from medical records on certain members.

You may receive correspondence asking for some of your patient records for risk adjustment. Please follow the instructions included with the correspondence and respond to the request as quickly as possible. If you have questions about the medical records request or risk adjustment process, please call your quality outreach consultant or Risk Adjustment at **1-855-413-8776**.

Pharmacy

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

Medicare Advantage & DSNP Prior Authorization Review Timeframes Updated for Part B Drugs

At the beginning of 2020, CMS updated the prior authorization review timeframes for Medicare Advantage plans. This includes expedited reviews and Part B (provider-administered medication) drug reviews.

Updated Timeframe Guidelines:

- Standard pre-service request: 14 calendar days from receipt of request
- Part B drug request: 72 hours from receipt of request
- Expedited: Pre-service request: 72 hours from receipt of request
- Expedited Part B drug request: 24 hours from receipt of request

Please submit all relevant clinical information with your initial request to Magellan Rx. This is particularly important for Part B drug authorization requests. This will help us meet the new timeframes and avoid potential denials or delays due to insufficient information.

Please note that while you can ask for a pre-service request extensions, they are not allowed for Part B drug requests.

Quality Care Rewards

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

Provider Star Ratings for Medicare Advantage and BlueCare Plus Now Available in Availity

The BlueCare Plus Quality+ Partnerships Program offered providers enhanced reimbursement for ratings of 3 STARs and above for quality scores and coding accuracy between Jan. 1 – Dec. 31, 2019. Participating providers can see their 2019 Star rating in Availity by accessing the Quality Care Rewards application and clicking on their 2020 BlueCare Plus VBC scorecard. The rating is at the top of the scorecard. Star ratings based on the previous year's performance impact current reimbursement rates, effective April 1, 2020.

The Medicare Advantage Quality+ Partnerships Program offered providers enhanced reimbursement for ratings of 4 STARs and above for quality scores and coding accuracy between Jan. 1 – Dec. 31, 2019. Participating providers can see their 2019 Star rating in Availity by accessing the Quality Care Rewards application and clicking on their 2019 Medicare Advantage scorecard. The rating is at the top of the scorecard. Star ratings based on the previous year's performance impact current reimbursement rates, effective April 1, 2020.

New fee schedules were included with the rebasing rate notification letters that we mailed at the end of March.

Contract amendments contain information about base rates, quality escalators and total earning potential. On May 1, you can find a complete listing of all providers with a 4-Star rating and above at provider.bcbst.com/working-with-us/quality-initiatives/.

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.

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**.

of Tennessee

MAY 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

During this state of emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **bcbstupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Provider Enrollment and Change Forms to Require Availity® Log In

We'll soon be moving provider enrollment to a more secure process by requiring an Availity log-in for submission of applications and change forms. The new log-in requirement will first be implemented for the provider enrollment form and will then be applied to the change form in the near future. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with **Availity**.

While in Availity, please visit the Contact Preferences section to add your email, along with other preferences, so we'll know how you'd like to receive communications from us.

Change of Schedule for All Blue Workshops

Due to the COVID-19 pandemic, we're rescheduling our All Blue Workshop events. We'll share updates in the BlueAlert newsletter and the **All Blue Workshops page** of our website when we have the new dates and locations. If you have questions, please contact your network manager.

Code/Modifier Requirement Reminder

Effective March 16, 2020, we began rejecting and/or returning claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus lines of business. You can resubmit these claims for reimbursement after correcting them with valid combinations. Also effective March 16, 2020, we began denying claims with invalid procedure code and modifier combinations for the BlueCare, TennCare*Select* and CoverKids lines of business. Once you correct the claims, you can resend them for reimbursement review.

You can find more information about billing modifiers in the **Provider Administration Manual**, or in the National Correct Coding Initiative (NCCI) policy manual at cms.gov. You can also call our Provider Service Line at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. ET. For BlueCare, please call **1-800-468-9736** and for TennCare*Select*, the number is **1-800-276-1978**.

Commercial

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

New Convenient Bill Pay Option for BlueCross Members

In late April, we introduced a new tool that allows Commercial members to pay providers from our website. InstaMed, a trusted nationwide health care payment system, is now available in their online member account. After logging in, members can review claims and conveniently pay you directly for any deductibles or out-of-pocket costs.

Depending on your level of participation, InstaMed will send the member's payment within one or two business days. Electronic payments are made as soon as the next day. Mailed payments arrive within seven to 10 business days.

If you already have an InstaMed account, there's nothing you need to do. However, if you want more information, want to register for or upgrade your account, please visit **InstaMed's website**.

Prior Authorization Changes Scheduled for Commercial Plans

The following prior authorization changes will be effective Aug. 1, 2020.

72-Hour Ambulatory Glucose Monitoring CPT® codes 95249 and 95250 will no longer need prior authorization.

BlueCare Tennessee

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

4 Ways to Make Appointment Scheduling Easier

Lifelong health starts with well-child care, but it's not always easy to keep children on track with their Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams.

Consider these best practices to make scheduling appointments easier for your patients — and your team:

1. Schedule a full year of visits for newborns at their first one. Children covered by BlueCare Tennessee are eligible for well-care visits on the **same schedule recommended by the American Academy of Pediatrics**.
2. Schedule the next well-child exam at the end of each appointment.
3. Make the most of your electronic medical records system patient reminder tools, such as letters, text messages and reports.
4. Consider offering extended or alternate office hours to make it easier for families to keep appointments. Some practices have found that offering appointments in the evenings or on weekends helps more kids and teens get their well-child checkups. If you're interested in adjusting your hours, ask your patients' parents and caregivers what times are most convenient for them.

Note: This article doesn't apply to CoverKids.

Prior Authorization Not Required for Maternity-Related Inpatient Care

As a reminder, you don't need to request prior authorization for a maternity-related inpatient hospital stay for your patients covered by BlueCare, TennCare*Select* or CoverKids. However, if you need assistance with discharge planning, we're happy to help. Please call our Utilization Management team at **1-888-423-0131**.

Abortion Eligibility and Claims Criteria

We cover abortions in accordance with federal and state laws and regulations. An abortion may be covered if it's medically necessary and performed to save the life of the mother, or if the pregnancy is a result of incest or rape.

To provide payment for a medically necessary abortion and related services, we need several important documents, including:

- Certification of Medical Necessity for Abortion form. You can find English and Spanish versions of this form on the Division of TennCare's Miscellaneous Provider Forms page. Please:
  - Complete each section, including the date of service, patient name, date of birth and address, applicable medical condition, provider name, NPI and address, and required signatures.
  - Sign the form. The form must include a provider's handwritten signature — not a stamp of the signature.
- Medical records documenting the life-saving nature of the abortion. Please include:
  - Records from the history and physical
  - Operative and pathology reports
  - Other medical records as requested

In cases of an abortion performed to end a pregnancy caused by incest or rape, please provide documentation from a law enforcement, public health or counseling agency indicating that the patient has made a credible report of incest or rape.

Claims that are missing any of the items listed here may be rejected.

For more information, please refer to the **BlueCare Tennessee Provider Administration Manual** or contact your provider network manager.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ plans.

Provider Assessment Form Reimbursement Extension

As a reminder, you may bill CPT® code 96160 for a Medicare Advantage Provider Assessment Form (PAF) at the $225 rate for dates of service through July 31, 2020. Please contact your Medicare Advantage Quality Outreach Consultant if you have questions.

Hyperbaric Oxygen Therapy Requests

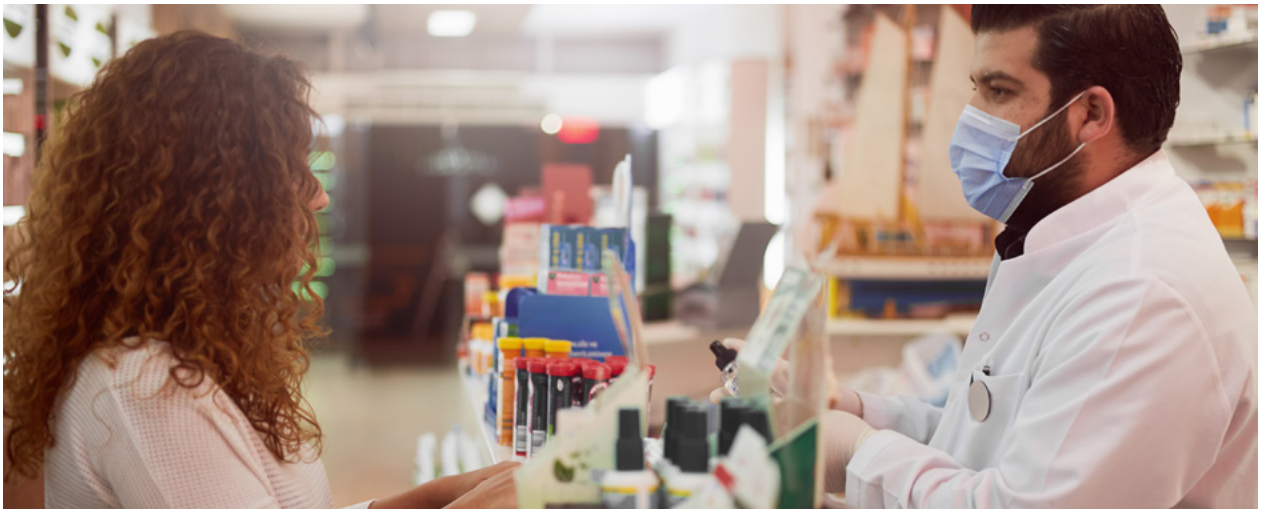
Prior authorization is required on hyperbaric oxygen therapy requests. Please make sure you send the proposed length of the session (e.g., 30 minutes, one hour) and frequency needed when submitting clinical information. According to Medicare coverage criteria, these will be reviewed every 30 days. Members with wounds are expected to have a face-to-face follow-up evaluation every 30 days. Medicare has a 60-session limit every 12 months per unique diagnosis. You can submit these requests by phone or fax.

New Limited Benefit: Acupuncture for Chronic Low Back Pain

Since Jan. 21, 2020, acupuncture is now a covered service for treatment of chronic low back pain under section 1862(a)(1)(A) of the Social Security Act for Medicare beneficiaries. This new benefit is limited to treatment of low back pain only and provides for up to 12 acupuncture visits in 90 days. Chronic low back pain is defined as: pain lasting 12 weeks or longer/having no identifiable systemic cause such as metastatic disease/inflammation/ or infection, and pain that is not associated with surgery or pregnancy. An additional eight sessions will be covered only if the member showed improvement with the initial 12 visits. No more than 20 acupuncture treatments will be covered yearly. These services must be performed under direct supervision of a Medicare participating provider and in that provider's office. These services require a prior authorization that can be requested by phone at **1-800-924-7141**, fax to **1-888-535-5243** or through Availity.

Pharmacy

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



COVID-19 Response: TennCare Pharmacy Program Phase II Updates

The Division of TennCare announced additional temporary changes to the TennCare Pharmacy Program on April 1, 2020, in response to the ongoing COVID-19 pandemic. To view the TennCare notice outlining these changes, please **click here**. We've included a summary of key points below.

Effective April 1, 2020, TennCare will temporarily:

- Cover certain over-the-counter (OTC) medications for adults at a $0 copay. These OTC products include acetaminophen, antihistamines, and cough expectorants and suppressants.
- Process maintenance medications for up to a 90-day supply, excluding opioids and other controlled medications
- Continue to suspend refill-too-soon edits, with specific exceptions for controlled medications and medications containing buprenorphine
- Automatically extend prior authorizations that are due to expire on or before June 15, 2020, for medications on the Attestation and Auto-Exempt lists. This extension postpones these expiration dates for an additional 90 days
- Cover mail or delivery options offered by local pharmacies

If you have questions about these changes, please call the Pharmacy Support Center at **1-866-434-5520**.

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

Quality Care Rewards

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

THCII Delivery System Transformation Annual Feedback Session

The Division of TennCare has scheduled the Tennessee Health Care Innovation Initiative (THCII) virtual annual feedback session for Wednesday, May 20. If you're a Quarterback participating in the BlueCare or CoverKids Episodes of Care program, this is a great opportunity to ask questions or voice any concerns.

To learn more and receive up-to-date information about the annual feedback session and other important updates, sign up for the Episodes of Care Newsletter at **stateoftennessee.formstack.com**.

THCII Episodes of Care Program Reports Available This Month

Quarterbacks participating in the Episodes of Care Program will receive their 2020 Interim Performance Reports for Medicaid and Commercial on May 21. Please log in to **Availity.com** to review your reports.

If you have trouble accessing your reports in Availity, please call **(423) 535-5717** and choose option 2, or email **eBusiness_Service@bcbst.com** for assistance.

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**.

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**.

of Tennessee

JUNE 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

INSIDE THIS ISSUE

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **bcbstupdates.com** for up-to-the minute guidelines on treating our members.

Learn How We're Planning to Offer Telehealth Permanently

Telehealth has made it easier for providers to treat our members during the COVID-19 emergency. That's why we've announced we're going to permanently support telehealth services for our Commercial line of business for in-network providers who offer them. At this time, the permanent expansion only applies to our Commercial line.

Until further notice, BlueCare Tennessee, Medicare Advantage and BlueCare Plus will continue covering telehealth during the COVID-19 emergency, as we have for the past few months. We'll continue to provide updates about the services we'll cover at **BCBSTupdates.com**, so please refer to this page often.

To read more about our Telehealth Expansion, please see the **article** posted on our News Center page.

Provider Enrollment and Change Forms to Require Availity® Log In

We'll soon be moving provider enrollment to a more secure process by requiring an Availity log-in for submitting applications and change forms. The new log-in requirement will first be implemented for the provider enrollment form and will then be applied to the change form in the near future. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with **Availity**. While in Availity, please visit the **Contact Preferences** section to add your email, along with other preferences, so we'll know how you'd like to receive communications from us.

All Blue Workshops to Resume in Spring 2021

Due to the COVID-19 emergency, we've decided to cancel the remainder of this year's All Blue Workshop events. You can still view the presentations by downloading the materials from the **All Blue Workshops page** of our website. We plan to resume the events next year and we look forward to seeing you in Spring 2021. If you have questions, please contact your Network Manager.

Updating Security for Our Websites

Whether you're scrolling through web pages, downloading files or email communication, security is essential. That's why we're updating all of our websites and secure systems to require Transport Layer Security (TLSv1.2). We're utilizing technology that ensures privacy, integrity and protection for our customers' information. These security updates may affect electronic claim filing and other electronic transactions. With this update, you'll no longer receive a Cisco Registered Envelope Service or be required to enter a password to access your email message from us.

We're also upgrading our Secure File Transfer Protocols (SFTP) system, which means you'll need to check with your vendor to make sure your SFTP security system is current. If it's not updated with the latest security settings before **July 17, 2020**, your system may not be able to connect to BlueCross.

To avoid disruption, please have your IT administrators verify system compatibility. If you have questions about this upgrade, you can call eBusiness Technical Support at **(423) 535-5717** and select option 2 or email **eBusiness_service@bcbst.com**.

Commercial

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

Submit CPAP Authorizations Through Availity

To save time and money, you can submit CPAP authorizations and supporting documents online through Availity. Most Commercial plans require prior authorization for durable medical equipment (DME) over $500 a month. If your request meets criteria, you can get an immediate approval.

Note: No prior authorization is required for CPAP rental price, unless the cost is more than $500 a month.

If you need assistance with Availity, please call **(423) 535-5717** and select eBusiness or contact your **eBusiness Marketing Consultant**.

Faith Daniel, East Tennessee
Faith_Daniel@BCBST.com
(423) 535-6796

Debbie Angner, West Tennessee
Debbie_Angner@BCBST.com
(901) 544-2285

Faye Mangold, Middle Tennessee
Fay_Mangold@BCBST.com
(615) 426-9122

Clinical Trial Claims Reminder

BlueCross covers only routine patient care and services associated with clinical trial claims for our Commercial members. You're required to let us know when your patient participates in a Phase I, II, III or IV clinical trial by sending us a fax on your practice's letterhead to **(423) 591-9080**.

To properly bill for clinical trials, please use these modifiers:

- Q0 - Investigational clinical service provided in a clinical research study that is in an approved clinical research study.
- Q1 - Routine clinical service provided in a clinical research study that is in an approved clinical research study.

Prior Authorization Changes Scheduled for Commercial Plans

Beginning **Aug. 1, 2020**, 72-Hour Ambulatory Glucose Monitoring CPT® codes 95249 and 95250 will no longer need prior authorization.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Aug. 1, 2020, the following CPT® codes will need prior authorization:

- 0172U
- 0173U
- 0175U
- 0179U

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 may send prior authorization requests through Availity or you can submit them to eviCore by fax at **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.

Assess Your Patients' Vision During Well-Child Checkups

Vision screening is one of the seven key components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Please let your patients know that we cover vision screening for children, teens and young adults. Please refer your patients to an eye specialist if you have concerns about their vision or eye development. We cover eyeglasses that are medically necessary.

Children, teens and young adults are eligible for well-child care on the **same schedule recommended by the American Academy of Pediatrics**. For more information, please see our **TennCare Kids Provider page**.

Note: This information doesn't apply to CoverKids.

Sterilization and Hysterectomy Eligibility and Claims Criteria

We cover sterilization and hysterectomy in accordance with federal and state laws and regulations. We need several important documents to provide payment for a sterilization or hysterectomy. Here are the criteria and claims requirements for each.

Sterilization

- Patients must be at least 21 years old, mentally competent and consent to the procedure.
- The claim must be submitted with a **Consent for Sterilization Form**. You can find directions for completing this form on **tn.gov**. Please refer to information on patient signature in TennCare's Instructions.
- There must be 30 days between the date the patient signs the Consent for Sterilization form and the date the procedure is performed. Exceptions may be made in emergency situations, as noted in the **BlueCare Tennessee Provider Administration Manual**.
- A copy of the operative report should be attached to the claim.

Hysterectomy

- Hysterectomy must be medically necessary.
- Patient must have been notified, in writing, that the procedure will prevent them from having children in the future.
- Providers must sign and attach the Title XIX Acknowledgement of Hysterectomy Information form to the claim after the procedure is performed.
- Claims must include a detailed history, physical and any office notes that outline conservative treatments tried before the procedure, the operative and pathology reports, and the Acknowledgement of Hysterectomy Information form signed by your patient. You can find this form on the Division of TennCare's **Miscellaneous Provider Forms** page. Please note your patient must write their full name on the signature line — we can't accept forms that have an initial in place of the patient's full last name.

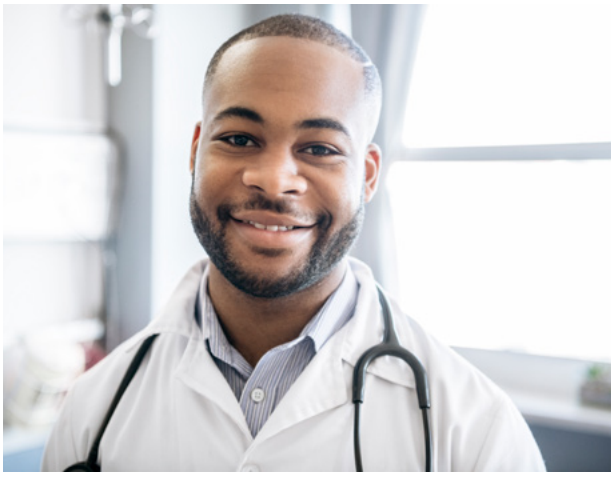
Please refer to the **BlueCare Tennessee Provider Administration Manual** for more information about these requirements and contact your provider network manager if you have questions.

Thank you for considering the complete health care needs of our members, including their emotional needs when managing these procedures.

Provider Satisfaction Survey Coming Soon

Providers in the BlueCare, TennCareSelect and CoverKids networks will receive our 2020 Provider Satisfaction Survey between June and September. When you receive the survey, we hope you'll take the time to share your feedback. We look forward to hearing from you.

To learn more about the survey and how you can participate, please **click here** to read the Division of TennCare's survey announcement.



BlueCare Tennessee and BlueCare Plus (HMO SNP)SM

This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus dual-eligible special needs plans.

Billing Requirements for Behavioral Health Providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering services to BlueCare Tennessee, BlueCare Plus or CoverKids members is different than the billing provider. If your agency bills for services that weren't provided by a licensed clinician, please enter the supervising professional as the rendering provider on the claim. Claims submitted without the rendering provider will be rejected and returned unprocessed.

Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

Provider Assessment Form Reimbursement Extension

You may bill CPT® code 96160 for a Medicare Advantage Provider Assessment Form (PAF) at the $225 rate for dates of service through **Aug. 31, 2020**. Please contact your Medicare Advantage Quality Outreach Consultant if you have questions.

Provider Quality+ Partnerships Program Educational Presentations Available

The Medicare Advantage Provider Education WebEx series has launched in **Availity**. These valuable education opportunities can serve as a resource for additional ways to your enhance performance in the MA Provider Quality+ Partnerships program. Presentations, which range from 15 to 60 minutes, include a program overview and cover topics such as the Quality Care Rewards Tool, 2020 quality program measures, medication reconciliation and more.

To access the presentations after logging in to Availity, choose **BlueCross BlueShield of Tennessee** within **Payer Spaces**, then **Resources**. On the Resources page, you'll see a list of available presentations. Additional presentations will be recorded and available within Availity throughout the coming months.

Pharmacy

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

Prior Authorization No Longer Required for Certain Drugs

Starting **July 1, 2020**, BlueCross won't require a prior authorization for these drugs:

- Fosnetupitant / Palonosetron (Akynzeo)
- Granisetron Extended-Release Injection (Sustol)
- Palonosetron hydrochloride (Aloxi)
- Histrelin Acetate Implant for Prostate Cancer (Vantas)

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee, Inc. comply 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, 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**.

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**.

20PED841417-3 (5/20)

of Tennessee

JULY 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

New Contact Types in Availity® Will Give Providers More Message Delivery Options

You now have more choices about how you receive messages from us. We've added five new options to **Availity's Contact Preferences** section so you can specify how you'd like to receive these types of notifications. The new contact types are:

- **Credentialing** - Information about your credentialing status (specific provider directory information that's not currently collected in CAQH)
- **Network Operations** - Updates about network enrollment and your listing in the BlueCross Provider Directory
- **Network Updates** - General business announcements, newsletter updates and surveys
- **Quality & Clinical** - Notifications of available clinical data, performance and payment reporting for our value-based programs
- **Financial** - Transactional notices about billing, Electronic Funds Transfer and tax-related items

You can update your contact preferences with your email address for each of these communication types. We've also added fax and phone number as optional communication preferences. Be sure to check your contact preferences to make sure you're getting important messages and announcements that apply to you. Also, please continue to look for updates under the **News & Announcements** and **Notification Center** sections of Availity.

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

Provider Enrollment Now Requires Availity Log In

We've updated our provider enrollment process to make it more secure. Now, if you're interested in joining a BlueCross network or, if you're already in our network and need to notify us about a change in your practice, please log into **Availity** and go to the BlueCross BlueShield of Tennessee, Inc. Payer Space. From there, you can apply to join our network by completing a Provider Enrollment Form — or you can submit a Change Form to let us know about an update to your existing practice, like a new practice location, a new Tax ID or other important changes.

If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with Availity.

Update to Clinical Practice Guideline for Asthma

We've updated the Medical Clinical Practice Guideline for asthma on our **guidelines web page**. To request a paper copy of our clinical practice guidelines, please call us at **(423) 535-6705**.

All Blue Workshops to Resume in Spring 2021

Due to the COVID-19 emergency, we've decided to cancel the remainder of this year's All Blue Workshop events. You can still view the presentations by downloading the materials from the All Blue Workshops **page**. We plan to resume the events next year and we look forward to seeing you in spring 2021. If you have questions, please contact your Network Manager.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so if you're not sure when 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. If a provider is terminated from the network because of an expired license, they must reapply and go through the credentialing process if they want to rejoin the network. It's also important to note that any claims submitted by an unlicensed provider will be denied.

Prior Authorization Changes Scheduled for August

Beginning Aug. 1, 2020, 72-Hour Ambulatory Glucose Monitoring CPT® codes 95249 and 95250 will no longer need prior authorization.

Reminder to Complete Medicare Required Special Needs Plan Model of Care Training

Providers participating in the BlueCare Plus (HMO SNP)[SM], BlueCare Plus Choice (HMO SNP)[SM], and BlueEssential (HMO SNP)[SM] special needs plans are contractually required to complete our **Model of Care Training** after initial contracting, then every year afterwards. This training is an expectation CMS has for all special needs plans. The training promotes tools that exist for improved quality of care and care coordination for special needs members with complex, chronic or catastrophic health care needs. You can access the brief, online self-study training and attestation by **clicking here**.

Commercial

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

BlueCross PCP Performance Ratings to be Refreshed Soon

In January 2020, we added a BlueCross Performance Rating in our online provider directory for Commercial primary care providers (PCPs) in Blue Network P and Blue Network S to help our members make informed health care decisions for themselves and their families.

The first annual refresh of those scores will take place in the fall of this year and will reflect changes to PCPs' scores using data from the 2019 performance year.

In mid-July, we'll send information to all practices with at least one PCP in our Commercial networks, including:

- Updated scores for the practice's individual PCPs
- A document with answers to frequently asked questions
- Who to contact if you have questions

The health and well-being of our members is our top priority. We appreciate the care you provide to them.

Reminder for Walk-In Retail Health Clinics

If your practice is classified as a walk-in health clinic, please submit Commercial claims using Place of Service (POS17). Using another code may impact the member's benefits and/or pricing. If you have questions, please call the Provider Service line at **1-800-924-7141**.

BlueCare Tennessee

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

Methadone Now a Covered Service

TennCare and its MCO partners have included methadone as a Medication Assisted Treatment (MAT) option in confronting the opioid crisis and helping members who struggle with opioid use and addiction. Since **June 1, 2020**, TennCare providers are reimbursed for methadone-related services.

MAT combines medications with counseling and behavioral therapies for a whole-patient approach to the treatment of Opioid Use Disorder (OUD). Because the needs of members recovering from opioid addiction can vary, we can better serve our members by offering options like office-based treatment and outpatient opioid treatment programs (OTPs), which integrate medical and behavioral therapies.

In addition to State and Federal regulations, the TennCare Opioid Treatment Program Description outlines treatment and clinical care activities expected of OTP facilities who dispense

MAT products and the professionals who provide therapy, care coordination or other ancillary services.

Refer to **TN Together** for more information on MAT service, finding providers or making a referral.

Be on the Lookout for Southeastrans Information Requests

We contract with Southeastrans to offer non-emergency transportation services to your patients covered by BlueCare and TennCare*Select*. Southeastrans conducts regular pre- and post-trip audits to make sure that our members use transportation for covered services only and that visits go as scheduled. As part of these audits, Southeastrans may call your office to verify your patients' appointments. This is a normal part of Southeastrans' process, and you may release the requested information.

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

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

ASH Claims Review Coming in Quarter 4 2020

During the fourth quarter of 2020, we'll review all BlueCare, TennCare*Select* and CoverKids claims that include an absolute or possible abortion, sterilization or hysterectomy (ASH) code submitted with a date of service between **July 1, 2019**, and **June 30, 2020**.

The ASH retrospective audit includes an in-depth review of documents that may not have been required at the time claims were submitted. If your practice submitted a claim containing an ASH code between July 2019 and June 2020, we may contact you to request additional records. Please note we may recover payment if we don't receive these records within the requested timeframe.

If you have questions about the ASH review or ASH claims guidelines, please see our **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

Hysterectomy Coverage Update*

Beginning **July, 1, 2020**, we'll cover hysterectomies performed to prevent a possible future cancer diagnosis for our BlueCare and TennCare*Select* members. Previously, we only covered medically necessary hysterectomies, as communicated in the **June BlueAlert**.

Please note we don't cover hysterectomies that are performed for the sole or primary purpose of sterilization.

If you have questions about your patients' coverage, please contact your Provider Network Manager.

Note: This update doesn't apply to CoverKids.

*This change will be included in the next Provider Administration Manual update.

BlueCare Tennessee and BlueCare Plus (HMO SNP)SM

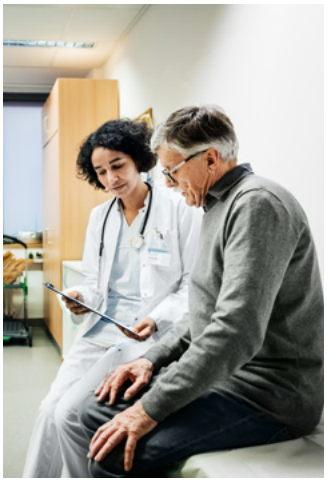
This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus dual-eligible special needs plans.

Billing Requirements for Behavioral Health Providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering services to BlueCare Tennessee, BlueCare Plus or CoverKids members is different than the billing provider. If your agency bills for services that weren't provided by a licensed clinician, please enter the supervising professional as the rendering provider on the claim. Claims submitted without the rendering provider will be rejected and returned unprocessed.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)SM and BlueEssential (HMO SNP)SM plans.



Reminder: Primary and Behavioral Care Costs Waived for Medicare Advantage Members

In an effort to bring peace of mind, help remove barriers and encourage members to seek the routine and preventive care they need during the COVID-19 emergency, coverage for Medicare Advantage members has been enhanced as of **May 19** by waiving member cost share for doctor's office and virtual telehealth visits specifically to network primary care and behavioral health care practitioners. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

Provider Assessment Form Incentive Extension

As a reminder, providers are able to bill CPT® code 96160 for a completed Provider Assessment Form (PAF) annually for all BlueAdvantage and BlueEssential members. The reimbursement for these forms is usually $225 for dates of service between Jan. 1 and June 30, and $175 for dates of service between July 1 and Dec. 31. Because of the potential risk for Medicare-aged members to have sought routine care during the COVID-19 emergency, we have extended our $225 level reimbursement for these forms through **Sept. 30, 2020**, to account for these members that may have avoided coming to your office during March and April for Wellness Exams and PAF completion. This date has been extended since we last published June's BlueAlert, which said we'd extend this level through Aug. 31, 2020. Please contact your Medicare Advantage Quality Outreach Consultant with questions.

Pharmacy

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

New Product for BlueAdvantage Hemophilia Program

BlueAdvantage members currently have the benefits of a Hemophilia Management Program in conjunction with our provider administered medication vendor, Magellan Rx. As of **June 30, 2020, Sevenfact**, a new recombinant coagulation factor VIIa concentrate product, has been added to oversight through this program.

The Medicare Advantage Specialty Pharmacy prior authorization list will be updated to add this new drug with prior authorization requirements. However, the manufacturer has not yet announced when this product will be available for administration, since its April approval by the FDA.

Tips for Coding Professionals

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

Tips for Coding Childhood and Adolescent Vaccines

Vaccines are a key element of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) TennCare Kids exams. Delivering vaccines on schedule not only protects your patients' health, but also lowers the risk of vaccine-preventable disease outbreaks. This is especially true for children age 2 and younger.

When administering and submitting claims for immunizations, please use the following CPT® codes:

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

You can view the immunization schedules for children and adolescents at **cdc.gov**. The American Academy of Pediatrics has also prepared a variety of resources, including a comprehensive **list** of all codes for commonly administered pediatric vaccines and **information** on delivering well-child care while minimizing their patients' COVID-19 exposure.

RP Modifier No Longer Required When Filing Vision Claims*

You no longer need to use modifier RP when billing BlueCare and TennCare*Select* claims for medically necessary replacement eyeglass lenses, frames and related dispensing fees. The modifier RP is no longer included in the Healthcare Common Procedure Code Set.

*We're updating the BlueCare Tennessee Provider Administration Manual to reflect this information.
Note: The information in this article doesn't apply to CoverKids.

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee, Inc. comply 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, 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**.

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**.

of Tennessee

AUGUST 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Submitting Provider Changes is Now Easier Using Availity®

We're moving away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes. It's available now in the BlueCross payer space at **Availity.com**. The PDF version of the **Provider Change Form** will be available at Provider.BCBST.com until Oct. 1, 2020. At that time we'll replace the PDF form with a link that directs you to log-in with Availity. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign-up with **Availity**.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of **CAQH ProView®** as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the Network Verification at **Availity.com**.

Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review. The Network Verification form in the **Provider Enrollment, Updates and Changes** tile, is located in the BlueCross payer space on Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification Form until we can migrate all providers to this new process.

If you have questions, please contact our Provider Service line at 1-800-924-7141 and select option 2 for Contracting and Credentialing.

Member ID Number Prefix Reminder

When submitting claims, please make sure the Member ID number is exactly as it appears on the Member ID card, including the prefix. We use prefixes to identify the member's type of coverage, obtain health plan contract information, and route claims to the correct Home Plan through the BlueCard and Inter-Plan programs. Please note that after Oct. 1, 2020, we'll start rejecting claims that don't have the complete Member ID numbers.

Commercial

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

Clarification: Prior Authorization Changes Scheduled for Commercial Plans

Beginning **Aug. 1, 2020**, 72-Hour Ambulatory Glucose Monitoring CPT® codes 95249 and 95250 will no longer need prior authorization.

The July BlueAlert didn't specify this change is for Commercial plans only.

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

BlueCare Tennessee

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

Help Your Patients Prepare for the New School Year

The beginning of every school year is a great time to check in with your patients and make sure they're up to date on preventive care. You can use the Quality Care Rewards application within Availity to find out which patients are past due for their checkup or any vaccines they may need for school.

This time of year, many patients also call in to schedule sports physicals. Stand-alone sports physicals and their corresponding codes aren't covered for BlueCare Tennessee members. However, if a patient is due for a checkup, you can convert the sports physical to a well-child exam. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams satisfy all components of sports physicals.

Web Prior Authorization Enhancement

Previously, the BlueCare, TennCare*Select* and CoverKids prior authorizations stored inside the Availity **Prior Authorization** application couldn't be updated after 45 days of inactivity. We've enhanced the Availity system so that clinical updates for existing prior authorizations can now be made beyond 45 days for most authorization types. If you need assistance with Availity, please call **(423) 535-5717** and select option 2 or contact your eBusiness Marketing Consultant.

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

Check Availity for BlueCare Tennessee and CoverKids Authorization Request Approvals

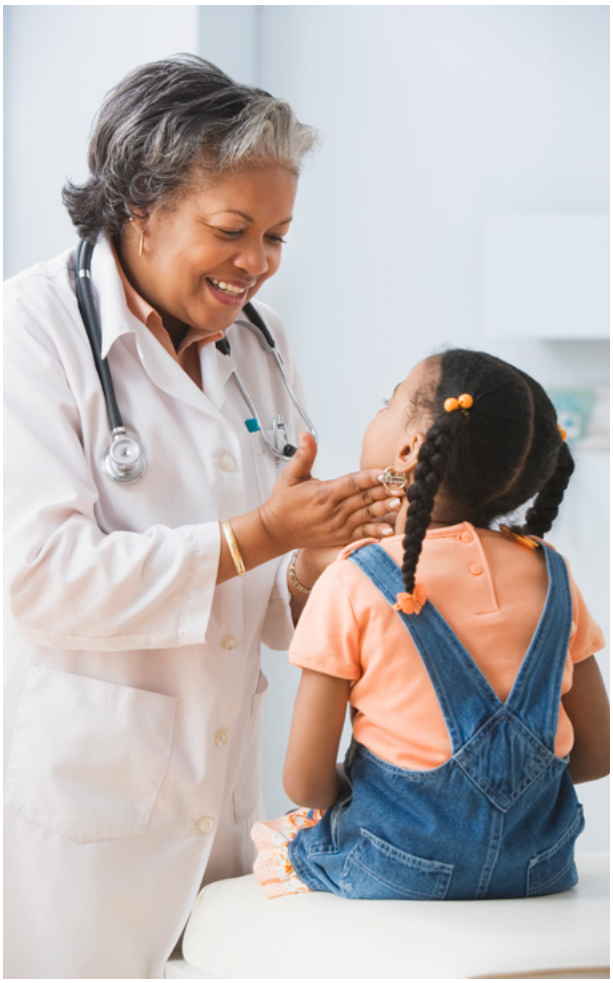
Effective Aug. 1, 2020, we'll no longer mail utilization management approval letters for BlueCare, TennCare*Select* or CoverKids members. To check on the status of authorization requests you've submitted, please log in to our Availity payer spaces application.

If you have questions about Availity or would like to schedule an on-site or webinar-based Availity training for your team, please contact the **eBusiness Marketing Consultant for your region**.

Process Change for Returned Claims

On June 15, 2020, we updated the way we notify providers about returned claims. If we need to return a claim, you'll get a letter with information about your patient and the dates of service, as well as the reason we're returning the claim. However, you'll no longer get a hard copy or image of the claim itself.

If you have a question about this change, please contact the Provider Service line for your patient's plan.



Updated Consent Form Instructions for Sterilization

The Division of TennCare recently updated the instructions for filling out the Consent for Sterilization form. Please click **here** to view the updated instructions, which went into effect on **July 1, 2020**.

We anticipate changes to the interpreter instructions to have the biggest impact on our members and network providers. If you use an interpreter to communicate with a patient about the procedure and the interpreter signs and dates the form after your patient's signature date, you must now wait at least 30 days from the date the interpreter signed the form to perform the procedure. For example, if your patient signed the form on July 29 and the interpreter signed it on July 30, you should wait until at least Aug. 30 to perform the sterilization. Exceptions to this 30-day waiting period may be made in emergency situations, as noted in the instructions.

If you have questions about these changes, please contact your Provider Network Manager.

ASH Claims Review Coming in Quarter 4 2020

During the fourth quarter of 2020, we'll review all BlueCare, TennCare*Select* and CoverKids claims that include an absolute or possible abortion, sterilization or hysterectomy (ASH) code submitted with a date of service between **July 1, 2019**, and **June 30, 2020**.

The ASH retrospective audit includes an in-depth review of documents that may not have been required at the time claims were submitted. If your practice submitted a claim containing an ASH code between July 2019 and June 2020, we may contact you to request additional records.

Please note we may recover payment if we don't receive these records within the requested timeframe.

If you have questions about the ASH review or ASH claims guidelines, please see our **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

BlueCare Plus (HMO SNP)SM

This information applies to our BlueCare Plus dual-eligible special needs plans.

Provider Perks: Incentives Can Benefit Patients and Increase Your Star Score

Annual Wellness Exams and Member Incentives

An annual wellness visit is an important first step to being healthy. Patients who complete an annual wellness visit at the beginning of the year are more likely to continue with important tests and screenings later on. Plus, they may be eligible to earn a reward for completing the exam. You can help your BlueCare Plus patients earn additional rewards for healthy living by scheduling and completing an annual wellness visit.

BlueCare Plus members are eligible for a reward under the BlueCare Plus rewards and incentives program after completing an annual wellness visit. Annual visits should be filed with 99387, 99397, 99385, 99395, 99386, 99396, 96160, G0402, G0438, G0439, plus appropriate E/M codes.

Note: The annual wellness visit is annual calendar-year benefit, so this means it's not necessary to wait exactly 365 days between exams.

Patient Assessment and Care Planning Form (PACF) Reimbursement

Network providers are eligible to receive payments for completing and submitting a Patient Assessment and Care Planning Form (PACF) for assigned BlueCare Plus patients. For attributed BlueCare Plus patients, please use CPT® code 96160 when submitting a claim for a completed PACF. BlueCare Plus will continue to reimburse the service as E/M Code 96160, reimbursed in the amount of $155.

Dual Special Needs Plans (DSNP) include as part of the plan, and components of the plan's Model of Care submitted to CMS, implementation of an interdisciplinary care team (ICT) to coordinate services and benefits for DSNP enrollees. The ICT brings together representatives of the DSNP and treating providers with the intent to promote better health and care for this vulnerable population. The ICT generally includes:

- Member's PCP and/or specialist provider
- DSNP care coordination team
- Member and/or member's family or representative
- Others requested by the member

When you complete the PACF or provide your equivalent medical record at the time you complete the annual wellness visit, or when we request it, you may submit a claim for participation in and update to the ICT using the applicable code. Appropriate claims submitted with the ICT code get paid $54. Also, providers who return post-discharge medical records for medication reconciliation may also able to bill the ICT code.

To receive reimbursement for completing the PACF, you must submit the completed form through Availity or by sending your completed form to the BlueCare Plus fax line -- (423) 591-9504. Please include the form in your patient's chart so it's part of their permanent record. For additional information about the PACF, please call 1-877-715-9503.

BlueCare Tennessee and BlueCare Plus (HMO SNP)SM

This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus dual-eligible special needs plans.

Billing Requirements for Behavioral Health Providers

Please note the following when providing behavioral health services to BlueCare, TennCare*Select*, BlueCare Plus and CoverKids members:

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering service is different than the billing provider. If your agency bills for services that weren't provided by a licensed clinician, please enter the supervising professional as the rendering provider on the claim. Claims submitted without the rendering provider will be rejected and returned unprocessed.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)SM and BlueEssential (HMO SNP)SM plans.

Provider Assessment Form Incentive Reminder

As a reminder, providers are able to bill CPT® code 96160 for a completed Provider Assessment Form (PAF) annually for all BlueAdvantage and BlueEssential members. The reimbursement for submitting completed PAF forms is usually $225 for dates of service between Jan. 1 and June 30, and $175 for dates of service between July 1 and Dec. 31. However, due to health concerns related to the COVID-19 emergency, we've extended our $225 level reimbursement for these forms through **Sept. 30, 2020**. We're making this one-time administrative exception to account for members who may have avoided coming to your office for annual wellness visits and PAF completion.

During the COVID-19 emergency, PAFs may be completed through a telehealth visit as long as the information becomes part of the permanent patient record. Any biometric data that can't be obtained through a virtual encounter can be charted during the next face-to-face visit with your patient. Please be sure to submit the updated PAF if the biometric data changes your assessment and treatment plan. Please note, there is no additional reimbursement for an updated or corrected PAF. Please contact your Medicare Advantage Quality Outreach Consultant with questions.

New Prior Authorization Forms Available

More specific prior authorization forms are now available in the **Medicare Advantage** section of the provider website under **Utilization Management**. The new custom forms include:

- Inpatient/outpatient admission/surgery requests
- Pre-determination requests
- Home health services
- DME requests
- Outpatient therapies
- Provider medical necessity appeals (i.e., post-service medical necessity appeals)

Medicare Advantage and BlueCare Plus (HMO SNP)

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus dual-eligible special needs plans.

Update: How to Submit Additional Diagnoses for Risk Adjustment

We've previously encouraged you to use CPT® code 99080 for additional diagnosis submissions beyond 12 when submitting all active chronic conditions for your BlueAdvantage, BlueEssential and BlueCare Plus patients. CMS now advises to use CPT® code **99499** to submit 12 diagnoses. This updated CPT® code can be submitted with a $0.01 charge for the same date of service when the patient encounter occurred. This CPT® can also be used multiple times for the same date of service to accommodate all the active chronic conditions with up to 12 diagnoses per additional claim.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise, and is intended as educational. Providers are responsible for determining what should be the appropriate codes included in claims submitted to the plan.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at 1-800-924-7141 and follow the prompts for option 1.

Quality Care Rewards

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

THCII Episodes of Care Program

The 2019 Final Performance Reports for our BlueCare Tennessee, State Employee Health Plan and Commercial Fully Insured lines of business will be released in August to Quarterbacks participating in the Episodes of Care Program. If you're a Quarterback and are having trouble accessing your quarterly report in Availity, please contact eBusiness Support for assistance. They can be reached by phone at **(423) 535-5717** (option 2) or by email at **eBusiness_service@bcbst.com**.

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee comply 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, 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**.

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**.

20PED893593-3 (7/20)

of Tennessee

SEPTEMBER 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Submitting Provider Changes is Now Easier Using Availity®

We're moving away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes. It's available now in the BlueCross payer space at **Availity.com**. The PDF version of the Provider Change Form will be available on our **provider page at BCBST.com** until **Oct. 1, 2020**. At that time we'll replace the PDF form with a link that directs you to log in with Availity. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign-up with Availity.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so if you're not sure when to renew your license, please take a look. A current license tops our list of required provider credentials, and we must terminate providers from our network when their licenses expire. If a provider is terminated because of an expired license, they must reapply and go through the credentialing process if they want to rejoin the network. It's also important to note that we'll deny any claims submitted by an unlicensed provider.

Join Us for a Virtual Health Information Technology (HIT) Program

Are you interested in Health Information Technology (HIT)? Then, please join us for a special virtual Health Information Technology Accelerator Program starting **Sept. 14, 2020**.

The Tennessee Chapter of the Healthcare and Information Management Systems Society (HIMSS) and the Center for Executive Education are offering a 14-week certification and acceleration program to healthcare information technology (HIT) professionals across Tennessee.

HIT professionals lead the training, covering best practices, real-world challenges and the future of health care and technology. The 14-week course starts Sept. 14 and meets every Monday night from 6:30 to 9:30 p.m. ET. The cost of the program is $2,495, and attendees will receive HIT certification when they've completed the program.

Registration is open until Sept. 14, the day of the first meeting. However, space is limited, so we encourage you to reserve your spot as soon as possible. Participants can dial into the teleconferences from a home or work computer. For more details about the classes, check out the **Fall 2020 Class Schedule**.

If you have additional questions about the program, please visit **tnhimss.org/education/hit-accelerator-program/** or contact **Erica Eubank**.

If you have questions about payment, please contact **Tiffany Madigan**, Executive Director at TN HIMSS.

Commercial

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

New High Performance Network Coming Soon

The Blue Cross Blue Shield Association is introducing a national network called Blue High Performance Network (Blue HPN) in January 2021. It's an alternative to BlueCard PPO and designed as a curated network that will provide improved, more affordable care. Quality measurement is a key feature, and plans are required to report on eight consistent national measures and eight market-specific clinical measures to address local gaps in care.

In Tennessee, we'll support Blue HPN through our existing Blue Network S as a statewide network. Availability is limited to self-funded employer groups in Chattanooga, Knoxville, Nashville and Memphis. Blue HPN won't replace existing BlueCard networks, but will be offered alongside BlueCard PPO as a second option.

Blue HPN is designed as an in-network only, Exclusive Provider Organization (EPO) product, so full benefits are limited to in-network providers only. If members need care when traveling outside of Blue HPN service areas, access is limited to urgent and emergency care services. Blue HPN members will have Member ID cards with Blue High Performance Network displayed on the front, along with an "HPN in a suitcase" logo.

The Blue HPN launch will not affect Blue Network S contracts or rates. Blue HPN providers will follow the same pre-service review and claims filing procedures used today for BlueCard PPO. For more information, please contact your Network Manager.

New Commercial Prior Authorization Forms

Two new forms are available for Commercial prior authorizations. You can find the **Commercial Hospice Services Request** and **Commercial Long-Term Acute Care Hospitalization (LTACH) Services Authorization Request** forms in the **Documents & Forms** section on our provider website.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning **Nov. 1, 2020**, the following CPT® codes will be added and will need prior authorization:

0203U	0208U	0212U	0215U	0218U
0204U	0209U	0213U	0216U	0220U
0205U	0211U	0214U	0217U	

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, or you may fax to eviCore at **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.

All Children and Teens Need Well-Child Care

Children with special health needs often require extra care and visits to specialists and their primary care providers. Even though you may see these patients frequently for ongoing care, they still need well-child checkups.

Your patients under age 21 are eligible for TennCare Kids Early and Periodic Screening, Diagnostic and Treatment exams on the same schedule recommended by the American Academy of Pediatrics. Consider using your electronic health records system or our Quality Care Rewards application to see which patients are due for well-child care, and contact them to schedule an appointment. If families are hesitant to visit your office during the COVID-19 outbreak, let them know about the precautions you're taking to help minimize COVID-19 exposure. For example, some practices have found it helpful to have separate office hours for "sick" and well-child care, while others with multiple locations have designated office sites for certain types of appointments.

For more information about delivering well-child care, please visit our TennCare Kids Tool Kit in the Provider **Tools and Resources** section of **bluecare.bcbst.com**. We recently updated our BlueCare EPSDT provider booklet, which includes the 2020 Bright Futures/American Academy of Pediatrics periodicity schedule.

To review the Division of TennCare's guidance for delivering well-child care during the COVID-19 outbreak, please visit **tn.gov/tenncare/information-statistics/tenncare-information-about-coronavirus.html**.

A New Look for Our BlueCare Tennessee Website

When you visit bluecare.bcbst.com, you'll likely notice that our home page looks different. We recently completed a redesign of the BlueCare Tennessee home and member web pages. The provider pages haven't changed, so you can still get the information you need by visiting bluecare.bcbst.com/providers or clicking any bookmarks you've saved.

You can also access the provider pages by logging in to bluecare.bcbst.com. Simply click **Provider Resources** in the banner at the bottom of the page or select **Providers** from the drop-down menu in the top-left corner.

Behavioral Health Transportation Process, Facility-to-Facility

TennCare covers non-emergency medical transportation (NEMT) between facilities for your eligible behavioral health patients going to a TennCare-approved facility. It's available 24/7, including weekends and holidays. Transportation can include a shared ride, personal vehicle or public transportation (bus) and offers mileage reimbursement.

The process and authorization requirements differ depending on the age of the patient, the network status of the facilities, and whether or not a facility is in-state.

There's now an easy-to-follow online resource to guide you through the process. **The Behavioral Health Transportation NEMT Overview covers** basic information on the transportation process and includes:

- How to get authorization, if needed, during regular business hours, after hours and holidays
- Who to call for transportation requests
- An overview of the process for BlueCare and TennCareSelect members in Department of Children's Services custody

ASH Claims Review Coming in Quarter 4 2020

During the fourth quarter of 2020, we'll review all BlueCare, TennCare*Select* and CoverKids claims that include an absolute or possible abortion, sterilization or hysterectomy (ASH) code submitted with a date of service between **July 1, 2019**, and **June 30, 2020**.

The ASH retrospective audit includes an in-depth review of documents that may not have been required at the time claims were submitted. If your practice submitted a claim containing an ASH code between July 2019 and June 2020, we may contact you to request additional records. Please note we may recover payment if we don't receive these records within the requested timeframe.

If you have questions about the ASH review or ASH claims guidelines, please see our **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

Request Prior Authorization for Durable Medical Equipment (DME) in Availity

Please use the Prior Authorization application within Availity to request DME prior authorization for your BlueCare, TennCare*Select* and CoverKids members.

We've recently made several enhancements to the system that will allow you to select the appropriate guideline and add documentation that explains the medical necessity of the requested service. If one of the guideline options isn't appropriate, please select "No Guideline."

If you have questions about using Availity, please call **(423) 535-5717**, option 2, or contact the eBusiness Marketing Consultant for your region:

Faith Daniel, East Tennessee
Faith_Daniel@bcbst.com

Debbie Angner, West Tennessee
Debbie_Angner@bcbst.com

Faye Mangold, Middle Tennessee
Faye_Mangold@bcbst.com

Prior Authorization Requirement Updates

Effective **Oct. 1, 2020**, your patients with BlueCare, TennCare*Select* and CoverKids coverage will need prior authorization for these services:

- Orthognathic surgery
- Autonomic nervous system testing
- Durable medical equipment and supplies costing more than $200

The following services will no longer require prior authorization as of **Oct. 1**:

- Electromyography (EMG)
- Nerve conduction studies (NCS)

Please note: In order to receive payment for NCS, the service must be performed/billed with an EMG.

For more information about these prior authorization requirements, please see the **BlueCare Tennessee Provider Administration Manual**.

BlueCare Plus (HMO SNP)SM

This information applies to our BlueCare Plus Choice Medicare Advantage, Fully Integrated Dual Eligible special needs plans. special needs plans.

BlueCare Plus Choice Fully Integrated Dual Eligible (FIDE) Special Needs Plan

BlueCare Plus Choice (BCPC) was introduced earlier this year to our Medicare and Medicaid CHOICES-eligible members. BCPC members can use their 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 processes both Medicare and Medicaid benefits on one remittance advice, which can help reduce paperwork. Please note this applies only to the BlueCare Plus Choice plan. BlueCare Plus plan members will still need to use their Medicaid program ID card when seeking Medicaid only services. If you have questions about this plan, please call the BlueCare Plus Provider Service line.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO/SNP)℠ plans.

Final Month for Provider Assessment Form Incentive Extension

As a reminder, providers are able to bill CPT® code 96160 for submitting a completed Provider Assessment Form (PAF) annually for all BlueAdvantage and BlueEssential members. The reimbursement for submitting completed PAF forms is usually $225 for dates of service between Jan. 1 and June 30, and $175 for dates of service between July 1 and Dec. 31. However, due to health concerns related to the COVID-19 emergency, we've extended our $225 level reimbursement for these forms through **Sept 30, 2020**. We're making this administrative exception to account for members who may have avoided coming to your office for annual wellness visits and PAF completion.

During the COVID-19 emergency, PAFs may be completed through a telehealth visit as long as the information gathered during the virtual assessment becomes part of the permanent patient record. Any biometric data that can't be obtained through a virtual encounter can be charted during the next face-to-face visit with your patient. Please be sure to submit the updated PAF if the biometric data changes your assessment and treatment plan. There is no additional reimbursement for submitting an updated or corrected PAF. You may contact your Medicare Advantage Quality Outreach Consultant with questions.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS annual survey is used by CMS to evaluate care and services provided to Medicare Advantage plan members. Care coordination is one specific category in which plan members are asked to respond to questions. The following are some care coordination tips that may help your patients who are Medicare Advantage plan members with a better experience:

- Consider establishing a system to follow-up on diagnostic or lab test results to include time frames to communicate results and educate patients on when and how they'll receive results.
- Educate patients on why they are being referred to a specialist, and consider having your staff help coordinate scheduling referrals and transferring records (where needed).
- Incorporate into reminder systems time frames for follow up with patients who have been referred to a specialist, and with specialists to obtain reports or visit summaries.
- If you know patients received specialty care, discuss their visit and the treatment plan they received at their next office or telehealth visit.

Questions Related to Services Provided to Medicare Advantage Members During the National Public Health Emergency

Please visit the Provider FAQs at **BCBSTupdates.com** for answers to questions on services for our Medicare Advantage plan members.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Review the List of Upcoming Code Edits

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before their effective dates.

If you have questions, please call us at **1-800-924-7141** and choose option 1.

Correct Modifier Reporting and Editing Reminder

Earlier this year, we published the Correct Modifier Reporting and Editing provider notification in the **Upcoming Code Edits**. These code edits became effective **April 30, 2020**. They address the use of modifiers as well as more complex coding situations that require manual review. The new edits include reviewing claim information and history to determine if the modifier is used correctly. Be sure your documentation supports these services, should medical records be required for a manual review.

You can view the **Correct Modifier Reporting and Editing** provider notification in the **Upcoming Code Edits**.

Need Help Finding Coding Updates?

- From our home page (**provider.bcbst.com**), select **Tools & Resources** from the upper left menu.
- Next, select **Coverage & Claims**.
- Once on **Coverage & Claims** page, scroll to the **Coding Information Codes for Submitting Claims** then click the drop-down arrow to view **Upcoming Code Edits**.

Quality Care Rewards

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

Division of TennCare Waiving Episodes of Care Risk-Sharing Payments

The Division of TennCare recently released a memo waiving the 2019 Episodes of Care risk-sharing payments in light of the COVID-19 emergency. Providers who owe a net risk-sharing payment for their final 2019 episode results will not have to make this payment.

Please note if a provider earned a gain-share payment based on their 2019 performance, they will still receive that payment from us.

Providers who participate in the Episodes of Care program can see if they have a risk- or gain-share payment by viewing their final 2019 reports in Availity.

For more information about this announcement, please see the **TennCare Memo: Waiving 2019 Episodes Risk-Sharing Payments**.

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee comply 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, 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**.

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**.

of Tennessee

OCTOBER 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at BCBSTupdates.com for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Flu Vaccines Are More Important Than Ever

Fall signals the beginning of flu season in Tennessee. This year, in light of COVID-19, it's even more important to educate patients about the importance of the flu vaccine. Consider offering these reminders to prepare your team – and your patients.

- Schedule patients' flu vaccines in advance, and send appointment reminders. The CDC recommends patients age 6 months and older get their flu shots by the end of October.
- Talk with your patients about the heightened importance of getting the flu vaccine and staying healthy during cold and flu season.
- If you have patients who will turn 6 months old toward the end of flu season, don't forget to order extra doses of the vaccine. It's often in short supply in February, March and April.

Non-Physician Practitioner Copay Amounts*

As part of ongoing oversight and monitoring activities, we discovered that – in some instances – our systems were not assigning the appropriate member copay for primary care or specialist services when the services were rendered by a nurse practitioner or physician assistant. Member copays for covered services provided by nurse practitioners or physician assistants should be consistent with the specialty type of their respective supervising physician and based on the type of provider (i.e., primary care or specialist) where the services were provided. We made system updates to correct this.

Starting Jan. 1, 2021, these system updates will be implemented and member copays for all lines of business (excluding Federal Employee Program members and BlueCard) will be based on whether the nurse practitioner or physician assistant is supervised and the services are provided by a primary care physician or specialist. For example, the copay for a member treated by a nurse practitioner supervised and occurring in a specialist office location will be the specialist copay provided for under the member's benefit plan.

As a reminder, we require all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. Supervising physicians need to also be participating in our provider network. Claims should be submitted under the rendering nurse practitioner or physician assistant NPI. Updated billing guidelines clarifying this will be published in the next update of your Provider Administration Manual.

Network Effective Dates Dependent on Receipt of Provider Information

We work hard to make the provider enrollment process fast and efficient. Please submit all new provider information as promptly as possible, so we can deliver effective dates and you can begin billing for the care they provide. We can't enroll providers in a new practice until we have the information necessary to make our system updates, even if you're only adding providers to an existing group. Network effective dates are based on when the individual provider is enrolled with BlueCross, not necessarily when the provider joins the group.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the Network Verification at Availity.com. Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review. The Network Verification form in the Provider Enrollment, Updates and Changes tile is located in the BlueCross payer space on Availity®. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification Form until we can migrate all providers to this new process. If you have questions, please contact our Provider Service line at **1-800-924-7141** and follow the prompts to reach Contracting and Credentialing.

Submitting Provider Changes is Now Easier Using Availity

We're moving away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes. It's available now in the BlueCross payer space at Availity.com. If you or your staff handles enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with Availity. We'll continue to accept PDF versions of the Provider Change Form until Nov. 1. After that date, all changes must be submitted through Availity.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under Coding Updates in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at **1-800-924-7141** and follow the prompts for option 1.

Member ID Number Prefix Reminder

When submitting claims, please make sure the Member ID number is exactly as it appears on the Member ID card, including the prefix. We use prefixes to identify the member's type of coverage, obtain health plan contract information and route claims to the correct Home Plan through the BlueCard and Inter-Plan programs. Please note that after **Oct. 1, 2020**, we'll start rejecting claims that don't have the complete Member ID numbers.

New Prior Authorization Requirement for Neuropsychological Testing

BlueCare℠, TennCare*Select*, CoverKids℠ and Commercial BlueCross BlueShield of Tennessee members (with the exception of FEP) will require prior authorization for neuropsychological testing beginning **Jan. 1, 2021**. Providers with appropriate training are encouraged to seek an automated authorization for psychological and neuropsychological testing through Availity. This option will make obtaining authorizations simpler. Training is available.

As always, we recommend that you also record time spent for all activities related to psychological testing in your patient record. When submitting claims, please remember to include necessary modifiers.

Providers not trained in neuropsychological and/or psychological testing should bill appropriately for behavioral health screenings.

To order copies of the CPT® codebook 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.

Commercial

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

New High Performance Network Coming Soon

The Blue Cross Blue Shield Association is introducing a national network called Blue High Performance Network (Blue HPN) in January 2021. It's an alternative to BlueCard PPO and designed as a curated network that will provide improved, more affordable care. Quality measurement is a key feature, and plans are required to report on eight consistent national measures and eight market-specific clinical measures to address local gaps in care.

In Tennessee, we'll support Blue HPN through our existing Blue Network S as a statewide network. Availability is limited to self-funded employer groups in Chattanooga, Knoxville, Nashville and Memphis. Blue HPN won't replace existing BlueCard networks, but will be offered alongside BlueCard PPO as a second option.

Blue HPN is designed as an in-network only, Exclusive Provider Organization (EPO) product, so full benefits are limited to in-network providers. If members need care when traveling outside of Blue HPN service areas, access is limited to urgent and emergency care services. Blue HPN members will have Member ID cards with Blue High Performance Network displayed on the front, along with an "HPN in a suitcase" logo.

The Blue HPN launch will not affect Blue Network S contracts or rates. Blue HPN providers will follow the same pre-service review and claims filing procedures used today for our BlueCard PPO. For more information, please contact your Network Manager.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Nov. 1, 2020, the following CPT® codes will be added and need prior authorization:

0203U	0211U	0216U
0204U	0212U	0217U
0205U	0213U	0218U
0208U	0214U	0220U
0209U	0215U	

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, or you may fax to eviCore at **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.

Coming Soon: Changes to the CoverKids Network*

Effective **Jan. 1, 2021**, the Division of TennCare is consolidating CoverKids into the TennCare Contractor Risk Agreement. At this time, CoverKids members will be assigned to one of the three TennCare managed care organizations. Those transitioning to BlueCare Tennessee will use the BlueCare network and have a primary care provider assigned to them.

Providers who've cared for at least one CoverKids member during the last 12 months will be invited to participate in the BlueCare network, if they're not part of the network already.

For more information, please see the Division of TennCare letter and FAQ document located under Announcements on the Provider News and Manuals page of our website. If you have questions about this change, please contact your Provider Network Manager.

*This change will be made to the next update of the Provider Administration Manual.

Help Families Feel at Ease When Visiting Your Office

We understand the COVID-19 outbreak has affected you and your patients, so we want to share some information that may be useful as you work to deliver preventive care.

Every practice is different and must decide what's best for the safety of their patients and staff. Some practices have found that performing "sick" and well-child visits at different times of the day or different locations is helpful. Others have patients call when they arrive and wait in their cars, when possible, to skip the waiting room.

When contacting patients who are overdue for well-child care, please remind them about the importance of routine checkups and let them know about any safety precautions you've put into place to limit COVID-19 exposure. The Tennessee Chapter of the American Academy of Pediatrics' Back to the Office Campaign contains helpful resources for having these conversations. If families are unable or unwilling to visit your office, a telehealth well-child visit may be an option. The Division of TennCare has extended its telehealth guidelines until **Dec. 31, 2020**. You can learn more here.

Transportation Is Available

If families need transportation to visit your office, please let them know that Southeastrans offers free rides to covered medical services and the pharmacy. Southeastrans has also taken precautions to help keep people safe during the COVID-19 outbreak and asks that passengers comply with all local mask mandates. To learn more about your patients' transportation benefit, please visit bluecare.bcbst.com and select **Get a Ride**.

Please note: This article doesn't apply to CoverKids.

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, which launches Oct. 2, 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 Tennessee

This information applies to our BlueCare Plus, and BlueCare Plus Choice Medicare Advantage, Fully Integrated Dual Eligible special needs plans unless stated otherwise.

Enhancing Health Care for Adults on the Autism Spectrum

BlueCare Plus primary care providers who see adults with autism or have an interest in this population are invited to join the Extension for Community Healthcare Outcomes (ECHO) project. Through ECHO, primary care providers will share complex patient cases and receive information from autism specialists using live videoconferencing. This six-month series will be held twice a month in the convenience of your office using live videoconferencing. Participants will receive free CME and MOC, Part 2 and Part 4, and compensation for completing pre- and post-training surveys. They'll also have opportunities to learn about resources for autistic patients. Please contact Janet Shouse at janet.shouse@vumc.org or **(615) 875-8833** by Nov. 1.

Medicare Advantage and BlueCare Plus Tennessee

This information applies to our BlueAdvantage (PPO℠), BlueEssential (HMO SNP)℠ and BlueCare Plus/BlueCare Plus Choice (HMO DSNP)℠ plans unless stated otherwise.

Medicare Advantage Extending Member Cost-Share Waiver

On Sept. 24, 2020, Medicare Advantage announced it will extend its cost-share waiver for members seeking care from network Primary Care Physicians and behavioral health specialists through the end of the year. The division has waived these costs since May 19, 2020 to remove barriers and encourage members to seek essential routine and preventive care. The waiver still applies to both in-office and telehealth visits. We've made this change to help members and providers during these uncertain times.

Complete Special Needs Plan Model of Care Training by End of 2020

Providers who care for BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plan members are required to complete our Model of Care Training after initial contracting and annually thereafter. This training promotes coordination care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking here.

All physicians are encouraged to complete the training and the last date to complete 2020 training and be compliant is **Dec. 31, 2020**.

In-Home Screenings Available for Your Patients

The relationship between you and your patient is instrumental in making sure they get certain preventive screenings you recommend. We understand it may be difficult to get patients into your office or for them to get follow-up testing. That's why we work with vendors who provide certain in-home preventive screenings. The following in-home test kits and preventive screenings are available for your BlueAdvantage, BlueEssential and BlueCare Plus/BlueCare Plus Choice patients:

- HbA1c testing
- Urine microalbumin screening
- iFOBT/FIT test
- Bone mineral density testing
- Diabetic retinal eye exam
- Peripheral artery disease testing
- Comprehensive history & physical exam

For more information or to arrange certain in-home preventive screenings for your BlueCross BlueShield of Tennessee Medicare Advantage patients, please contact your local Medicare Advantage provider outreach consultant.

New Provider Education WebEx Presentations

The BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series that launched in Availity earlier this year has two new presentations on Provider Assessment Forms and the risk adjustment process. These educational opportunities can serve as a resource to enhance your performance in the BlueCross Medicare Advantage Provider Quality+ Partnerships program. The presentations range from 15 to 60 minutes long and topics include a program overview, the Quality Care Rewards Tool, 2020 quality program measures, medication reconciliation and more.

To access the presentations after logging in to Availity, choose **BlueCross BlueShield of Tennessee** within **Payer Spaces** and then select **Resources**. On the Resources page you'll see a list of all the WebEx presentations.

Provider Assessment and Patient Care and Planning Form Updated

We've updated our standard Provider Assessment Form (PAF) and Patient Care and Planning Form (PACF). As a reminder, a PAF/PACF should be completed either with a face-to-face or telehealth (both audio and video components required) visit for each BlueAdvantage, BlueEssential and BlueCare Plus member annually to document all active, acute and chronic conditions and how they are assessed and managed. The PAF/PACF data may also close some quality measure gaps.

You may complete a PAF/PACF at the same time as an annual wellness visit. Also, BlueCare Plus plan members will be eligible to receive a gift card incentive for their annual wellness visits and so will your BlueAdvantage and BlueEssential plan members if they're enrolled in our My Healthpath® member incentive program. To get the PAF reimbursement for BlueAdvantage and BlueEssential members ($225 through Nov. 30 and $175 for Dec. 1 through Dec. 31), submit your claim with CPT® Code 96160 with the visit E/M code. To receive the $155 reimbursement rate for BlueCare Plus members, submit your claim with CPT® code 96160 with the visit E/M code. You may fax PAF/PACFs or upload them in the Quality Care Rewards tool within Availity. Please contact your Medicare Advantage Provider Outreach Consultant if you have questions about the Provider Assessment Forms.

Update: Provider Assessment Form Incentive Extension

As a reminder, providers are able to bill CPT® code 96160 for a Provider Assessment Form (PAF) annually for all BlueAdvantage and BlueEssential members. The reimbursement for these forms is usually $225 for dates of service between Jan. 1 and June 30, and $175 for dates of service between July 1 and Dec. 31. However, to address member concerns about seeking preventive services, going to regular office visits or having follow-up care during the COVID-19 public health emergency, we have extended our $225 level reimbursement for these forms through **Nov 30, 2020. We're making this exception** to account for these members that may have avoided coming to your office for their annual wellness exam or other preventive screenings. This date has been extended since we last published September's BlueAlert, which said we'd extend this level through **Sept. 30, 2020**.

During the national public health emergency, PAFs can be completed through a telehealth visit as long as the information becomes part of the permanent patient record. Any biometric data that can't be obtained through a virtual encounter can be charted during the next face-to-face visit with the member. Please be sure to submit the updated PAF if the biometric data changes your assessment and treatment plan. Please note, there is no additional reimbursement for an updated or corrected PAF. Please contact your Medicare Advantage Quality Outreach Consultant with questions.

Pharmacy

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

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please click here to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Pharmacy Coverage Review Insourcing

In order to better serve our members and providers, we're working to manage Commercial pharmacy coverage reviews at BlueCross – not through a third-party vendor. We'll update our BlueCross BlueShield of Tennessee Provider Administration Manual as well as the Availity Provider Portal when these changes are complete. As always, we'll inform you of any process changes or updates through the BlueAlert newsletter. Please continue to check for updates each month.

2021 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
- Release of new generic drugs to the market
- Removal of drugs from the market by the FDA

Please visit the following links on the Pharmacy Resources & Forms page to view the 2021 Formulary changes

- 2021 Preferred Formulary Changes
- 2021 Essential Formulary Changes

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Modifier Billing Requirements for Behavioral Health Providers

We always want to reimburse you quickly and accurately for the services you provide to BlueCare, TennCare*Select*, BlueCare Plus and CoverKids members. You can help us by using the correct modifier code based on one of the behavioral health provider's licensure levels listed here:

- **None** – M.D. Level
- **SA** – Nurse practitioner or physician assistan rendering services in collaboration with a physician
- **HO** – Master's Level
- **HP** – Doctoral Level

Failure to follow these billing guidelines can result in overpayments, audits and recovery of the overpayments.

For more information, please review your contract and the BlueCare Tennessee Provider Administration Manual. If you have questions regarding your contract or billing guidelines, please contact your Provider Network Manager.

Quality Care Rewards

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

Highlighting Your MA Star Quality Ratings in the Provider Directory

We want to take every opportunity to highlight your hard work and success in our MA Star Quality Ratings program. It's important for your current and prospective patients to be able to see the quality outcomes you're achieving. Beginning **Oct. 1, 2020**, BlueAdvantage and BlueEssential Star ratings (combined) at the group level from the 2019 program year will be included in the provider directory for each provider. This rating is simply the final Star rating that your group achieved at the end of the 2019 program year, which was finalized in March 2020. These scores will be updated annually when final ratings for the next program year are available in March. Thank you for your continued commitment to the quality of care of Medicare beneficiaries. Please contact your MA Provider Outreach consultant with questions about the provider directory quality ratings for MA.

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee comply 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, 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.

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**.

20PED945508 (9/20)

of Tennessee

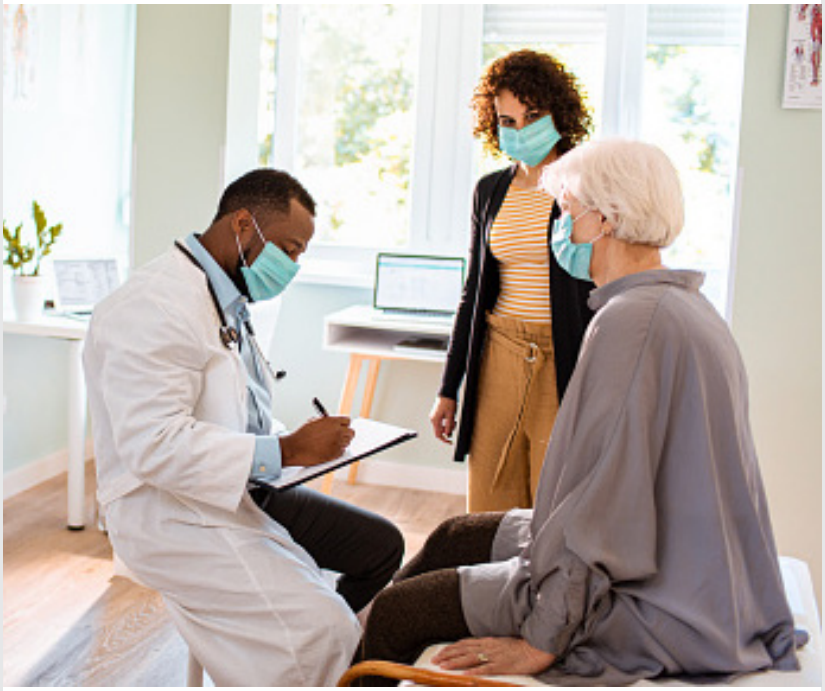
NOVEMBER 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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



COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Hearing-Related Products and Services Billing Reminder

As a reminder, when billing for hearing-related services and equipment, please use the most appropriate "V" HCPCS code and number of units. Not all plans cover hearing aids for all members. Some plans have dollar limits for hearing aids. Be sure to verify benefits before providing services.

Please note the following billing guidelines:

- Reimbursement for codes classified as durable medical equipment (including hearing aids), medical supplies, orthotics and prosthetics without an established maximum allowable is based on the Medicare Administrative Contractor for Jurisdiction C (DME MAC) guidelines, BlueCross reimbursement guidelines and billing guidelines.
- Contracted providers agree to cooperate with reasonable requests from us and applicable payers if we need to investigate any member complaints.
- Providers agree to accept reimbursement made according to the terms of BlueCross provider contracts, plus any applicable member copayments/deductibles and coinsurance amounts as the maximum amount payable for covered services.

These guidelines apply to services billed on professional claims for our Commercial plans, with the exception of the Federal Employee Program, unless otherwise stated in the contract. Please refer to the Hearing Products policy guidelines in our **Provider Administration Manuals** for more information about submitting claims for hearing aids. Please note, the member's plan and evidence of coverage control covered benefits and member cost-share for such benefits.

New Prior Authorization Requirement for Neuropsychological Testing

BlueCare℠, TennCare*Select*, CoverKids℠ and Commercial BlueCross BlueShield of Tennessee members (with the exception of FEP) will require prior authorization for neuropsychological testing beginning **Jan. 1, 2021**. Providers with appropriate training are encouraged to seek an automated authorization for psychological and neuropsychological testing through Availity®. This option will make obtaining authorizations simpler.

Training is available. **Providers not trained in neuropsychological and/or psychological testing should bill appropriately for behavioral health screenings.**

As always, we recommend that you also record time spent for all activities related to psychological testing in your patient record. When submitting claims, please remember to include necessary modifiers.

To order copies of the CPT® codebook 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.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the Network Verification at Availity.com.

Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review. The Network Verification form, in the **Provider Enrollment, Updates** and **Changes** tile, is located in the BlueCross payer space on Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification Form until we can move all providers to this new process. If you have questions, please contact our Provider Service line at **1-800-924-7141** and select option 2 for Contracting and Credentialing.

Submitting Provider Changes is Now Easier Using Availity

We're moving away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes. It's available now in the BlueCross payer space at **Availity.com**. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with Availity. We'll continue to accept PDF versions of the Provider Change Form until the end of the year, but after that date all changes must be submitted through Availity.

Network Effective Dates Dependent on Receipt of Provider Information

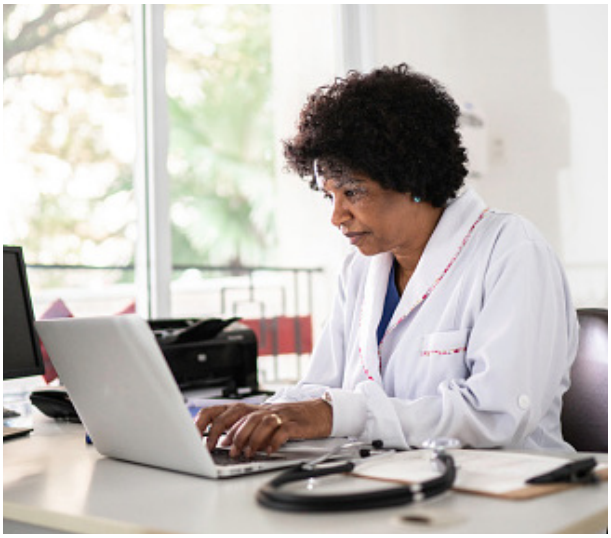
We work hard to make the provider enrollment process fast and efficient. Please submit all new provider information as promptly as possible, so we can deliver the earliest effective dates for your new providers. We can't enroll providers in a new practice until we have the information necessary to make our system updates. This includes the addition of providers to an existing group. Network effective dates are based on when the individual provider is enrolled with BlueCross, not necessarily when the provider joins the group.

Provider Dispute Resolution Procedure Reminder

Our provider dispute resolution procedure is clearly described in our provider administration manuals. You can find these manuals on our **provider website**.

Effective Jan. 1, 2021, we'll no longer allow providers to commence a dispute later than the stated time frame in our manuals. This isn't a policy change – just a notice that we're fully enforcing our long-standing policy. We encourage you to refer to the manuals to review the entire process.

If you have questions about our dispute resolution procedure, please contact your **Provider Network Manager**.



Process Your InstaMed Prepaid MasterCard Payments Before They Expire – No Additional Fees

In April, we launched a convenient online bill pay tool for Commercial and individual members to pay providers through their BlueCross account. Many members have taken advantage of this service, which lets them review claims and pay you directly for any deductibles or out-of-pocket costs using InstaMed, a nationwide health care payment network.

Depending on your level of participation, InstaMed sends you the member's payment electronically or by mail. Electronic payments are made as soon as the next day. Mailed payments, which include a pre-paid MasterCard, arrive within seven to 10 business days.

We've recently learned some providers aren't processing the InstaMed payments that were sent to them on time. This means providers have to reach back out to members for payment. Please know you don't need to create an InstaMed account to process the payment. You simply process it the same way you do other credit card payments. You'll receive your payments faster, and you won't be charged additional fees to cash or deposit your payment (outside of typical credit card processing fees).

If you already have an InstaMed account, there's nothing you need to do. However, if you want more information, want to register for or upgrade your account, please visit **InstaMed's website**.

Member ID Number Prefix Reminder

When submitting claims, please make sure the Member ID number is exactly as it appears on the Member ID card, including the prefix. We use prefixes to identify the member's type of coverage, obtain health plan contract information and route claims to the correct Home Plan through the BlueCard and Inter-Plan programs. Please note that as of **Oct. 1, 2020**, we've started rejecting claims with incomplete Member ID numbers.

Commercial

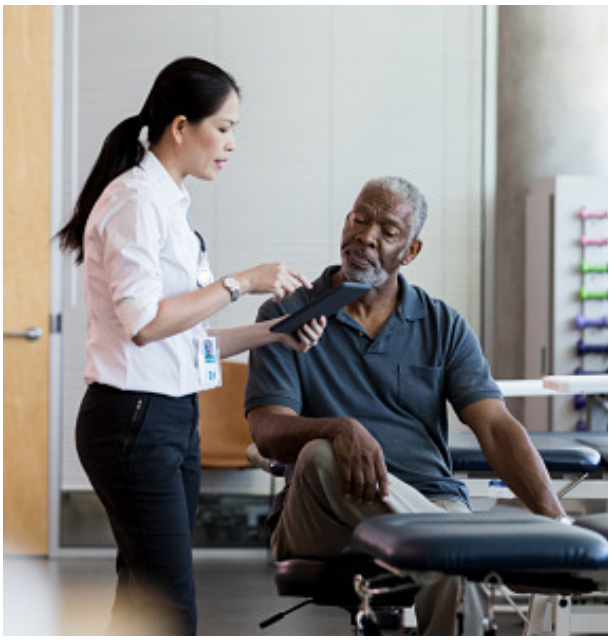
This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning **Jan. 1, 2021**, CPT® code 0016M will require prior authorization. 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, or you may fax them to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

New High Performance Network Coming Soon



The Blue Cross Blue Shield Association is introducing a national network called Blue High Performance Network (Blue HPN) in January 2021. It's an alternative to BlueCard PPO and designed as a curated network that will provide improved, more affordable care. Quality measurement is a key feature, and plans are required to report on eight consistent national measures and eight market-specific clinical measures to address local gaps in care.

In Tennessee, we'll support Blue HPN through our existing Network S as a statewide network. Availability is limited to self-funded employer groups in Chattanooga, Knoxville, Nashville and Memphis. Blue HPN won't replace existing BlueCard networks, but will be offered alongside BlueCard PPO as a second option.

Blue HPN is designed as an in-network only, Exclusive Provider Organization (EPO) product, so full benefits are limited to in-network providers only. If members need care when traveling outside of Blue HPN service areas, access is limited to urgent and emergency care services. Blue HPN members will have Member ID cards with Blue High Performance Network displayed on the front, along with an "HPN in a suitcase" logo.

The Blue HPN launch will not affect Network S contracts or rates. Blue HPN providers will follow the same pre-service review and claims filing procedures used today for BlueCard PPO. For more information, please see the **BlueCross Provider Administration Manual**. It includes more details about Blue HPN, as well as images of the Member ID card. You can also contact your Network Manager with questions.

BlueCare Tennessee

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

Flu Vaccine Reimbursement Update for Children and Teens

We want to make sure that vaccines are accessible for all children and teens in our state, so we're covering flu vaccines for patients under age 19 outside of the Vaccines for Children (VFC) program. This means that if you give a flu vaccine to a child or teen covered by BlueCare Tennessee and don't participate in the VFC program, we'll reimburse you for the vaccine and the cost of delivering it.

If you aren't in the VFC program, please bill modifier 32 on the flu vaccine line item on your claims to receive payment for the vaccine and administering it to patients age 18 and younger.

If you have access to the Tennessee Immunization Information System (TennIIS), please also report that you've administered the flu vaccine in the system.

If you're enrolled in the VFC program, please disregard this information and continue to follow your normal process for vaccine administration.

Please note this guidance goes into effect on Sept. 1, 2020, and it's effective for the 2020-2021 flu season only.

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

Coming Soon: Changes to the CoverKids Network

Effective Jan. 1, 2021, the Division of TennCare is consolidating CoverKids into the TennCare Contractor Risk Agreement. At this time, CoverKids members will be assigned to one of the three TennCare managed care organizations. Those transitioning to BlueCare Tennessee will begin using the BlueCare network and will have a primary care provider assigned to them.

Providers who don't currently participate in the BlueCare network, but who have cared for a CoverKids member during the last 12 months, will be invited to participate in the BlueCare network.

For more information, please see the Division of TennCare℠ letter and FAQ document located under Announcements on the **Provider News and Manuals page** of our website. If you have questions about this change, please contact your Provider Network Manager.

Resources to Support Well-Child Care

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 – This manual, which is updated quarterly, 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.

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) also offers guidance about delivering well-child care, including EPSDT visits and coding.

For more information, please visit the **American Academy of Pediatrics website**. If you have questions about these TNAAP resources, please contact Janet Sutton, CPC, RHIT, TNAAP EPSDT and Coding Program Manager, at (615) 447-3264.

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

Improving Health Outcomes in Tennessee

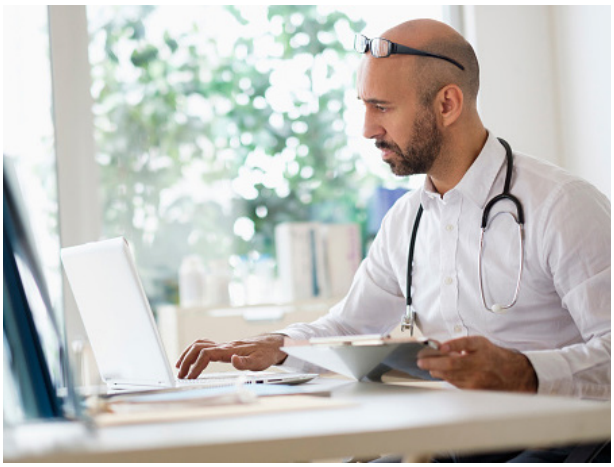
Good health outcomes start in the communities where your patients live, work and play. The Division of TennCare wants to learn more about the challenges your patients face in their communities to help you improve your patients' health. Please take a few minutes to complete the Provider CARES survey at **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.

Stay Up to Date on the BlueCare Tennessee Provider Appeals Process

If you disagree with the way we've processed a claim, you may use our claims reconsideration and appeal process to request a second look. To help make sure reconsideration and appeal requests are processed quickly and correctly, we've put together a few reminders to help with submission. Please note the below process differs from the process used for utilization management or clinical authorization appeals.

Level 1: Reconsideration – Reconsideration requests must be received within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or that contain multiple claims.**

Please note you must file a request for reconsideration before submitting an appeal, unless your request is related to a non-compliance denial.



Step 2: Appeal – An appeal must be received in writing within 60 days of the date of the initial denial notification. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each form should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeals process, please see the **BlueCare Tennessee Provider Administration Manual**.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO/SNP)℠ plans.

Extension of Primary and Behavioral Care Cost Waiver

In an effort to bring peace of mind, help remove barriers to care and encourage members to seek the routine and preventive care they need during the COVID-19 national emergency, coverage for Medicare Advantage members was enhanced as of May 19 and will now continue through **Dec. 31, 2020**. We'll continue to waive member cost share for doctor's office and virtual telehealth visits **specifically to network primary care practitioners and behavioral health care practitioners**. This date has been extended since we published September's BlueAlert, which said we'd extend this level through Sept. 30, 2020. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the-minute guidelines on treating our Medicare Advantage plan members.

Use Correct Modifier for Durable Medical Equipment Purchase (DME) and Rental Requests (RR)

When submitting authorization requests for DME, please make sure requests are submitted with the correct modifier for RR instead of purchase (NU). **All items with Medicare-capped rental requirements, should be submitted with the RR rental modifier.** We've seen instances where the authorization request is submitted with an NU modifier, but the claim is submitted with an RR modifier. You can find a list at CMS.gov of all items that are considered capped rentals. Incorrectly submitting authorization and claim requests with inappropriate modifiers could result in payment delay or claim denials.

Perform Medication Reconciliation after Each Patient Discharge

Medication reconciliation is important for your patients who have recently been discharged from a facility. Not only is this a CMS Star measure, it's a good way to check in with your patients and take the first steps to reduce readmission. A registered nurse, nurse practitioner, physician assistant, clinical pharmacist or physician may complete this service within 30 days of discharge. Please note nurses and pharmacists performing this service can only bill with CPT® code 1111F.

Your patients may have multiple admissions and discharges during the year. These tips can help you make sure they get the medications they need after each hospital visit:

- A list of your patients who've been discharged is available in the Quality Care Rewards application.
- Each discharge to a community setting requires medication reconciliation.
- Medication reconciliation isn't required when patients transfer to an acute or non-acute inpatient setting (i.e., a skilled nursing facility or long-term acute care hospital).
- The documented medication reconciliation should be completed and signed by an appropriate provider.
- Your documentation should show that you were aware of the patient's hospitalization and discharge. It should also address both the discharge medications and current medications, as well as reconciliation between the two.

For more information on medication reconciliation and appropriate CPT® codes, please contact your Medicare Advantage Quality Outreach consultant.

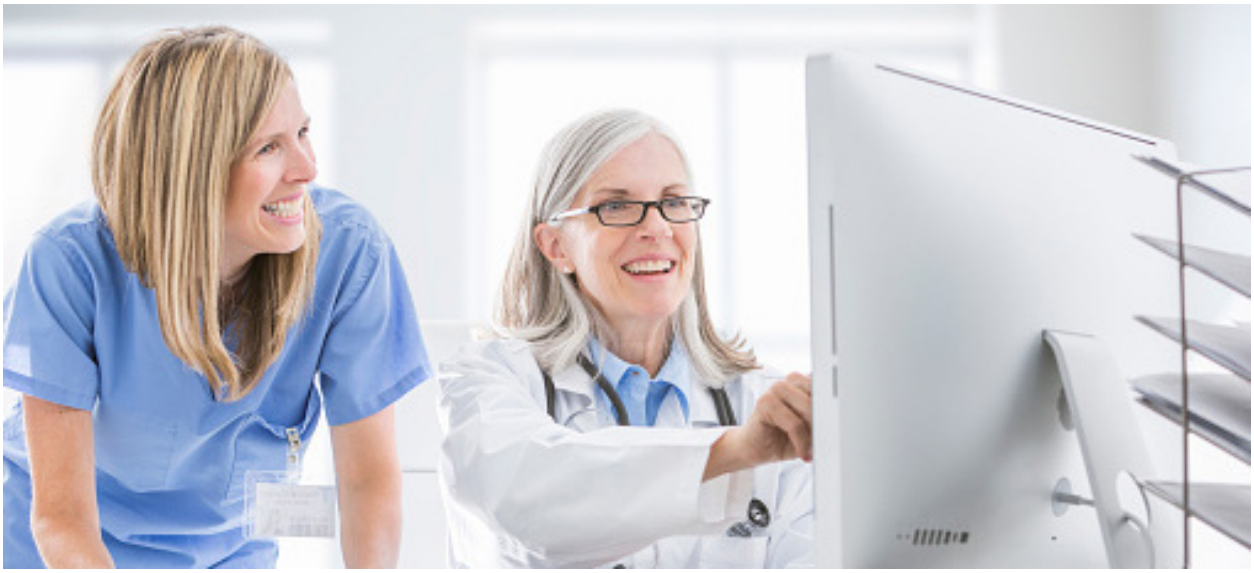
Medicare Advantage and BlueCare Plus Tennessee

This information applies to our BlueAdvantage (PPO℠), BlueEssential (HMO SNP)℠ and BlueCare Plus/BlueCare Plus Choice (HMO DSNP)℠ plans unless stated otherwise.

Complete Special Needs Plan Model of Care Training by End of 2020

Providers who care for BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plan members are required to complete our Model of Care Training after initial contracting and annually thereafter. This training promotes coordination of care for members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking **here**.

All physicians are encouraged to complete the training and the last date to complete 2020 training and be compliant is **Dec. 31, 2020**.



New Provider Education WebEx Presentation

A new presentation on the Member Survey Experience is available as part of our BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series in Availity®. This presentation reviews core questions included in both the CAHPS and HOS patient/member surveys and provides recommendations and tips to improve the member experience. As a reminder, there are additional episodes on other topics such as medication reconciliation, Provider Assessment Forms, program measures and more. These presentations can serve as a resource for additional ways to enhance your performance in the MA Provider Quality+ Partnerships program.

To access the presentations after logging in to Availity, choose **BlueCross BlueShield of Tennessee** within **Payer Spaces** and then select **Resources**. On the Resources page you'll see a list of all the WebEx presentations.

Pharmacy

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

New Tool Supports NDC and J-Code Claim Filing

Effective Jan. 1, 2021, for all lines of business, claims with provider-administered drug charges must include the valid NDC code. Claims submitted without an NDC will be rejected. Claims submitted with an invalid combination of HCPCS and NDC will result in the line item being denied.

We've launched the RC Claim Assist tool to help you validate NDC and HCPCS combinations and dosages with unit conversions to file medical and pharmacy claims. Simply log in to Availity, go to Payer Spaces and click the RC Claim Assist link. You may be asked to register as a new user, but you won't incur any additional charges.

Changes to Commercial Plan Prior Authorizations

Beginning **Jan. 1, 2021**, the following drugs will transition from Magellan RX to our prior authorization list:

Tecartus	Yescarta	Brineura	Zolgensma	Givlaari
Kymriah	Spinraza	Luxturna	Exondys 51	Vyondys 53

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 may submit authorization requests through Availity, fax to Commercial Utilization Management at **1-866-558-0789** or call **1-800-924-7141**.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Coverage Review Insourcing

To better serve our members and providers, we'll be managing Commercial pharmacy coverage reviews internally starting **Dec. 7, 2020**. We will no longer use a third-party vendor. You may submit coverage review inquiries electronically through the CoverMyMeds tool in Availity. You can also go to CoverMyMeds.com and use your existing sign-on credentials. We'll share more information about any process changes or updates in future issues of BlueAlert.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at **1-800-924-7141** and follow the prompts for option 1.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply 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, 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**.

Contact Availity Online

Availity makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

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:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

of Tennessee

DECEMBER 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Get the Answers You Need Through Availity®

From coverage information to claims management updates, Availity helps streamline operations, making it easy for you to do business with us online. You'll find the information you need all day any day. When checking benefits, you'll receive a unique Transaction ID that'll be your reference number.

You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details (including a Fast Path phone option if you can't find what you need)
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Review Quality Care Rewards
- Update PCP rosters
- Manage your contact preferences
- Send a message

We encourage you to use the Feedback options in Availity. Your feedback can help us create more online tools to enhance your experience with us.

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:

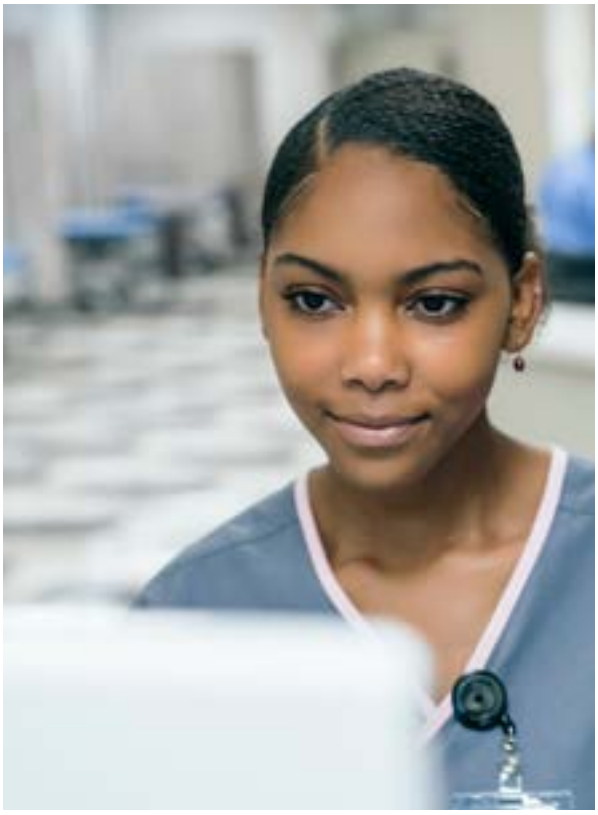
- Hip Osteoarthritis: Is it Time to Think About Surgery?
- Knee Osteoarthritis: Is it Time to Think About Surgery?
- Pregnancy: Your Birth Options After Cesarean
- Pregnancy: Birth Options if Your Baby is Getting Too Big

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.**

Member ID Number Prefix Reminder

When submitting claims, please make sure the Member ID number is exactly as it appears on the Member ID card, including the prefix. We use prefixes to identify the member's type of coverage, obtain health plan contract information and route claims to the correct Home Plan through the BlueCard and Inter-Plan programs. Please note that as of Oct. 1, 2020, we're rejecting claims with incomplete Member ID numbers.



Submitting Provider Changes is Easier Using Availity

We're moving away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes. It's available now in the BlueCross payer space at Availity.com. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with Availity. We'll continue to accept PDF versions of the Provider Change Form until the end of the year, but after that date all changes must be submitted through Availity.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the Network Verification at Availity.com.

Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review.

The Network Verification form, in the Provider Enrollment, Updates and Changes tile, is located in the BlueCross payer space on Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification Form until we can move all providers to this new process. If you have questions, please contact our Provider Service line at 1-800-924-7141 and select option 2 for Contracting and Credentialing.

Network Effective Dates Dependent on Receipt of Provider Information

We work hard to make the provider enrollment process fast and efficient. Please submit all new provider information as promptly as possible, so we can deliver the earliest effective dates for your new providers. We can't enroll providers in a new practice until we have the information necessary to make our system updates. This includes the addition of providers to an existing group. Network effective dates are based on when the individual provider is enrolled with BlueCross, not necessarily when the provider starts working at your practice or group.

Commercial

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

New High Performance Network Coming Soon

The Blue Cross Blue Shield Association is introducing a national network called Blue High Performance Network (Blue HPN) in January 2021. It's an alternative to BlueCard PPO and designed as a curated network that will provide improved, more affordable care. Quality measurement is a key feature, and plans are required to report on eight consistent national measures and eight market-specific clinical measures to address local gaps in care.

In Tennessee, we'll support Blue HPN through our existing Network S as a statewide network. Availability is limited to self-funded employer groups in Chattanooga, Knoxville, Nashville and Memphis. Blue HPN won't replace existing BlueCard networks, but will be offered alongside BlueCard PPO as a second option.

Blue HPN is designed as an in-network only, Exclusive Provider Organization (EPO) product, so full benefits are limited to in-network providers only. If members need care when traveling outside of Blue HPN service areas, access is limited to urgent and emergency care services. Blue HPN members will have Member ID cards with Blue High Performance Network displayed on the front, along with an "HPN in a suitcase" logo.

The Blue HPN launch will not affect Network S contracts or rates. Blue HPN providers will follow the same pre-service review and claims filing procedures used today for BlueCard PPO. For more information, please see the BlueCross Provider Administration Manual. It includes more details about Blue HPN, as well as images of the Member ID card. You can also contact your Network Manager with questions.

Process Your InstaMed Prepaid MasterCard Payments Before They Expire – No Additional Fees

In April, we launched a convenient online bill pay tool for Commercial and individual members to pay providers through their BlueCross account. Many members have taken advantage of this service, which lets them review claims and pay you directly for any deductibles or out-of-pocket costs using InstaMed, a trusted nationwide health care payment network.

Depending on your level of participation, InstaMed sends the member's payment electronically or by mail. Electronic payments are made as soon as the next day. Mailed payments, which include a pre-paid MasterCard, arrive within seven to 10 business days.

We've recently learned some providers aren't processing their mailed InstaMed payments on time, which means they have to reach back out to members for payment. Please know you don't need to create an InstaMed account to process the payment. You process it the same way you would other credit card payments. You'll quickly receive your payments, and you won't be charged additional fees to cash or deposit your payment (outside of typical credit card processing fees). If you work with an outside billing company, please share this information with them.

If you already have an InstaMed account, there's nothing you need to do. However, if you want more information, want to register for or upgrade your account, please visit **InstaMed's website.**

BlueCare Tennessee

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

Thank You for Your Dedication to Tennessee's Kids

We know it's been a challenging year, and we thank you for the care you've given to children covered by BlueCare Tennessee throughout the COVID-19 outbreak. As we move into 2021, we encourage you to keep talking with patients about the importance of well-child care, including getting an annual flu shot, and the steps you've taken to minimize COVID-19 exposure when families visit your office.

Additionally, consider watching for the warning signs of family violence during well-child checkups. COVID-19 has impacted nearly every aspect of your patients' lives. The ongoing school year – and the holiday season – may look very different this year. The resulting stress can increase the risk of family violence, including child abuse and domestic violence, according to an article recently published in Pediatric Perspectives. The authors of the article discuss several warning signs to keep in mind, as well as recommendations for talking with parents about their stress levels and coping mechanisms. You can review the article **here.**

For more tips and information about caring for patients during the COVID-19 pandemic, please see previous issues of BlueAlert, or visit **BCBSTupdates.com** or **tn.gov/tenncare.**

Please note: TennCare Kids exams don't apply to CoverKids members.

Coming Soon: Changes to the CoverKids Network

Effective Jan. 1, 2021, the Division of TennCare is consolidating CoverKids into the TennCare Contractor Risk Agreement. At this time, CoverKids members will be assigned to one of the three TennCare managed care organizations. Those transitioning to BlueCare Tennessee will begin using the BlueCare network and will have a primary care physician (PCP) assigned to them.

Providers who don't currently participate in the BlueCare network, but who have cared for a CoverKids member during the last 12 months, will be invited to participate in the BlueCare network.

Additional Details about This Transition – Starting Jan. 1, please verify that any CoverKids member you see is assigned to your patient listing or the listing of another participating PCP in your group. You can view the PCP Member Roster on Availity.com to confirm assignment by choosing the CoverKids line of business. You can also check CoverKids eligibility within Availity. CoverKids members will continue to be identified by the group CoverKids.

Please note CoverKids will be excluded from the Vaccines for Children (VFC) Program, so immunizations administered to CoverKids members will be reimbursed by fee for service. For more information, please see the BlueCare Tennessee Provider Administration Manual.

To learn more about this change, please see the Division of TennCare letter and FAQ document located under Announcements on the **Provider News and Manuals page** of our website. If you have questions, please contact your Provider Network Manager.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO/SNP)℠ plans.

New Insulin Savings Model for 2021

For some of these beneficiaries, access to insulin can be a critical component of their medical management, with gaps in access increasing the risk of serious complications including vision loss, kidney failure, foot ulcers/amputations, and heart attacks. Cost of insulin can be a barrier for your patient's appropriate compliance with your planned medical management of diabetes.

New for 2021, the **Part D Senior Savings Model** is designed to address this barrier, and offer our BlueAdvantage and BlueEssential members access to insulin at an affordable and predictable cost. For the list of insulins below, Part D medication copays will be the same in all stages until the Catastrophic Coverage Stage is reached.

Basaglar	Toujeo	Novolin N	Fiasp	Novolog Mix 70-30
Humulin R	Lantus	Tresiba	Novolog	
Soliqua	Novolin R	Novolin 70-30	Levemir	

For more information about the Part D Senior Savings Model, please contact your local Medicare Advantage Provider Quality Outreach consultant or our MA Quality Programs Pharmacist Sarah Smith, PharmD, BCPS, at (423) 535-4566.

Update to the BlueEssential Chronic Special Needs Plan for 2021

In January of 2020, we launched BlueEssential, a Medicare Advantage Chronic Condition Special Needs Plan (C-SNP) to address the wide range of costly and difficult-to-coordinate health needs for diabetic patients. Starting Jan. 1, 2021, we'll expand this special needs plan to include patients with select cardiovascular conditions. The member must have a diagnosis of coronary heart disease, hypertension, peripheral vascular disease and/or chronic venous thromboembolic disorder to qualify for this plan. A member can have diabetes and/or the cardiovascular condition, but both diagnoses aren't required to qualify. Other plan benefit updates for 2021 include:

- Copay for cardiologist specialist visits is reduced to match PCP
- Inclusion of an additional pharmacy tier at a lower cost-share for select care drugs commonly used to treat diabetics as well as associated chronic conditions
- Lower fixed copays for select branded insulins, including through the coverage gap as part of the Part D Senior Savings program
- Patients who have been discharged from an acute observation stay are eligible to receive meals that support the dietary plan of care for five days after discharge
- Members have access to a defined no-cost transportation benefit to help them get to provider appointments

Beneficiaries must sign up specifically for this plan and have one of the chronic conditions to enroll in BlueEssential. In addition, the beneficiary's treating provider must confirm the diagnosis as part of the enrollment process. For more information about the BlueEssential plan, please contact your local Medicare Advantage Provider Quality Outreach consultant.

Provider Assessment Form Incentive Extension Through December

As a reminder, providers are able to bill CPT® code 96160 for a Provider Assessment Form (PAF) each calendar year for all BlueAdvantage and BlueEssential members. The reimbursement for these forms is usually $225 for dates of service between Jan. 1 and June 30, and $175 for dates of service between July 1 and Dec. 31. However, to address member concerns about seeking preventive services, going to regular office visits or having follow-up care during the COVID-19 public health emergency, we have extended our $225 level reimbursement for these forms through Dec 31, 2020. This date has been extended since we last published in BlueAlert, which said we'd extend this level through Nov. 30, 2020.

During the national public health emergency, PAFs may be completed through a telehealth visit as long as the information becomes part of the permanent medical record. Any biometric data that can't be obtained through a virtual encounter can be charted during the next face-to-face visit with the member. Please be sure to submit the updated PAF if the biometric data changes your assessment or treatment plan. Please note, there is no additional reimbursement for an updated or corrected PAF. If you have questions, please contact your Medicare Advantage Quality Outreach Consultant with questions.

Provider Assessment Form Reimbursement for 2021 Returning to Regular Schedule

In 2021, you'll again be eligible to receive reimbursement for submitting a completed Provider Assessment Form (PAF) for your BlueAdvantage and BlueEssential members. The reimbursement for submission of completed PAFs will return to the regular schedule beginning in January 2021 set out below:

- **$225** for dates of service between Jan. 1 and June 30, 2021
- **$175** for dates of service between July 1 and Dec. 31, 2021

To be reimbursed, please submit the completed PAF by uploading to the Quality Care Rewards application located in Availity or fax a completed PAF to 1-877-922-2963. Please use CPT® code 96160 to file a claim for PAF submission. The completed PAF should also be included in your patient's medical record. You don't need to wait 365 days between PAF submissions as the benefit is each calendar year. For additional information about the PAF, please visit the **Quality section on our provider website.**

Medicare Advantage and BlueCare Plus Tennessee

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

New Provider Advanced Illness and Frailty Exclusions WebEx Presentations

The BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series that launched in Availity earlier this year has a new presentation on advanced illness and frailty exclusions. It reviews how patients can qualify for these exclusions and measures in which the exclusions apply. As a reminder, there are additional episodes on topics like medication reconciliation, the Provider Assessment Form, program measures and more. These presentations can help you improve your performance in the MA Provider Quality+ Partnerships program.

To access the presentations after logging in to Availity, choose BlueCross BlueShield of Tennessee within **Payer Spaces** and then select **Resources.** On the Resources page, you will find a list of current presentations.

Complete Special Needs Plan Model of Care Training Before Dec. 31, 2020

Providers who care for BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plan members are contractually required to complete our Model of Care Training after initial contracting and annually thereafter. This training promotes coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking **here.**

The last date to complete 2020 training and be considered a compliant provider is Dec. 31, 2020. All providers are strongly encouraged to complete the training before the end of the year.

Pharmacy

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

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Step Therapy for Additional Medicare Part B Drugs

Beginning Jan. 1, 2021, BlueAdvantage, BlueCare Plus and BlueEssential will implement step therapy for additional Part B drugs. This will affect members who are new to therapy. Prior authorization and step therapy will be in line with CMS regulations and required for the following additional Part B drugs: Avastin, Herceptin, Rituxan, Rituxan Hycela, Treanda, Visudyne, HP Acthar, Herceptin Hylecta, Infugem, Marquibo and Soliris. You can view our online medical policies by **clicking here.**

Patients with Diabetes Need Statin Medication Fill

If you have Medicare Advantage patients between the ages of 40 to 75 and have filled at least two prescriptions for any medication used to treat diabetes this year, they'll need to receive at least one fill of a statin medication before the end of the year based on the CMS Star quality measure. Statin medication intensity can be written based on risk and patient-specific factors because there isn't a minimum dosage requirement under the Statin Use in Persons with Diabetes (SUPD) quality measure. Patients who have end-stage renal disease or receive hospice services are excluded from this measure. All generic statins are included in the BlueCross Medicare Part D formulary when filled at preferred pharmacies. Copays range from $0 to $1 for a 90-day supply depending on the member's plan type. This measure is also included in the MA Quality + Program as a triple weighted measure this year.

New Tool Supports NDC and J-Code Claim Filing

Effective Jan. 1, 2021, for all lines of business, claims with provider-administered drug charges must include the valid NDC code. Claims submitted without an NDC will be rejected. Claims submitted with an invalid combination of HCPCS and NDC will result in the line item being denied.

We've launched the RC Claim Assist tool to help you validate NDC and HCPCS combinations and dosages with unit conversions to file medical and pharmacy claims. Simply log in to Availity and go to Payer Spaces, Resources tab, RC Claim Assist. You may be asked to register as a new user, but you won't incur any additional charges.

Coverage Review Insourcing Reminder

Starting Dec. 7, 2020, we'll manage Commercial pharmacy coverage reviews internally and not through Express Scripts (ESI).

You may submit coverage review inquiries electronically through CoverMyMeds (CMM link) in Availity or CoverMyMeds.com and use your existing sign-on credentials. You may also call our Provider Service Line at **1-800-924-7141** and follow the prompts. Please do not contact ESI for coverage review inquiries after Dec. 6, 2020.

Changes to Commercial Plan Prior Authorizations

Beginning **Jan. 1, 2021,** the following will transition from Magellan RX to our prior authorization list:

Tecartus	Zolgensma	Kymriah	Exondys 51	Luxturna
Spinraza	Vyondys 53	Brineura	Yescarta	Givlaari

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 may submit authorization via fax form to Commercial Utilization Management at **1-866-558-0789** or call **1-800-924-7141** following the prompts to **Prior Authorization** and select option 9.

Commercial Prior Authorization Criteria

We'll publish the pharmacy prior authorization criteria for the Preferred, Essential and Essential Plus formularies Jan. 1, 2021. We'll include a link to the criteria under the **Pharmacies & Prescriptions** links on both provider and member **Documents & Forms** pages on our website. The links to the prior authorization criteria will be in January's BlueAlert.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at 1-800-924-7141 and follow the prompts for option 1.

Changes to Hi-Tech Imaging and Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Feb. 1, 2021, the following CPT® codes will require prior authorization through eviCore's Hi-Tech Imaging Program:

0609T	0610T	0611T	0612T	C9762	C9763

Beginning Feb. 1, 2021, CPT® code 81545 will no longer require prior authorization through eviCore's Genetic Testing Program. However, the following codes will need prior authorization:

81351	81529	0228U	0231U	0234U	0237U
81353	81546	0229U	0232U	0235U	0238U
81419	81554	0230U	0233U	0236U	0239U

Billing Update for Early Elective Deliveries*

Beginning Jan. 1, 2021, BlueCare Tennessee providers will need to bill a Z3A diagnosis code to show the gestational age when billing one of the following CPT® codes:

59400	59510	59515	59610	59614	59620
59409	59514	59525	59612	59618	59622
59410					

At this time, you'll also need to include a supporting medically necessary diagnosis code for early elective deliveries if the gestational age is 37 or 38 weeks. Claims submitted without Z3A, or without the medically necessary diagnosis code to support an early elective delivery, will be denied.

Please note we're updating the BlueCare Tennessee Provider Administration Manual with this information. If you have any questions, please contact your Provider Network Manager.

Dental and Vision

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

Dental Cosmetic Orthodontic Processing Guidelines

Effective Jan. 1, 2021, Commercial orthodontic claims filed with dates of service of Jan. 1, 2021, and after, will be reimbursed based on your network status and group's reimbursement option. Dental Preferred Providers agree to accept reimbursement according to the terms of their provider contract with BlueCross. Find more information in the Balance Billing section of your BlueCross BlueShield of Tennessee Provider Administration Manual.

Quality Care Rewards

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

Medicare Advantage 2021 Quality Program Measures

Beginning Jan. 1, Medicare Advantage will have an updated list of 15 quality measures included in the Quality+ Partnerships 2021 program. The updated quality program removes two previously included HEDIS measures (Comprehensive Diabetes Care – Medical Attention for Nephropathy and Disease-modifying Anti-rheumatic Drug Therapy for Rheumatoid Arthritis) and introduces two new member experience survey measures from the Consumer Assessment of Healthcare Systems and Providers (CAHPS®) and the Health Outcomes Survey (HOS). The 2021 program year measures are listed below in order of measure weight:

Measure	Weight
Comprehensive Diabetes Care (CDC) - HbA1c Control <9%	3
Medication Adherence for Cholesterol (Statins)	3
Medication Adherence for Hypertension (RAS Antagonists)	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	3
Plan All-Cause Readmissions (PCR)	3
Breast Cancer Screening (BCS)	1
Colorectal Cancer Screening (COL)	1
Comprehensive Diabetes Care (CDC) - Eye Exam	1
Controlling High Blood Pressure (CBP)	1
Medication Reconciliation Post-Discharge (MRP)	1
Member Survey Experience - CAHPS	1
Member Survey Experience - HOS	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	1
Statin Use in Persons with Diabetes (SUPD)	1

For more information about the new program year measures, please contact your local Medicare Advantage Provider Quality Outreach consultant.

THCII Episodes of Care Gain- and Risk-Share Payment Update

The 2019 Final Performance Reports for BlueCare Tennessee and Commercial were released in August 2020 to Quarterbacks participating in the Episodes of Care Program. We'll distribute payment in December to Quarterbacks who achieved a gain-share payment reflected on the cover page of their 2019 Final Performance Reports.

As a reminder, the Division of TennCare has released a memo waiving 2019 Episodes of Care risk-sharing payments. This means that BlueCare Tennessee providers who participate in the Episodes of Care Program and owe a risk-sharing payment reflected on the cover page of their 2019 Final Performance Reports won't have to make that payment. For more information, please read the **TennCare Memo: Waiving 2019 Episodes Risk-Sharing Payments.**

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply 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, 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.**

Contact Availity Online

Availity makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

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:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.