of Tennessee

BlueAlert

January 2014

Common questions about the Health Insurance Marketplace

We have heard from many health care providers with questions about the Marketplace. Following are some of the most common questions and answers.

How can providers identify a patient with Marketplace coverage?
The same way you identify any other BlueCross BlueShield of Tennessee member – through their member ID card. It is the same card you have seen for years.

It is important to remember that there is no difference between a "marketplace" member and another individual member in terms of your reimbursement. The Marketplace is just a vehicle through which a patient purchased health insurance.

As always, we encourage you to verify benefits and eligibility and provide services accordingly.

What is the provider reimbursement fee schedule for treating patients with coverage through the Marketplace?
It is the same as your currently contracted fee schedule. If you are a provider in our Blue Networks S, E or P, you will be reimbursed at your current contracted rate.

Do I need to take any action to be able to see patients with Marketplace coverage? Is there a new BlueCross network just for the Marketplace?
Most health care providers will naturally see patients with Marketplace coverage, especially if you are already contracted with BlueCross BlueShield of Tennessee through Blue Network S or Blue Network P, or if you are one of our Blue Network E contracted providers.

You do not need to take any action to begin seeing new patients with Marketplace plans. Just be sure to verify that your patients have purchased a plan that is in the network(s) for which you are contracted. For example, if a patient purchased a Marketplace plan that uses Blue Network E – and you are not a Blue Network E provider – please remind them that they will be considered "out of network" and may have to pay more for the services you provide. Patients can use our "Find A Doctor" tool on www.bcbst.com to make sure the doctor or facility they visit is in our network.

Please tell me more about Blue Network E.
Blue Network E is a limited regional network that is only offered on the Marketplace. It is not available through any other individual or group product offered by BlueCross. BlueCross has already contracted with Blue Network E providers.

Blue Network E is a *regional* network built around major health systems in major metropolitan markets. It does not offer state-wide coverage. It may be a good choice for patients who place more value on cost savings than whether they see a specific provider for care. Regions of service include Chattanooga, Knoxville, Memphis and Nashville. Patients who have purchased plans utilizing Blue Network E must receive services from a Blue Network E provider in one of these four regions; otherwise they will pay out-of-network rates.

For more information see our company website at <http://www.bcbst.com/providers/health-insurance-marketplace.page>.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective Feb. 9, 2014

- Genetic Testing for CHARGE Syndrome

- Electrical Fields for the Treatment of Glioblastoma
- Abbreviated Daytime Sleep Study (e.g. PAP-NAP)

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

New drugs added to commercial specialty pharmacy listing

Effective Jan. 1, 2014, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:

Gazyva (PA)
Granix (PA)

Self-administered via pharmacy benefit:

Actemra SubQ (PA)
Adempas (PA)
Atripla
Bethkis (PA)
Complera
Imbruvica (PA)
Opsumit (PA)
Stribild
Valchlor (PA)

The provider-administered drug listed below is currently on our specialty list and does require prior authorization, but **effective Jan. 1, 2014** this drug will no longer require prior authorization:

- Jevtana

The provider-administered drugs listed below are currently on our specialty list, but **effective Jan. 1, 2014** the drugs will be removed from the specialty list:

- Mirena
- Omontys
- Skyla

Providers can obtain prior authorization for:

- Provider-administered drugs that have a valid HCPCS code by logging on to BlueAccess®, the secure area of www.bcbst.com and selecting Service Center from the Main menu, followed by Authorization/Advance Determination Submission. Physicians not registered with BlueAccess or needing assistance using our website should contact eBusiness Solutions†.
- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.
- Self-administered specialty drugs by calling Express Scripts at 1-877-916-2271.

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

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming modifications to select Utilization Management Guidelines. The *Modified Utilization Management Guidelines* can be viewed online at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm>.

Effective Feb. 12, 2014

The following as relates to Inpatient & Surgical Care:

- Sacral Colpopexy, Abdominal Approach

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

ADMINISTRATIVE

Web authorizations upgrade coming soon!

In February 2014, BlueCross will be upgrading its online authorization tool. This upgrade to the tool will improve the guideline selection and documentation process of your web authorization requests.

An online step-by-step quick reference guide will be available in January to help you through the details of the changes. Also, look for more information in the February *BlueAlert*.

Specialty pharmacy network changes

As of Jan. 1, 2014, CVS/Caremark Specialty Pharmacies along with the Walgreens Specialty Pharmacies have chosen to no longer participate in the BlueCrossBlueShield of Tennessee specialty pharmacy network. BioPlus Specialty Pharmacy, Amerita, Inc and CoramRx have recently joined our existing specialty pharmacy network which includes Accredo Health Solutions and CuraScript specialty pharmacy. The Curascript name will be going away at the first of the year, now that the merger with Accredo Health Solutions is complete.

Prior authorization requirement changes *

Beginning Jan. 1, 2014, prior authorization is no longer required for the following services:

- Tonsillectomy and Adenoidectomy under age three (3)
- Tonsillectomy under age three (3)
- Neurobehavioral Status Exam
- Destruction of Cutaneous Vascular Proliferative Lesions less than 10 sq. cm (laser technique)

Additionally, BlueAdvantage and commercial plans no longer require prior authorization for the following Musculoskeletal Program services (administered by Triad):

- 95970- Spinal Cord Stimulator
- 95971- Spinal Cord Stimulator
- 95972- Spinal Cord Stimulator
- 95973- Spinal Cord Stimulator

Reminder: Cultural disparities analysis

BCBST conducted an analysis of top medical conditions by race/ethnicity of its commercial and TennCare members using 2012 claims data. Following is a summary of those findings for your review and information.

Asians

Asian commercial and BlueCare Tennessee members had lower prevalence for every top condition except hyperlipidemia and blood borne cancer when compared to all other racial/ethnic groups.

The prevalence of obesity for Asian commercial members was more than half of other racial/ethnic groups.

African Americans

African American commercial members had a much lower rate of hyperlipidemia compared to other racial/ethnic groups.

African American BlueCare Tennessee members had significantly higher rates of STDs compared to other racial/ethnic groups.

Hispanics

Hispanic commercial members had low compliance with most preventive measures.

The prevalence of hypertension was significantly lower for Hispanic BlueCare members compared to other racial/ethnic groups.

American Indian/Alaskan Native

AI/AN TennCare members had almost double the prevalence of endocrine gland disease or disorder compared to all the other racial/ethnic groups.

White

White commercial members had a significantly higher prevalence of hypertension compared to other racial/ethnic groups.

Thank you for your help in closing gaps in care!

NDC required for provider-administered medications

Beginning Jan. 1, 2014, the National Drug Code (NDC) will be required on all CMS-1500 claims for provider-administered medications for all BCBST members, including commercial members. This has been a requirement for provider-administered medications billed to TennCare for a number of years and will now apply to all lines of business.

BlueCare Tennessee

ADMINISTRATIVE

Reminder: Enroll your patients in the CareSmart® program

In 2012, our Population Health Chronic Disease CareSmart program was improved by adding telemonitoring support for members learning how to manage their chronic illness. This includes weight, pulse, blood pressure and pulse oximetry. Members engaged in this program who meet the criteria are offered this support as well as education with the goal of reducing readmissions and emergency room visits. To refer your BlueCare Tennessee patients for enrollment in our CareSmart program, please contact us at 1-888-416-3025.

New claims editing system *

Implementation of Igenex Claims Editing System or iCES, the new claims editing system for both professional and facility claims is rescheduled to begin in first quarter 2014. iCES utilizes industry rules, as well as federal regulations and policies governing health care claims. You may see some slight differences in how claims are processed as a result of our change to iCES. Look for more information in upcoming articles in *BlueAlert* or online at <http://bluecare.bcbst.com/Providers/index.html>.

Clarification of rate increase for Rural Health Centers and Federally Qualified Health Centers

Providers such as Rural Health Centers, (RHC) and Federally Qualified Health Centers (FQHC) are reimbursed on the basis of an all-inclusive rate under their own Medicaid benefit categories. We wanted to provide an important clarification as to whether the enhanced payment could be paid to a qualified physician for qualified physician services, provided in a hospital and being paid on a fee for service basis for which an RHC or FQHC does not receive a wrap around payment from the state (as they are not providing clinic services in this circumstance). As specified in the final regulation, only services provided under the physician benefit and billed using a physician fee schedule are eligible for higher payment. Example: since the state reimburses the hospital codes on a fee for service basis and does not pay the

all-inclusive rate, those services would be eligible for higher payment if the physician who provides them properly self attests to eligibility. However, services provided by the physician that are reimbursed through the all-inclusive rate would not be eligible. Providers that bill for the rate bump as described herein will be required to complete an attestation form and maintain records to prove they do not bill TennCare for the wrap around payment and provide records upon request to BlueCare Tennessee and TennCare in the event of a CMS audit in order to justify the payment.

The Enhanced Payment Attestation form can be located at: <http://bluecare.bcbst.com/forms/5.PCP_Attestation_Form_Enhanced_Payments.pdf>

You may also reference the Primary Care Physician Enhanced Rates Attestation Form Required letter at: <http://bluecare.bcbst.com/forms/5.PCP_attestation_requirement%20_letter.pdf>

Speech therapy clarification

BlueCare Tennessee has established a process to facilitate the coordination of TENNderCare services when members under 21years of age have been identified as needing to receive therapy services in an educational setting. BlueCare Tennessee requires a copy of the child's Individualized Education Plans (IEP) and a signed Release of Information/Parental Consent. This process is in support of the TENNderCare Connections process for IEPs.

Speech therapy is covered as medically necessary in accordance with TENNderCare requirements and must be performed by a licensed speech therapist. BlueCare Tennessee will NOT pay for speech therapy provided in a group setting in a school unless the group setting is specifically written in the IEP, specifically ordered by the PCP and performed by a licensed speech therapist.

Cover Tennessee

ADMINISTRATIVE

Cover Tennessee changes *

CoverTN – As communicated in previous issues of the *BlueAlert*, CoverTN coverage will no longer be available effective Jan. 1, 2014. A recent request by Governor Bill Haslam to extend coverage for CoverTN enrollees through April 30, 2014, was recently denied. CoverTN enrollees have been notified their coverage will be ending on Dec. 31, 2013.

AccessTN – The AccessTN Board recently approved the extension of coverage for all current AccessTN members through April 30, 2014. Effective May 1, 2014, AccessTN coverage will only be available for members that are below 100 percent of the Federal Poverty Level (FPL) and are also receiving premium assistance. AccessTN members have been notified of these changes.

CoverKids Buy-In – The CoverKids Buy-In eligibility category (members that are over 250 percent of the FPL and who pay a monthly premium for coverage) will close at the end of the year. CoverKids Buy-In members have been notified their coverage will end on Dec. 31, 2013.

As is the case today, providers can verify eligibility by calling our Provider Service Line† or by logging on to BlueAccess, the secure area of www.bcbst.com.

BlueCross will be closed on Jan. 20, 2014, in observance of Martin Luther King, Jr. Day.

*These changes will be included in the appropriate 4 Q 2013 or 1Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)

Operation Hours
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

Medical Management Hours
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
SelectCommunity 1-800-292-8196
Monday – Friday, 8 a.m. to 6 p.m. (ET)

BlueCare Tennessee Medical Management Hours
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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

February 2014

Bluealert

Marketplace

"Know Then Go" network education campaign targets BlueCross members

Health care providers are starting to see new patients who purchased health plans through the Health Insurance Marketplace. Many of these plans are based on high-value provider networks.

As you are aware, BlueCross BlueShield of Tennessee has a new *regional* network available through the Marketplace – Blue Network E – in addition to the existing statewide Blue Networks S and P.

With so many new members gaining access to health insurance for the first time, and because Network E is regional in its scope, BlueCross is launching an extensive member education campaign called "Know Then Go" to explain the importance of staying in network.

Here are a few things we're doing to educate our members.

- Network information is on the bcbst.com homepage.
- Educational inserts are in member welcome packets.
- Adaptations have been made to member ID cards to emphasize the network.
- Network information is included on ID card carriers.
- And more.

Health care providers can help, too.

- Make sure your patients are in a network with which you are contracted.
- If they are not in your network, please explain they will pay a higher deductible, copay and coinsurance for the care you provide out-of-network.
- Help refer them to an in-network provider. They can use our "Find A Doctor" tool on bcbst.com or call the member service number on the back of their ID card to verify in-network providers.
- Please be sure to use participating network facilities when treating your patients.

Stay tuned for more information on "Know Then Go," including updates on the provider web pages of bcbst.com and educational webinars hosted by BlueCross and key professional organizations. Thank you for your support in educating your patients about the importance of staying in-network for care.

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective March 13, 2014

- Aqueous Shunts and Stents for Glaucoma (only addressing Stents)
- Natural Orifice Transluminal Endoscopic Surgery (NOTES) (only addressing peroral endoscopic myotomy [POEM]for the treatment of esophageal achalasia)
- Surgical Deactivation of Headache Trigger Sites
- Genetic Testing for Hereditary Pancreatitis
- Lipid and Non-Lipid Biomarkers in the Risk Assessment and Management of Cardiovascular Disease
- Paclitaxel (Protein-Bound)

Effective May 9, 2014

- Rituximab

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

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

2014 HEDIS® medical record review project to begin

Each year BlueCross BlueShield of Tennessee and BlueCare Tennessee are required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. This is a requirement stated in the Contractor Risk Agreement with the Bureau of TennCare and is also needed to meet Centers for Medicare and Medicaid Services (CMS) reporting requirements. Data is collected for Medicaid, Medicare Advantage, Commercial and CoverKids products.

We will be seeking medical records related to prevention and screening, diabetes care, cardiovascular care, access and availability and utilization measures.

Your cooperation is greatly appreciated and important to the success of the outcome. A BlueCross and/or BlueCare Tennessee representative will work directly with your office to arrange the most appropriate method for obtaining medical record information. This may include scheduling an onsite review in your office or arranging to receive records via fax or FedEx. Staff will need to scan pertinent elements of member charts to support abstraction results due to required oversight audits of our medical record abstraction methodology.

If you use a copy service, please notify them of the need to respond promptly to record requests.

As allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered entities (such as practitioners and their practices) are not required to obtain patient authorization to disclose protected health information (PHI) to another covered entity (such as BlueCross and BlueCare Tennessee), as long as both parties have a relationship with the patient and the PHI pertains to that relationship for the purposes of treatment, payment, and health care operations (TPO). Additionally, all nurses reviewing charts on behalf of BlueCross and BlueCare Tennessee have signed a HIPAA-compliant confidentiality agreement.

New claims editing system for BlueCare Tennessee and CoverKids

Implementation of Ingenix Claims Editing System or iCES, the new claims editing system for both professional and facility claims is scheduled to begin March 1, 2014 for BlueCare Tennessee and CoverKids. iCES utilizes industry rules, as well as federal regulations and policies governing health care claims. You may see some slight differences in how claims are processed as a result of our change to iCES.

New electronic funds transfer tool streamlines the enrollment process

BlueCross BlueShield of Tennessee is partnering with the Council for Affordable Quality Healthcare (CAQH®) on a new, universal electronic funds transfer (EFT) enrollment tool for providers that offers a single point of entry for adopting EFT. By streamlining and automating the EFT enrollment process, the CAQH tool will help eliminate administrative redundancies and create efficiencies and cost savings for both providers and BlueCross.

BlueCross BlueShield of Tennessee is very pleased to currently accept EFT enrollment through CAQH. All licensed health care providers are eligible to enroll in CAQH at no cost. As a valued provider in the BlueCross network, we encourage you to visit https://solutions.caqh.org to learn more about CAQH's new EFT enrollment tool and sign up today. However if you are enrolled for EFT with BlueCross, no action is required by you at this time. Should you need to change or update to your information related to EFT, we ask that this be done through CAQH EFT. You will be notified when any other action is required.

Additionally, BlueCross is working with CAQH to implement use of their Universal Provider Datasource (UPD) in the near future. Look for more information about our partnership with CAQH regarding UPD coming soon.

Upcoming change to prepare for ICD-10*

Effective Oct. 1, 2014, federal regulations require that ICD-10 codes replace ICD-9 codes, which will require business and system changes throughout the health care industry.

Many HIPAA entities are looking into their processes and making necessary changes to prepare for ICD-10. One such change is the CMS-1500 paper claim form. The National Uniform Claim Committee (NUCC) revised the CMS-1500 paper claim form to accommodate ICD-10 diagnosis codes. Here are some important dates and activities:

- **Jan. 6, 2014:** Payers begin receiving and processing paper claims submitted on the revised 1500 Claim Form (version 02/12).
- **Jan. 6 to March 31, 2014:** Dual use period during which payers continue to receive and process paper claims submitted on the old 1500 Claim Form (version 08/05).
- **April 1, 2014:** Payers receive and process paper claims submitted only on the revised 1500 Claim Form (version 02/12).

In the Billing and Reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual*, providers are notified that, "Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated." While reviewing your organization's needs for ICD-10 and the new CMS-1500 form, we encourage all providers to take the steps necessary to become fully electronic wherever possible to meet this requirement.

For more information regarding ICD-10 implementation and BCBST progress, please visit the ICD-10 dedicated web page online at, www.bcbst.com by clicking ICD-10 or you can type the following link in your URL <http://www.bcbst.com/providers/icd-10.shtml>.

Web authorization improvements

Important upgrades are being implemented to our Web Authorization tool. These changes are being made to better serve you in the coming months. Enhancements made to the authorization inquiry tool has a more streamlined format, which includes authorization status information, number of authorized units and requested length of stay (LOS) information.

February upgrades to the web authorization tool are intended to improve the guideline selection and documentation process for web authorization requests. A few of the changes that will be implemented include; removal of the "No Guideline" option. The initial free-form text box will no longer be available. **All** authorizations submitted online will have the MCG (formerly Milliman Care Guidelines) criteria applied. Guidelines with a sticky note option will allow you to add clinical notes. You will be able to choose and/or change a primary diagnosis by selecting a radio button. You will also see guidelines that include a "…", which indicates there is additional information that can be accessed upon clicking the guideline.

Musculoskeletal Program coding changes

The following musculoskeletal (MSK) CPT® codes haves been updated for BlueAdvantage and Commercial plans.

- New codes that require prior authorization for joint surgery: 23333, 23334, and 23335
- Deleted codes no longer used for joint surgery: 23331 and 23332
- Please note descriptions have been modified for the following codes: 23077, 23078, 27049, 27059, 27329, and 27364

Before submitting prior authorization requests to the BlueCross BlueShield of Tennessee Musculoskeletal Program (administered by Triad Healthcare), please verify member benefits and eligibility via BlueAccess®, the secure area on the company website or by calling the Provider Service line†.

Submit prior authorization requests via fax to 1-800-520-8045 or through BlueAccess. The MSK/Triad code must be the primary CPT® code for requests.

Plain language

Plain language is part of a national program to encourage health care providers to promote health literacy among their patients by ensuring they **understand** written and oral health information.

Many informed consent forms and medication package inserts are written at high school level or higher, while the average patient reading level is closer to sixth grade. Most patients will not tell you they do not understand.

Using plain language allows your patients to understand their treatment plan, know how to take their prescriptions properly, and follow your instructions better. This is also important for your patients who do not speak English as their primary language. For additional information on Health Literacy, please refer to the Department of Health and Human Services website at <http://www.hrsa.gov/publichealth/healthliteracy/>.

Provider reference numbers

Beginning in 2014, BlueCross BlueShield of Tennessee's Utilization Management staff will provide reference numbers for all commercial and Medicare Advantage authorization requests. The reference numbers will serve as the provider's verification of notification to BlueCross of the intent to provide service and will assist providers when calling Utilization Management or using the provider self-service features.

The reference number is not a confirmation of benefits, coverage or the determination of an authorization request and serves only as a tracking resource until a decision is rendered.

Quality focus: Heart month

In February, most people's thoughts turn to hearts…as in Valentines. This month, you can help us shift that focus toward having a healthy heart. BlueCross BlueShield of Tennessee encourages preventive screenings to ensure continued health and wellness within our member populations. Members will be receiving information in February about controlling high blood pressure, continuing on antihypertensive medications (ACE and ARBs) if prescribed, and managing their cholesterol.

We are asking for your help to reinforce these messages by talking with your patients about the importance of a healthy heart and the impact dietary or lifestyle changes may make for them. Adding a daily walk may help reduce stress and lower their blood pressure. They should also be aware of what medicines they are taking and the role they play in their heart health. Patients with diagnosed cardiovascular conditions may not realize the importance of watching their cholesterol. Patients may be more likely to respond to suggestions from their physician so your assistance with this initiative is appreciated.

Prior authorization requests made by phone require new details up front

The fastest way to get a prior authorization request reviewed and approved is by submitting the request online at bcbst.com in the secure BlueAccess portal. Many requests submitted online are approved automatically – with no wait time for you.

Many providers prefer to call our automated phone system to gain authorization requests. Those providers may notice a few changes to the process beginning March 1, 2014. Having a few key details available up front will speed up the process, so it's important to be prepared.

When using the automated phone system you will be asked to enter your provider ID number, the facility ID number, the member ID number when you call for prior authorization. Once this information is recorded, you will be transferred to a representative who will assist you with the request.

Remember, entering this same information online through BlueAccess will provide you with a much faster response or approval from BlueCross. Get started today at www.bcbst.com/providers.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

It is estimated that 20 percent of patients seen in family practice have substance abuse disorders

Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol and substance abuse is a way to identify, and intervene with people who may be using substances in a harmful way. This can provide early intervention and treatment for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Billing codes for structured screening and brief intervention services:
99408 and 99409

For referral assistance to specialty care call:

BlueCare Tennessee/CoverKids
1-**800-367-3403**

Commercial/MedicareAdvantage
1-**800-776-2466**

Prior authorization process change for spine surgery

Beginning March 1, 2014, spine surgery prior authorization requests for BlueAdvantage members will be provided by BlueAdvantage Utilization Management. Prior authorization requests for these procedures can be submitted to BlueAdvantage Utilization Management by calling the BlueCross BlueShield of Tennessee Provider Service line† or via BlueAccess. BlueAdvantage prior authorization request forms will be available on the company website on March 1, as well as a list of CPT® codes that require prior authorization for the Musculoskeletal Program.

BlueCare Tennessee
ADMINISTRATIVE

Behaviorally Effective Healthcare in Pediatrics (BEHIP) webinar

Do you need help managing behavioral health issues in your office? Would you like to increase your competence in the area of behavioral health? Join us for a short 30-minute webinar with additional time for *Questions and Answers* to learn more about the *Behaviorally Effective Healthcare in Pediatrics* (BEHIP) training program. Two webinar training sessions are offered on the TNAAP website on Thursday Feb. 13, 2014:

- 11 to 11:30 a.m. (CT), and
- 12:30 to 1 p.m. (CT)

For more information and to register for the BEHIP training, click the following link: BEHIP Introductory Webinar.

Reminder: Epidural steroid injections

Consistent with the state's recently announced limits on epidural steroid injections, services for codes 62310, 62311, 62318, 62319, 64479, 64480, 64483, and 64484 are limited to three (3) in any period of six (6) consecutive months. The counts began with the first shot on or after Oct. 1, 2013. Prior authorization requirements for these injections also began on Oct. 1, 2013. **NOTE**: **The limit will NOT apply in conjunction with labor and delivery.**

All requests will be reviewed based on benefit limit as well as medical necessity criteria utilizing the appropriate guideline based on the procedure submitted.

Home health billing specifications

For home health, the billing week is defined as Monday through Sunday. A separate claim is required for each billing week. Each home health service requires a separate claim line item for each date of service in the billing week. Submission of more than one claim per week will result in denial of the second and subsequent claims for that service week. Providers should not bill private duty services with extended or intermittent nursing visits on the same day during the same benefit week. Therapies (OT, ST, and PT) are an exception to this rule.

Eligibility application process changed for TennCare

If you have a patient applying for TennCare, they will no longer apply through the Department Human Services (DHS), but will now apply through the Health Insurance Marketplace. Applications are accepted online at www.healthcare.gov or by calling 1-800-318-2596.

Note: DHS still processes applications for food stamps, Presumptive Eligibility and other non-Medicaid programs.

On Jan. 1, 2014, the State of Tennessee opened the Tennessee Health Connection, a new service center to assist people with questions concerning the TennCare program, assist new enrollees with applying for the CHOICES program, and help members who have changes to address, name, income or the number of people in their households.

Tennessee Health Connection
PO Box 305240
Nashville, TN 37230-5240
Phone number: 1-855-259-0701
Fax number: 1-855-315-0669

BlueAdvantage
ADMINISTRATIVE

High-risk medications: Glyburide and Amitriptyline

At BlueCross BlueShield of Tennessee, ensuring patient safety is one of our top priorities. High risk medications (HRM) are drugs that have potential clinical concerns when used in the elderly. In the November publication of BlueAlert, we discussed the clinical risks associated with promethazine. This month, we would like to shift the focus to glyburide and amitriptyline. Both these agents have high incidence of chronic use in our members.

When used in elderly patients, glyburide carries higher risk of prolonged hypoglycemia than

alternative sulfonylureas. Glimepiride or glipizide have lower risk of hypoglycemia in this population and may be considered as an alternative if appropriate.

Amitriptyline may induce stronger anticholinergic effects, confusion, and somnolence in the elderly. If clinically appropriate, nortriptyline, desipramine, or trazodone may be used as an alternative antidepressant.

You may receive a letter from us with a list of patient(s) from your practice who filled a prescription for glyburide or amitriptyline within the last 90 days. If appropriate, please consider whether there is a safer alternative for the patient(s). We recognize that physicians are in the best position to determine the right treatment regimen for the patient. We are excited to work with you to ensure optimal outcomes for your patient(s) and our member(s).

CoverTennessee
ADMINISTRATIVE

Reminder: AccessTN changes

The AccessTN Board recently approved an extension of coverage for all current AccessTN members through April 30, 2014.

Effective May 1, 2014, AccessTN coverage will only be available for members that are below 100 percent of the Federal Poverty Level (FPL) and are also receiving premium assistance. AccessTN members have been notified of these changes.

*These changes will be included in the appropriate 4 Q 2013 or 1Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus 1-800-299-1407
SelectCommunity 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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at (**423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

March 2014

Blue alert

Marketplace

New CMS regulations allow Marketplace members to make plan change by March 31

The Centers for Medicare & Medicaid Services (CMS) has finalized a series of processes and policies regarding enrollment and termination for health plan issuers participating in the Marketplace that will now allow consumers to make certain changes to their health insurance plans during the initial open enrollment period.

The member may only make changes if ALL of the following criteria apply:

- Change to another plan offered by the same issuer;
- Change to another plan offered at the same metal level and Cost Sharing Reduction levels;
- Change in order to move to a plan with a broader provider network; and
- Change is requested within the initial open enrollment period, which ends March 31.

The ability to change plans will be particularly helpful to those members who may have selected a network that did not include their preferred provider or was otherwise not what they intended to purchase.

Effective dates of new plans will follow the standard Open Enrollment effective date rules:

- Change requests made on or before the 15th of the month will be effective the first of the following month.
- Change requests made on or after the 16th of the month will be effective the first day of the second following month.

Members' current plans will remain in force until the effective date of the plan change; they will not experience any break in coverage due to the requested change.

How can members change plans under this new guidance?
Members should contact BlueCross BlueShield of Tennessee at the Member Service number listed on the back of their ID card. We can facilitate the change as long as it remains within the same metal level and maintains the same Cost Sharing Reduction level. (i.e. 87 percent actuarial value silver plan to 87 percent actuarial value silver plan, etc.) It is important to know that the changes are all prospective and not retrospective.

Understanding "On" and "Off" Marketplace Terminology

- **Group number 127600** indicates members purchased coverage "On" the Marketplace. When you contact BlueCross to verify benefits and eligibility, you may see this represented as "*On Exchange*."
- **Group number 129800** indicates members purchased coverage "Off" the Marketplace, meaning they purchased a traditional individual insurance plan from an independent source – not through the Marketplace. When you contact BlueCross to verify benefits and eligibility, you may see this represented as "*Off Exchange*."

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

The *BlueCross BlueShield of Tennessee Medical Policy Manual* has been updated to reflect the following policies. The full text of policies listed below can be accessed at

<http://www.bcbst.com/providers/mpm.shtml> under the "Upcoming Medical Policies" link.

Effective April 10, 2014

- Quantitative Electroencephalography as a Diagnostic Aid for Attention-Deficit/Hyperactivity Disorder (ADHD)
- Human Epidermal Receptor Type 2 (HER 2) Testing
- Hematopoietic Stem Cell Transplantation for Autoimmune Diseases
- Endothelial Keratoplasty

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

ADMINISTRATIVE

"Know Then Go" network education resources available to you

Health care providers already understand how seeking in-network care can benefit BlueCross BlueShield of Tennessee members. But with so many new dynamics in place with the Health Insurance Marketplace, we're all working hard to ensure our members understand that it truly pays to stay in-network.

You may have heard about some of the things we're doing to educate our members.

- Network information is on the bcbst.com homepage.
- Educational inserts are in member welcome packets.
- Adaptations have been made to member ID cards to emphasize the network.
- Network information is included on ID card carriers.
- And more.

You have new resources as well. All are available via the provider web pages on bcbst.com.

- Learn more by viewing a presentation about the educational campaign.
- Use our "Find A Doctor" tool to make sure any referrals you make are to in-network providers and facilities.
- Request and display the "Know Then Go" window cling for your location.
- Share the member education materials posted on the Provider page of bcbst.com.

Many of these materials referenced can be found online at www.bcbst.com/knowthengo and on the provider web pages on bcbst.com in the coming weeks.

Some of these materials will be available in a printed format as well. Please e-mail us at BCBSTexchange@bcbst.com to request copies of "Know Then Go" materials for your location. And if you haven't yet done so, be sure to sign up to receive the Marketplace Brief e-mails BlueCross sends on a regular basis. Just e-mail your request to BCBSTexchange@bcbst.com. You may also find archived copies of the Marketplace Brief on the provider web pages under the "Materials for You" header.

Thank you for your continued support in educating your patients about the importance of staying in-network for care.

High Risk Medications

At BlueCross BlueShield of Tennessee, ensuring patient safety is one of our top priorities. The Centers for Medicare & Medicaid Services (CMS) endorses several critical patient safety measures. One of these measures, High Risk Medication, includes several therapeutic categories associated with potential clinical concerns when used in the elderly.

Providers enrolled in BlueAdvantage℠, BlueCare Plus℠ and/or BlueChoice℠ networks may receive a letter from us with a list of patient(s) from your practice that filled a prescription within the last 30 days for one of the high risk medications listed below:

- Ambien
- Amitriptyline
- Doxepin
- Glyburide
- Hydroxyzine
- Nitrofurantoin
- Promethazine

If appropriate, please consider whether there is a safer alternative for your patient(s). We recognize that physicians are in the best position to determine the right treatment regimen for the patient. We are looking forward to working with you to ensure optimal outcomes for your patient(s) and our member(s).

More detailed information about each of these high risk medications will be available soon in the Patient Safety section on our company website.

Upcoming change to prepare for ICD-10*

Effective Oct. 1, 2014, federal regulations require that ICD-10 codes replace ICD-9 codes, which will require business and system changes throughout the health care industry. Many HIPAA entities are looking into

their processes and making necessary changes to prepare for ICD-10. One such change is the CMS-1500 paper claim form.

The National Uniform Claim Committee (NUCC) revised the CMS-1500 paper claim form to accommodate ICD-10 diagnosis codes. Here are some important dates and activities:

- Jan. 6, 2014: Payers began receiving and processing paper claims submitted on the revised 1500 Claim Form (version 02/12).
- Jan. 6 to March 31, 2014: Dual use period during which payers continue to receive and process paper claims submitted on the old 1500 Claim Form (version 08/05).
- April 1, 2014: Payers receive and process paper claims submitted only on the revised 1500 Claim Form (version 02/12).

In the Billing and Reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual*, providers are notified that, "Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated." While reviewing your organization's needs for ICD-10 and the new CMS-1500 form, we encourage all providers to take the steps necessary to become fully electronic wherever possible to meet this requirement.

For more information regarding ICD-10 implementation and BlueCross BlueShield of Tennessee progress, please visit the ICD-10 dedicated web page on the Provider page of our website, www.bcbst.com by clicking ICD-10 or you can type the following link in your browser <http://www.bcbst.com/providers/icd-10.shtml>.

Contraceptive program

While health care reform requires employers to provide benefits for contraceptive services, new regulations exempt some employers from this requirement. For employers that meet certain criteria, BlueCross will pay for eligible contraceptive services at no cost to commercial members.

Please note the following regarding contraceptive services:

- These services include eligible contraceptive and sterilization services only.
- The services must be provided by in-network providers and pharmacies.
- There will be a separate member ID card for this coverage.
- "Contraceptive Program" will appear at the top right corner of the ID card.
- The color of the ID card is pink.

If you have any questions about the Contraceptive Program or the pink ID card, please call our Provider Service line†.

Getting the best impression

The first person your patients usually see is the medical receptionist. The journal *Social Science and Medicine* recently published a study on their work. The study found receptionists are not just the "gatekeepers" or "person behind the desk." Their responsibilities often extend far beyond their administrative duties. They are a vital part of patient care.

Medical receptionists deal directly with everyone coming into the office from patients to pharmaceutical representatives, mail carriers, lab couriers, etc. In addition to their administrative function, they may confirm prescriptions with an angry patient, congratulate a new mother, console a patient whose spouse just died or help a mentally ill patient make an appointment. A significant portion of their work involves managing the emotions and care of patients and families. Medical receptionists are a key part of the relationship between patients and doctors and patients' feelings about the receptionist may be reflected in their opinions of their doctor.

Reminder: Be aware of member rights and responsibilities

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

Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and BlueCare Tennessee provider administration manuals, which are available on *BlueSource*, BlueCross' quarterly provider information CD and online at www.bcbst.com and http://bluecare.bcbst.com/.

Reminder: New electronic funds transfer tool streamlines the enrollment process

BlueCross BlueShield of Tennessee accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and electronic remittance advice (ERA). The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at https://solutions.caqh.org.

New continuing education resource available

The appropriate prescribing of opiate drugs for pain is receiving increased scrutiny by the medical profession, law enforcement and state and national legislatures.

BlueCross is pleased to provide "Continuing Education for Controlled Substances" under the "Tools" headline on this page <http://www.bcbst.com/providers/pharmacy-resources.page> - a free continuing education resource to health care providers that will help ensure appropriate practices are in place when prescribing opiates for pain.

PainEdu.org (Inflexxion) is a recognized source of information that is focused solely on information and education about management of patients with both acute and chronic pain.

Reminder: Web authorization improvements

Important upgrades are being made to our **web authorization tool**. The tool will be under construction and unavailable the evening of Feb. 28 through March 2. Web authorizations will be available again on March 3, 2014.

These changes are needed to better serve you in the coming months. Enhancements made to the authorization inquiry tool will have a more streamlined format, which includes authorization status information, number of authorized units and requested length of stay (LOS) information.

Upgrades to the web authorization tool are intended to improve the guideline selection and documentation process for web authorization requests. A few of the changes implemented will include:

- Removal of the "No Guideline" option.
- The initial free-form text box will no longer be available.
- **All** authorizations submitted online will have the MCG (formerly Milliman Care Guidelines) criteria applied.
- Guidelines with a sticky note option will allow you to add clinical notes.
- You will be able to choose and/or change a primary diagnosis by selecting the appropriate option button, also referred to as a radio button.
- You will also see guidelines that include "…". This indicates that there is additional information that can be accessed upon clicking the guideline.

BlueCare Tennessee
ADMINISTRATIVE

Reminder: Sterilization and hysterectomy forms

When completing the Sterilization Consent Form, please make sure you include the city, state, and ZIP code as part of the facility address. To reduce your administration time in completing the Hysterectomy Acknowledgement Form, please note you are required to only complete Section A, B or C. These forms, along with instructions, are located online at <http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html>.

Identification numbers for newborns *

TennCare requires each individual have a unique identification (ID) number. Parents are required apply for TennCare through the Health Insurance Marketplace to request an ID number for newborns. The Parents can apply online at www.healthcare.gov or call at 1-800-318-2596.

Claims can be filed under the mother's unique ID number for 30 calendar days after the birth of the baby. If the baby has been issued an ID number, claims should be filed using the baby's unique ID and baby's name. After the initial 30 days, if newborn charges are filed using the mother's ID number the claim will be denied.

Please contact the parents for the newborn's ID number or call the BlueCare or TennCare*Select* Provider Service Line† for assistance.

Reminder: Coverage for Medial Block Injections

The Bureau of TennCare revised their policy on Medial Block Injections effective Oct. 1, 2013 with the following changes:

- Therapeutic Facet/Medial Block Injections are no longer covered
- Diagnostic Medial Branch Block Injections are covered as follows:
  - Limit of four per calendar year
  - Must be performed by a physician/practitioner as required by Tennessee Acts 2012, Public Chapter No. 961/SB No. 1935

Claims for Diagnostic Medial Branch Block Injections must be accompanied by supporting documentation, including the Medial Branch Block Injections Certification form to be considered for reimbursement. This form is available online at <http://bluecare.bcbst.com/forms/Provider%20Information/Medial_Branch_Block_Injections_Certification.pdf>.

Reminder: Newborn authorization requirements

All NICU admissions levels II, III, or IV (revenue codes 0172, 0173 or 0174,) require an Authorization. Failure to obtain authorization will result in claim denial.

Note: The NICU authorization can be obtained under the mother's ID number for the first 30 days. However, when requesting the authorization you must use the baby's name or a reference that the request is for the baby (i.e. baby girl/boy).

BlueCare Plus℠
ADMINISTRATIVE

BlueCare Plus, Dual Special Needs Plan

BlueCare Plus now offers a Dual Special Needs Plan (D-SNP) that improves the coordination of care for members with Medicare A, Medicare B and Medicaid. BlueCare Plus is a Medicare Advantage HMO introduced Jan. 1, 2014, that offers the same benefits as Medicare with new value-added benefits for our dual-eligible members. BlueCare Plus includes a Model of Care (MOC) that provides the necessary structure to deliver care management and services to vulnerable Medicare Advantage dual-eligible members with special health care needs.

Enrollment in the BlueCare Plus provider network began Oct. 19, 2012. The BlueCare Plus Amendment became effective 30 days after the delivery of the notice.

If you have questions about the implementation of BlueCare Plus (D-SNP), please contact your local Provider Network Manager or the number below and you will be referred to your Network Manager. You may also visit the Provider page at http://bluecareplus.bcbst.com or call the BlueCare Plus Provider Service Line at 1-800-299-1407.

Regional Office	Telephone Number
Chattanooga	(423) 535-6307
Jackson/Memphis	(731) 664-4127
Johnson City	(865) 588-4644
Knoxville	(865) 588-4640
Nashville	(615) 386-8630

BlueAdvantage℠
ADMINISTRATIVE

Prior authorization process for spine surgery

Beginning March 1, 2014, spine surgery prior authorization requests for BlueAdvantage members will be provided by BlueAdvantage Utilization Management. Prior authorization requests for these procedures can be submitted to BlueAdvantage Utilization Management by calling the BlueCross BlueShield of Tennessee Provider Service line† or via BlueAccess.

BlueAdvantage prior authorization request forms are available on the company website as well as a list of CPT® codes that require prior authorization for the Musculoskeletal Program.

CoverTennessee
ADMINISTRATIVE

Reminder: AccessTN changes

The AccessTN Board recently approved the extension of coverage for all current AccessTN members through April 30, 2014. Effective May 1, 2014, AccessTN coverage will only be available for members that are below 100 percent of the Federal Poverty Level (FPL) and are also receiving premium assistance. AccessTN members have been notified of these changes.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*****These changes will be included in the appropriate 1Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus 1-800-299-1407
SelectCommunity 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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at (**423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

April 2014

Bluealert

Marketplace

Health Insurance Marketplace reference materials available

More than 78,000 Tennesseans purchased health insurance plans through the Health Insurance Marketplace via HealthCare.gov. While open enrollment through the Marketplace officially ended March 31, you may continue to have questions about the Marketplace, the plan designs, network offerings, benefit designs and more.

We encourage you to visit the provider web pages on bcbst.com to find helpful resources, including copies of the Marketplace Briefs which cover topics of importance to health care providers. You may also email us at BCBSTexchange@bcbst.com if you have questions or would like more information.

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective May 10, 2014

- Alemtuzumab
- Certolizumab Pegol
- Genetic Panel Assay for Psychiatric Disorders
- Genetic Testing for Macular Degeneration

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

New drugs added to commercial specialty pharmacy listing

Beginning April 1, 2014, the following drugs have been added to our Specialty Pharmacy drug list. Those drugs requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:

Vimizim (PA)

Self-administered via pharmacy benefit:

Myalept (PA)

Northera (PA)

Olysio (PA)

Orenitram (PA)

Sovaldi (PA)

Providers can obtain PA for:

- Provider-administered drugs that have a valid HCPCS code by logging onto BlueAccess®, the secure area of www.bcbst.com and select Service Center from the Main menu, followed by Authorization/Advance Determination Submission. Physicians not registered with BlueAccess or needing assistance using our website should contact eBusiness Solutions†.

- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.
- Self-administered specialty drugs by calling Express Scripts at 1-877-916-2271.

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

High risk medications - Geriatrics Society releases

At BlueCross BlueShield of Tennessee, ensuring patient safety is one of our top priorities. The Centers for Medicare & Medicaid Services (CMS) endorses several critical patient safety measures. One of these measures, high risk medications (HRM), includes several therapeutic categories associated with potential clinical concerns when used in the elderly.

The HRM measure was first developed by the National Committee for Quality Assurance (NCQA), through its Healthcare Effectiveness Data and Information Set (HEDIS), then adapted and endorsed by the Pharmacy Quality Alliance (PQA).

If appropriate, please consider whether there is a safer alternative for your patient(s). We recognize physicians are in the best position to determine the right treatment regimen for their patient(s).

Measures	Geriatrics Society Recommendation
High Risk Medication: *Benzodiazepines and hypnotics*	Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.
High Risk Medication: *Nitrofurantoin*	Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.
Medication Therapy Management	Don't prescribe a medication without conducting a drug regimen review

Providers enrolled in BlueAdvantage℠, BlueCare Plus℠ and/or BlueChoice℠ can find more information about high risk medications, in the Patient Safety section on our company website at <http://www.bcbst.com/providers/pharmacy-resources.page>.

ADMINISTRATIVE

ICD-10 self-help testing tool coming soon

As of Oct. 1, 2014, all HIPAA-covered entities must use ICD-10 codes for health care services. BlueCross will provide you with a self-help tool to test claims with ICD-10 codes. You will be able to execute test scenarios to ensure your system is working properly. Testing is strongly recommended to have a smooth transition on the implementation date.

If you would like to test with us, please indicate your interest to ICD10_GM@bcbst.com.

CMS-1500 claim form revised *

The 1500 Health Insurance Claim Form is the basic paper claim for use by practitioners and suppliers, and in some cases, for ambulance services. The National Uniform Claim Committee has released a revised CMS-1500 (02/12) claim form for use in accommodating the ICD-10 Diagnosis Code changes. The following dates align with Medicare's timeline for transitioning to the revised format:

- Providers submitted only CMS-1500 (08/05) version through Jan. 5, 2014.
- Submitted either the CMS-1500 (08/05) or CMS-1500 (02/12) forms Jan. 6 through March 31, 2014.
- As of April 1, 2014, submit only CMS-1500 (02/12); CMS-1500 (08/05) version discontinued.

Note: Corrected bills should be identified in Block 22 of the CMS-1500 (02/12) version claim form. Previously these were identified in Block 19.

New cost data available soon for review

As of July 2013, providers were able to view their cost data for the National Consumer Cost Tool (NCCT) within BlueAccess. A refresh of the cost data is performed every six months and will be available for review 60 days prior to being accessible to members. Please logon to BlueAccess to check the latest data refresh that will be available for review on May 1, 2014.

More information is available online at <http://www.bcbst.com/providers/news/Accessing_NCCT_Data_via_BlueAccess.pdf>.

Update: Upcoming change to prepare for ICD-10

In the March BlueAlert, an article "Upcoming change to prepare for ICD-10" mentioned the new CMS-1500 (02/12) version claim form. Be careful completing the new form to avoid using the layout and guidelines from the old (08/05) version. Avoid using the most common errors that may result in rejected claims:

- Block 17 – missing the qualifier defining the provider listed;
- Block 21 - displaying the diagnosis codes in two rows of two (four diagnosis codes should be submitted on row 1 in positions A – D then row 2, then row 3);
- Block 24e - being submitted with numeric diagnosis code pointers (tied back to the incorrect layout of Block 21) rather than the alphabetic pointers required by the new form.

Please be sure to follow the National Uniform Claim Committee (NUCC) list of changes to the form: <http://www.nucc.org/images/stories/PDF/1500_claim_form_change_log_2012_02.pdf>.

If you do not comply with the new version of the CMS-1500 form, your claims may be rejected.

In the Billing and Reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual*, providers are notified that,

"Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated." While reviewing your organization's needs for ICD-10 and the new CMS-1500 (02/12) claim form, we encourage all providers to take the steps necessary to become fully electronic wherever possible to meet this requirement.

For more information regarding ICD-10 implementation and BlueCross' progress, please visit the ICD-10 dedicated web page online at, www.bcbst.com or you can type the following link in your URL <http://www.bcbst.com/providers/icd-10.shtml>.

Reminder: Reporting claims data appropriately

To help ensure accurate and timely claims payment, please remember that all services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission. Claims data is vital to report measurements and statistics needed for the Healthcare Effectiveness Data and Information Set (HEDIS) and Utilization Review Accreditation Committee (URAC) requirements. For more information see the Billing and Reimbursement section of the provider administration manuals.

Reminder: Reporting occurrence code 55 and date of death

To ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted after Oct. 1, 2012 with a discharge status 20, 40, 41, or 42 must also include an occurrence code 55 and date of death.

BlueCare Tennessee
ADMINISTRATIVE

Reminder: Authentication of verbal orders

When requesting an authorization review for any type of service, please include the authentication of verbal orders by having the physician sign prior to calling, faxing, or processing online. If a prior authorization request is received without verbal order authenticated, clarification will be needed prior to processing review.

Reminder: Behavioral health provider initiated notice

Behavioral Health Provider Initiated Notices (PINs) are now available through BlueAccess®. **All providers are asked to submit PINs via the web**. Please make sure all form fields are completed correctly to ensure faster processing. Providers will be able to view and print the completed letters. If you need technical support or training for BlueAccess or help with any of BlueCross' online provider tools, please contact eBusiness Technical Support†.

Update to Lab Exclusion List

Changes to the *2014 Quest/BlueCare Tennessee Lab Exclusion List* follow:

- Addition of 83861 – Microfluidic analysis, tear osmolality
- G0434 replaces G0430 – Drug Screen by CLIA waived test, per patient encounter

All other codes remain unchanged. These changes go into effect May 1, 2014.

New durable medical equipment HCPCS codes

Effective May 1, 2014, the following new durable medical equipment (DME) HCPCS codes **will require prior authorization** for BlueCare and TennCare*Select* members:

A4555	L0641	L3916
A7047	L0642	L3918
E0766	L0643	L3924
E1352	L0648	L3930
L0455	L0649	L4397
L0457	L0650	L5969
L0467	L0651	L8679
L0469	L3809	

For an updated list of DME HCPCS codes that **do not require prior authorization**, please visit our website at<http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf>.

BlueCard
ADMINISTRATIVE

Prior authorization review for inpatient facility services required for out-of-state members

Beginning July 1, 2014, all Blue Plans will require participating providers to obtain prior authorization review for out-of-state members to receive inpatient facility services.

Participating providers obtaining prior authorization review for inpatient facility services should:

- Notify the appropriate Home plan within 48 hours of a change to the original prior authorization
- Notify the appropriate Home plan within 72 hours for emergency or urgent admissions

If prior authorization is required and is not obtained for inpatient facility services, the facility will be financially responsible for their services and the member will be held harmless.

As a reminder, *Electronic Provider Access (EPA) Out-of-Area Pre-service Review* is now an available tool to request an authorization from a member's Home plan. This tool is located in the BlueCard/FEP section of BlueAccess, the secure area on the company website, www.bcbst.com. For more information, please contact us at 1-800-705-0391.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*****These changes will be included in the appropriate 1Q or 2Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus 1-800-299-1407
SelectCommunity 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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at (**423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

CoverTennessee
ADMINISTRATIVE

Reminder: AccessTN changes

The AccessTN Board recently approved the extension of coverage for all current AccessTN members through April 30, 2014. Effective May 1, 2014, AccessTN coverage will only be available for members that are below 100 percent of the Federal Poverty Level (FPL) and are also receiving premium assistance. AccessTN members have been notified of these changes.

PROVIDER NEWS FLASH

of Tennessee

May 2014

BlueAlert℠

Marketplace

Health Insurance Marketplace provider resources available

More than 130,000 Tennesseans who purchased health insurance through the Health Insurance Marketplace, or HealthCare.gov, chose BlueCross BlueShield of Tennessee plans. As part of our commitment to our members and to you, our provider partners, we have developed numerous educational materials to help explain the new benefit plans.

The "Health Care Provider Guide to the Health Insurance Marketplace" is a summary of many of the main components of the Marketplace. In addition to the series of materials we released in the months leading up to and through open enrollment, this guide addresses many of your questions and provides additional details about the Marketplace.

You may refer to an electronic copy online – along with other Marketplace educational materials – at <www.bcbst.com/providers/health-insurance-marketplace.page>. Should you have additional questions about the Marketplace, please contact your provider service representative or email us at BCBSTExchange@bcsbt.com.

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective June 14, 2014

- Vincristine Sulfate Liposome injection
- Analysis of MGMT (O6-methylguanine-DNA methyltransferase) Promoter Methylation
- Non-invasive Prenatal Testing Using Cell-free Fetal DNA (cffDNA)
- Genetic Testing for Epilepsy
- Kinesio Taping
- Orthoptic Training for the Treatment of Vision or Learning Disabilities
- Treatment of Congenital Port Wine Stains and Hemangiomas
- Cranial Electrotherapy Stimulation and Transcranial Magnetic Stimulation

Effective June 18, 2014

- Temozolomide

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

Medical Policy for Positron Emission Tomography

The medical policy titled Positron Emission Tomography (PET) for Miscellaneous Applications has been reviewed and revised, and is now consistent with MedSolutions guidelines. A draft of this revised policy can be accessed on BlueCross' Draft Medical Policies site at: http://www.bcbst.com/DRAFTMPs/.

Clinical Practice Guidelines adopted April 1, 2014

BlueCross BlueShield of Tennessee has adopted the following guidelines as practice resources:

Guidelines for the Diagnosis and Management of Asthma (EPR-3 – 2007) <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>

NAEPP Working Group Report on Managing Asthma During Pregnancy: Recommendations for Pharmacologic Treatment (Update 2004)

<http://www.nhlbi.nih.gov/guidelines/asthma/astpreg.htm>

AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline From the American Heart Association and American College of Cardiology Foundation (2011)
<http://circ.ahajournals.org/content/124/22/2458>

Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report (2002)
<http://www.nhlbi.nih.gov/guidelines/cholesterol/profmats.htm>

Global strategy for the diagnosis, management and prevention of COPD (Updated January 2014)
<http://www.goldcopd.org/uploads/users/files/GOLD_Report2014_Feb07.pdf>

Standards of Medical Care in Diabetes – 2014 American Diabetes Association
<http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf+html>

Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society (2012)
<http://www.neurology.org/content/78/17/1337.full.pdf+html?sid=1bc82d50-bf16-4f1f-b950-7a9a433b18d7>

Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults: The Evidence Report (September 1998)
<http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf>

Recommended Immunization Schedules for Persons Aged 0 through 18 Years (United States, 2014)
<http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>

ACOG (American Congress of Obstetricians and Gynecologists): Guidelines for Perinatal Care, Seventh Edition (2012)
Available for Purchase at:
<http://sales.acog.org/Guidelines-for-Perinatal-Care-Seventh-Edition-P262C54.aspx>

ICSI: Health Care Guideline: Routine Prenatal Care (15th edition. 2012, July)
<https://www.icsi.org/_asset/13n9y4/Prenatal.pdf>

Hyperlinks to these guidelines are also available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company website at http://www.bcbst.com/providers/hcpr/. Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Managing low back pain

When a patient has low back pain (LBP), is immediate imaging important? According to a study conducted at The University of Tampa the evidence indicates that immediate, routine lumbar spine imaging in patients with LBP, without features indicating a serious underlying condition did not improve outcomes compared with usual clinical care that did not include immediate imaging. The report states that clinical care without immediate imaging seems to result in no increased odds of failure in identifying serious underlying conditions in patients without risk factors for these conditions. In addition to lacking clinical benefit, routine lumbar imaging is associated with radiation exposure (radiography and CT) and increased direct expenses for patients and may lead to unnecessary procedures. This evidence from this study confirms that clinicians should refrain from routine, immediate lumbar imaging in primary care patients with nonspecific, acute or sub-acute LBP with no indications of underlying serious conditions.

Specific consideration of patient expectations about the value of imaging was not addressed here; however, this aspect must be considered to avoid unnecessary imaging while also meeting patient expectations and increasing patient satisfaction.

Reference:
Journal of Athletic Training 2011;46(1):99–102 g by the National Athletic Trainers' Association, Inc. www.nata.org/jat
Chou R, Fu R, Carrino JA, Deyo RA. Imaging strategies for low-back pain: systematic review and metaanalysis. Lancet. 2009;373(9662): 463–472

ADMINISTRATIVE

ICD-10 compliance date delay

In April, a newly enacted federal law delayed the ICD-10 compliance date until at least 2015. Nonetheless, BlueCross BlueShield of Tennessee will continue taking steps to prepare for the ICD-10 transition while we await further direction from the Centers for Medicaid & Medicare Services (CMS).

Despite the delay, BlueCross BlueShield of Tennessee will provide a self-help testing tool. This self-help testing tool is available and we are ready to test with you. Facilities and physicians will be able to execute test scenarios to assist with ICD-10 readiness. Please e-mail your request to use the self-help testing tool at ICD10_GM@bcbst.com.

BlueCross will keep you updated with additional details as it relates to the ICD-10 compliance date deadline in future issues of the *BlueAlert*.

Independent laboratory reporting requirement *

All free-standing clinical laboratories whose claims are submitted with place-of-service 81 will soon be required to provide lab test results electronically to BlueCross. Beginning in July 2014, representatives from BlueCross Medical Informatics will begin contacting each contracted Lab to assist in their compliance with this new requirement. If you have questions about this new requirement, please call the Provider Service Line† or your local Network Manager.

Commercial prior authorization requirements update *

Effective June 30, 2014, **Hyperbaric Treatments** will be added to the list as requiring prior authorization for commercial plans in an inpatient or outpatient setting. The updated list is located on the company website at <http://www.bcbst.com/providers/utilization-management-resources.page>.

If providers are treating diabetic wounds they will need to be prepared to provide $P_{tc}O_2$ levels when requesting this service.

Authorization is not a confirmation of coverage or benefits. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member's eligibility at the time services are rendered.

Contact information to request prior authorization:

Behavioral Health
1-800-888-3773
Diagnostic Imaging/Radiology
1-888-693-3211
Durable Medical Equipment
1-866-558-0789
Medical & Surgical
1-800-924-7141
Musculoskeletal Management
1-800-388-8978

New HIPPS Code billing requirement

Beginning with dates of service July 1, 2014, the Centers for Medicare & Medicaid Services (CMS) will require the HIPPS codes when billing BlueAdvantage℠ and BlueCare Plus℠ plans as is currently being required by Original Medicare. CMS is, however, encouraging you to begin billing our plans with the HIPPS codes before July 1 if possible. The HIPPS codes integrate the RUG codes you may be using.

Examples

Claim Line 1: Include HIPPS codes with revenue codes 0022 Skilled Nursing, 0023 Home Health and 0024 Rehabilitation with a zero dollar charge.

Other claim lines: If you are contractually obligated to bill other revenue codes, bill them on line two and after.

First and interim bill: Include Request for Anticipated Payment (RAP) HIPPS code. **Note**: For in-network providers**,** bill as per your contract agreement adding the appropriate line for the HIPPS codes.

Final bill:

- HIPPS codes are available at CMS.gov under HIPPS Master Code (to access open the zip file and select the appropriate Excel spreadsheet.)
- Bill for the last unpaid date(s) of service using final bill type 3x9.

Claim rejections after July 1, 2014

Claims received for processing with dates of service of July 1, 2014, and after that do not include HIPPS coding with revenue codes 0022, 0023 or 0024 will be rejected and require resubmission with the appropriate HIPPS code.

If you have questions, call the appropriate Provider Service line†:

Blue Advantage℠ PPO
1-800-841-7434
BlueChoice (HMO)℠
1-866-781-3489
BlueAdvantage Group
1-800-818-0962
BlueCare Plus (HMO SNP)℠
1-800-299-1407

Important change to most BlueCross BlueShield of Tennessee pharmacy plans

Beginning June 2, 2014, compounded medicines made from bulk powders and select bulk chemicals will no longer be covered by many BlueCross commercial pharmacy plans.

Safety concerns of compound medications have had nation wide news attention, prompting legislation on both the national and state levels. The clinical efficacy of these products is questionable.

The dramatic increase in compounds seems to be a national trend that is getting the attention of payers and sponsoring plans. The majority of

compound medications are not proven to be clinically effective or medically necessary. Due to availability of commercial products, lack of approval by the FDA, questionable drug efficacy, and exceptionally high cost, bulk powders and select bulk chemicals are being excluded from the formulary of BlueCross BlueShield of Tennessee's fully insured plans.

If you have questions, please call the Provider Service line†.

Reminder: What is a healthy weight?

According to national guidelines, a healthy weight depends on three factors:

- body mass index (or BMI)
- waist measurement, and
- risk factors for obesity-related diseases and conditions

BMI scores are valid – but may overestimate body fat in athletes and very muscular people, and underestimate body fat in seniors and those who have lost muscle mass. Waist size is a good indicator of **abdominal fat level**, another predictor of heart disease and illness risk. *Combining* the two measurements shows a more appropriate risk for developing obesity-associated diseases than either factor alone. Additional risk factors include:

- High blood pressure
- High LDL-cholesterol
- Low HDL-cholesterol
- High triglycerides
- High blood sugar
- Family history of premature heart disease
- Physical inactivity
- Cigarette smoking

Specific racial or ethnic backgrounds may pre-dispose your patients to some of the risk factors, such as hypertension for Caucasians and obesity for African-Americans. Remember, if your patients can lose just 5 to 10 percent of their body weight it can have a significant **positive** impact on their health risk.

Reminder: Billing monthly supplies and accessories

Due to frequent changes in membership and eligibility, no more than one month of medical supplies and accessories should be dispensed at a time. Prospective billing for dates of service beyond the occurring month is not eligible for reimbursement. Regular submission of claims for supplies that exceed the usual utilization may prompt a request for medical records to support the need for additional supplies.

Additional supplies must be requested by a member or caregiver before being dispensed. Supplies should not be automatically dispensed on a predetermined regular basis. For more information regarding medical supplies and accessories, please refer to the Billing and Reimbursement section of the *BlueCare Tennessee Provider Administration Manual.* Additional information on this topic can also be found in the MedAdvantage section of the manual.

Invalid HCPCS codes causing delays

Many Durable Medical Equipment (DME) prior authorization requests are being submitted with invalid HCPCS codes. Please verify codes prior to submission to assure timely response, as BlueCross systems cannot process invalid codes.

PWK fax process

As communicated earlier, BlueCross BlueShield of Tennessee is committed to the increased use of electronic processes, including increasing the submission of claims to us in the electronic format. As part of this effort, we are working to remove barriers that prevent providers from submitting 100 percent of their claims to us electronically. One such barrier that has been identified is the inability to send required documentation in an electronic format when the claim is submitted.

We are pleased to announce that we are implementing the PWK process which will allow BlueCross providers to send required documentation at the same time they submit claims electronically. This process uses standard functionality within the ANSI 837 transaction to link the claim to your documentation. Additional information regarding the PWK process is included in a letter that will be mailed to providers and will also be posted with the PWK Fax Cover Sheet in the provider section of the company website at www.bcbst.com/providers.

If you have questions about this process, you can speak with one of the technical support specialists in eBusiness Technical Support by calling (423) 535-5717, option 2, or 1-800-924-7141, Monday through Thursday 8 a.m.to 5:15 p.m. (ET), or Friday 9 a.m. to 5:15 p.m. (ET). Also contact us via e-mail at eBusiness_Service@bcbst.com.

Qualitative Drug Screen changes

Per the American Medical Association (AMA), and in accordance with recommended updates from the Centers for Medicare & Medicaid Services (CMS), proper coding of a multiplex drug screening test kit is a single unit of 80104, not multiple units of 80101. This guideline for billing Qualitative Drug Screens was implemented by the State Bureau of TennCare on Oct. 1, 2013. To be consistent with these policies, BlueCross will no longer accept certain 80000 series drug screen CPT® Codes for dates of service July 1, 2014, and after for its commercial line of business. Commercial claims submitted under

codes 80100, 80101, and 80104 will no longer be reimbursed. Specifically, CPT® Codes 80100, 80101, and 80104 will be non-covered for more appropriate HCPCS/ CPT® Codes G0431 and/or G0434. CPT® Codes G0431 and/or G0434 will be limited to one test unit per date of service.

Additional information about this policy will be available in the Billing and Reimbursement section of the second quarter *BlueCross BlueShield of Tennessee Provider Administration Manual*.

Note: This policy change does not apply to BlueAdvantage.

Updated physician quality information available

The bi-annual update to Physician Quality Information will be available on May 1, 2014 for private physician review on our secure BlueAccess® Web portal. Physicians have a 60-day review period, during which time they can submit self-report information at the patient level to help improve their rating. After the 60-day review period, provider ratings will be updated to reflect the self-reported submissions. The updated provider ratings are also included in our provider directories that are available to our members on the company website.

BlueCross Formulary change

Beginning May 1, 2014, RibaPak will no longer be covered by most patients' pharmacy benefit plans. Generic ribavirin remains on the BlueCross Formulary. However, patients currently taking RibaPak may complete their treatment on this product.

If you have clinical rationale why a new patient should be placed on RibaPak, rather than generic ribavirin, you may request an exception to the formulary by faxing a letter to 1-888-343-4232.

If you have questions about our formulary policy change, please call Provider Service†.

BlueCare Tennessee
ADMINISTRATIVE

PCP Rate Bump Changes for 2014

Effective Jan. 1, 2013 through Dec. 31, 2014, qualified PCPs, as detailed by the Centers for Medicare & Medicaid Services (CMS) regulation, are to receive a rate change for eligible CPT® codes. This rate change is also referred to as the PCP Bump or the PCP Rate Enhancement Payment. The 2014 rates are currently available. Several codes reflect a decrease from the 2013 rate. Claims that have been impacted by the 2014 rate change will be identified and adjusted retroactively to Jan. 1, 2014.

Visit our website at http://bluecare.bcbst.com for information.

Reminder: Billing Telemedicine Originating Site Fees

For dates of service on or after Sept. 1, 2013, providers who deliver services via Telemedicine may be eligible to bill Originating Site fees.

Reimbursement for services rendered via Telemedicine are made in accordance with BlueCare Tennessee, the Centers for Medicare & Medicaid Services (CMS), and TennCare Guidelines. Qualifying codes under BlueCare Tennessee are consistent with CMS, and TennCare guidance. By filing claims for encounters rendered via Telemedicine, providers are attesting that claims were rendered according to these rules and guidelines.

Additional information is available in the Billing and Reimbursement Section of the *BlueCare Tennessee Provider Administration Manual*. Questions should be directed to your regional Provider Network Manager.

Reminder: Filing corrected bills appropriately

Corrected bills must be submitted within 120 days of the BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

Claims that have been processed (providers receive a Remittance Advice that includes the claim) and were paid incorrectly because of an error or omission on the claim may be filed as a "Corrected Bill." A true corrected bill includes additional/changed dates of service, procedure or diagnostic codes, units, member name, ID and/or charges that were not filed on the original claim.

Please refer to the Billing and Reimbursement section of the *BlueCare Tennessee Provider Manual* for the required method for electronic claims and for paper claims.

Note: Claims returned or rejected should not be submitted as corrected claims. Only claims that have completed adjudication should be submitted as corrected bills. When sending a Corrected/Replacement Claim you must re-send the claim in its entirety including the corrections.

New online portal for Best Practice Network providers

BlueCare Tennessee will be launching Care Team Connect (CTC), a new online portal in second quarter of 2014. This new portal will offer detailed information to providers about their patients who are in state custody. Best Practice Network

providers who serve children in state custody will now have easy access to view their patient's medical history. We will be contacting you to discuss the registration and training process. In the meantime, contact Heather Smith at (615) 386-8564 in West Tennessee, or Sandra DeBord at (865) 588-4641 in East Tennessee with any questions.

BlueCard
ADMINISTRATIVE

Prior authorization review for inpatient facility services required for out-of-state members

Beginning July 1, 2014, all Blue Plans will require participating providers to obtain prior authorization review for out-of-state members to receive inpatient facility services.

Participating providers obtaining prior authorization review for inpatient facility services should:

- Notify the appropriate Home plan within 48 hours of a change to the original prior authorization
- Notify the appropriate Home plan within 72 hours for emergency or urgent admissions

If prior authorization is required and is not obtained for inpatient facility services, the facility will be financially responsible for their services and the member will be held harmless.

As a reminder, *Electronic Provider Access (EPA) Out-of-Area Pre-service Review* is a tool now available to request an authorization from a member's Home plan. This tool is located in the BlueCard/FEP section of BlueAccess.

For more information, please contact us at 1-800-705-0391.

BlueAdvantage
ADMINISTRATIVE

QUALITYCARE REWARDS

Medicare Advantage LPPO Physician Quality Program

Starting June 1, 2014, BlueCross BlueShield of Tennessee will begin a new Physician Quality Program. This program will recognize primary care physician practices that close individual patient's quality gaps in care.

Bonus and fee schedule reimbursement payments are based on practices achieving targeted goals for a pre-defined set of 18 potential quality measures for physicians who treat BlueCross' Medicare Advantage members enrolled in our LPPO Network.

The program consists of two key components: **Pay for Gap Closure** and the **Practitioner Assessment Form**.

Pay for Gap Closure
A quality bonus payment of up to $125 per attributed patient will be paid when all of an individual patient's quality gaps in care are closed.

Practitioner Assessment Form
The Practitioner Assessment Form is independent from the Physician Quality Program. A service fee of $155 will be paid annually per patient for each practitioner assessment form that is completed. In order to be paid for this service, providers must fax the completed assessment form to 1-877- 922-2963 and file a claim for the service using E/M code 99420.

Note: Bonus payments for procedure-based performance measures will be reconciled on a quarterly basis.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*****These changes will be included in the appropriate 1Q or 2Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus℠ 1-800-299-1407
BlueChoice℠ 1-866-781-3489
SelectCommunity 1-800-292-8196
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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

June 2014

BlueAlert SM

Marketplace

Health Insurance Marketplace provider resources available

More than 134,000 Tennesseans who purchased health insurance through the Health Insurance Marketplace, or HealthCare.gov, chose BlueCross BlueShield of Tennessee plans. As part of our commitment to our members and to you, our provider partners, we have developed numerous educational materials to help explain the new benefit plans.

The "Health Care Provider Guide to the Health Insurance Marketplace" is a summary of many of the main components of the Marketplace. In addition to the series of materials we released in the months leading up to and through open enrollment, this guide addresses many of your questions and provides additional details about the Marketplace.

You may refer to an electronic copy online – along with other Marketplace educational materials – at <www.bcbst.com/providers/health-insurance-marketplace.page>. Should you have additional questions about the Marketplace, please contact your provider service representative or email us at BCBSTExchange@bcsbt.com.

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective July 12, 2014

- Genetic Testing for Dilated Cardiomyopathy (DCM)
- Intraocular Radiotherapy for Age-related Macular Degeneration (AMD)

Effective Aug. 19, 2014

- Romidepsin
- Bariatric Surgery
- Genetic Testing (CFTR Mutations) for Cystic Fibrosis

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

A reminder about acetaminophen combination drugs

The FDA is reminding health care professionals and pharmacists to stop prescribing/dispensing prescription combination drug products that contain more than 325 milligrams (mg) of acetaminophen per tablet, capsule, or other dosage unit.

These products have been voluntarily withdrawn and are no longer considered safe by the FDA. Pharmacists are recommended to contact the prescriber if they receive a prescription for a combination product with more than 325 mg of acetaminophen per dosage unit.

Best Practice for ADHD treatment

Psychopharmacological treatment is recommended by The American Academy of Child and Adolescent Psychiatry (AACAP) for members diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

- Child patients initially diagnosed with ADHD and prescribed ADHD medication should receive one follow-up visit with a prescribing practitioner within 30 days of the initial visit;
- Child patients who remain on ADHD medication should have at least two more visits with their prescribing practitioner within 270 days (nine months) following the 30-day visit.

Appropriate follow-up care for children prescribed ADHD medication is measured by the Healthcare Effectiveness Data and Information Set (HEDIS). This measure is defined as the percentage of children from ages 6-12 with newly prescribed ADHD medication who meet the above standards of care.

Other problems often co-occur with ADHD, such as: conduct problems, anxiety and depressive disorders, or substance use, which can make the diagnosis and treatment more difficult. In these instances, a referral to a behavioral health provider should be considered. If you would like assistance referring a patient for behavioral health services, please call 1-800-367-3403 for BlueCare, TennCare*Select,* CoverKids and BlueCare Plus (HMO SNP)℠; and 1-800-776-2466 for Commercial, Medicare Advantage and AccessTN.

ADMINISTRATIVE

Reminder: Physician Quality Information Portal available until June 30, 2014

The Physician Quality Information Portal on BlueAccess® will be available for physician review and self-reporting until June 30, 2014. After June 30, provider ratings will be updated to reflect the self-reported submissions. The updated provider ratings will be included in our provider directories that are available on the company website for our members.

Tennessee Health Care Innovation Initiative

The State of Tennessee is launching the Tennessee Health Care Innovation Initiative. This initiative is to begin transforming the payment system from fee-for-service to value-based models of care. To learn more about the initiative please visit the following link: http://www.tn.gov/HCFA/strategic.shtml. Tennessee insurers, including BlueCross BlueShield of Tennessee are participating in this multi-payer approach to transforming the payment system.

Part of the initiative will focus on episodes of care. With input from Tennessee clinicians and insurers, the initiative is implementing a first wave of three episodes; perinatal care, total joint replacement (hip and knee), and acute asthma exacerbations. Over time, additional episodes will be added; each developed with input from Tennessee clinicians.

For each episode of care there is a principal accountable provider, also called the quarterback. The quarterback is represented as the tax identification number (TIN) of the provider, who is in the best position to provide cost and quality care for an episode. For example, the quarterback for a perinatal episode is the TIN of the provider delivering the baby (Ob/Gyn, family practitioner, nurse midwife.) The quarterback is the TIN of the facility where the patient went to the emergency department or for an inpatient stay related to an asthma exacerbation episode. For the total joint (hip or knee) replacement the quarterback is the TIN of the surgeon.

Reports regarding the quarterback's performance within an episode of care are generated by the insurers participating in this initiative. If you are a provider with a shared TIN as the designated quarterback, but do not treat these episode types (perinatal, asthma, hip and knee replacement), you will still have access to the provider reports for that TIN.

This initiative will not change the way providers currently deliver health care and submit claims. Patients will seek and receive health care as they do today and BlueCross will continue to reimburse for services in the same manner. Lines of business included in these episodes are State of Tennessee, BlueCare℠, TennCare*Select*, Commercial, CoverKids and fully-insured.

As of May 12, 2014, BlueCross began generating reports reflecting the quarterback's TIN episodes of care through BlueAccess. To view these reports, select the Tennessee Health Care Innovation Initiative link in BlueAccess and choose the quarterback's TIN and line of business.

For questions related to this program, e-mail payment.reform@tn.gov, or contact the BlueCross BlueShield of Tennessee Provider Service Line†.

Appropriate billing for revenue code 0360

During routine audit processes, BlueCross' Provider Audit Department discovered many facilities are billing revenue code 0360 (*Operating Room Services)* incorrectly. Facilities are reporting this revenue for procedures not performed in the operating room, but were actually performed in the emergency room (ER) or wound care clinic. Procedures performed in the ER should be billed with revenue code 0450, while procedures performed for wound care should be billed with revenue code 0519. The facility must also be contracted for wound care to bill for these services. Additional information on wound care guidelines may be found in the provider administration manuals which are available on the Provider page on the company websites, www.bluecare.bcbst.com and www.bcbst.com.

Reminder: Qualitative Drug Screen changes

Per the American Medical Association (AMA), and in accordance with recommended updates from the Centers for Medicare & Medicaid Services (CMS), proper coding of a multiplex drug screening test kit is a single unit of 80104 not multiple units of 80101. This guideline for billing Qualitative Drug Screens was implemented by the State Bureau of TennCare on Oct. 1, 2013. To be consistent with these policies, BlueCross will no longer accept certain 80000 series drug screen CPT® Codes for dates of service July 1, 2014, and after for its commercial line of business. Commercial claims submitted under codes 80100, 80101, and 80104 will no longer be reimbursed. Specifically, CPT® Codes

80100, 80101, and 80104 will be non-covered for more appropriate HCPCS/ CPT® Codes G0431 and/or G0434. CPT® Codes G0431 and/or G0434 will be limited to one test unit per date of service.

Additional information about this policy will be included in the next available update to the *BlueCross BlueShield of Tennessee Provider Administration Manual*.

Note: This policy change does not apply to BlueAdvantage℠.

Reminder: CMS-1450 (UB-04) billing

When filing a CMS-1450 (UB04) please be mindful of Admission Type (Form Locator 14), Admission Source (Form Locator 15), and Discharge Status (Form Locator 17). We have seen an increase in claims rejecting for either missing or invalid codes. Please refer to your UB04 manual for additional information on these form locators.

Reminder: Duplicate claims handling for Medicare crossover

Effective Oct. 13, 2013, when a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting the claim to BlueCross. If filed as a paper claim, CMS remit must show the date CMS processed and released. If submitted electronically, there is a claim segment to show the other carrier paid date. Medicare primary claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date will be returned or rejected by BlueCross BlueShield of Tennessee.

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for you to receive payment or instructions from the Blue Plan.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the member's benefit policy to be applied. To view a list of frequently asked questions, please visit our website at http://www.bcbst.com/providers/news/ and click on the *Medicare Crossover Duplicate Claims FAQs*.

Commercial prior authorization requirements update for hyperbaric treatments

Effective June 30, 2014, **hyperbaric treatments** will be added to the list as requiring prior authorization for commercial plans in an inpatient or outpatient setting. The updated list is located on the company website at <http://www.bcbst.com/providers/utilization-management-resources.page>.

Authorization is not a confirmation of coverage or benefits. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member's eligibility at the time services are rendered.

Contact information to request prior authorization:

Behavioral Health
1-800-888-3773
Diagnostic Imaging/Radiology
1-888-693-3211
Durable Medical Equipment
1-866-558-0789
Medical & Surgical
1-800-924-7141
Musculoskeletal Management
1-800-388-8978

Reminder: Important change to most BlueCross BlueShield of Tennessee pharmacy plans

Beginning June 2, 2014, compounded medicines made from bulk powders and select bulk chemicals will no longer be covered by many BlueCross commercial pharmacy plans.

Safety concerns of compound medications have had nation-wide news attention, prompting legislation on both the national and state levels. The clinical efficacy of these products is questionable.

The dramatic increase in compounds seems to be a national trend that is getting the attention of payers and sponsoring plans. The majority of compound medications are not proven to be clinically effective or medically necessary. Due to availability of commercial products, lack of approval by the FDA, questionable drug efficacy, and exceptionally high cost, bulk powders and select bulk chemicals are being excluded from the formulary of BlueCross BlueShield of Tennessee's fully insured plans.

If you have questions, please call the Provider Service line†.

Electronic dental secondary claims

Did you know BlueCross accepts electronic dental secondary claims? Save time and money by avoiding the mailing of paper claims and explanation of benefit statements. Contact your software vendor or clearinghouse with the information at the following link to get started: <http://www.bcbst.com/providers/ecomm/bcbst_5010/Electronic_Secondary_Claim_Guideline.pdf>.

If you have further questions, please contact eBusiness Solutions†.

BlueCare Tennessee
ADMINISTRATIVE

Prior authorization requirement change for CPT® code 92558

As of May 1, 2014, CPT® code 92558 (evoked otoacoustic emissions, screening "qualitative measurement of distortion product or transient evoked otoacoustic emissions", automated analysis) no longer requires prior authorization for BlueCare or TennCare*Select* members.

iCES billing update

Durable Medical Equipment providers may bill for diabetic pump supplies on a monthly basis. These supplies can be on one line of the claim. Example: A4221 can now be billed with four units.

New requirements for certain medications

Beginning June 1, 2014, the medications listed below will only be covered if they are patient administered and have an approved authorization from Magellan Pharmacy Solutions. To request an authorization for patient-administer medication please call 1-866-434-5524. If these medications are provider administered, the prescriber should bill the medications through the member's medical benefit plan:

- ✓ Mesnex®
- ✓ Neupogen®
- ✓ Neumega®
- ✓ Neulasta®
- ✓ Leukine®

We value our relationship with you and look forward to continuing to work together to help ensure TennCare members receive quality, affordable health care.

Medicare Advantage
ADMINISTRATIVE

QUALITYCARE REWARDS

Medicare Advantage LPPO Physician Quality Program

Starting June 1, 2014, BlueCross BlueShield of Tennessee is beginning a new Physician Quality Program. This program will recognize primary care physician practices that close individual patient's quality gaps in care.

Bonus and fee schedule reimbursement payments are based on practices achieving targeted goals for a pre-defined set of eighteen potential quality measures for physicians who treat BlueCross' Medicare Advantage members enrolled in our LPPO Network.

The program consists of two key components: **Pay for Gap Closure** and the **Practitioner Assessment Form**.

Pay for Gap Closure
A quality bonus payment of up to $125 per attributed patient will be paid when all of an individual patient's quality gaps in care are closed.

Practitioner Assessment Form
The Practitioner Assessment Form is independent from the Physician Quality Program. A service fee of $155 will be paid annually per patient for each practitioner assessment form that is completed. In order to be paid for this service, providers must fax the completed assessment form to 1-877-922-2963 and file a claim for the service using E/M code 99420.

Note: Bonus payments for procedure-based performance measures will be reconciled on a quarterly basis.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*****These changes will be included in the appropriate 2Q or 3Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines (includes CoverTN; CoverKids) **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CHOICES	**1-888-747-8955**
BlueCare PlusSM	**1-800-299-1407**
BlueChoiceSM	**1-866-781-3489**
SelectCommunity	**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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

July 2014

Bluealert SM

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective Aug. 9, 2014

- Collagenase Clostridium Histolyticum
- Gene Expression Profile Analysis for Prostate Cancer Management
- Positron Emission Tomography (PET) for Miscellaneous Applications

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

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming modifications to select Modified Utilization Management Guidelines. The *Modified Utilization Management Guidelines* can be viewed on the Utilization Management Web page at http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm

Effective August 19, 2014

The following as relates to Ambulatory Care:

- Proton Beam Therapy

The following as relates to Home Care:

- Hyperemesis Gravidarum

The following as relates to Inpatient and Surgical Care:

- BlueCross modifications related to Disorders of Fluid, Electrolyte, and Acid-Base Balance (ICD-9 276) will be removed.
- BlueCross modifications related to Other and ill-defined Conditions Originating in the Perinatal Period (ICD-9 779) will be removed.
- BlueCross modifications related to Prostatectomy, Laparoscopic Radical Observation goal length of stay will be removed.
- BlueCross modifications related to Radius/Ulna Fracture, Closed or Open Reduction will be removed, therefore the MCG Care Guideline will be used.
- BlueCross modifications related to Shoulder Arthroplasty will be removed, therefore the MCG Care Guideline will be used.

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

New drugs added to commercial specialty pharmacy listing

Beginning July 1, 2014, the following drugs have been added to our Specialty Pharmacy drug list. Those drugs requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:

- Cyramza (PA)
- Entyvio (PA)
- Sylvant (PA)

Self-administered via pharmacy benefit:

- Oralair (PA)
- Otezla (PA)
- Zykadia (PA)

Providers can obtain PA for

- Provider-administered drugs that have a valid HCPCS code by logging onto BlueAccess®, the secure area of www.bcbst.com and select Service Center from the Main menu, followed by Authorization/Advance Determination Submission. Physicians not registered with BlueAccess or needing assistance using our website should contact eBusiness Solutions†.

- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.

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

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

ADMINISTRATIVE

ICD-10 self-help testing tools

In our ongoing effort to prepare for the transition to ICD-10 codes, BlueCross is offering an online, scenario based ICD-10 testing tools. Providers will be able to choose ICD-10 codes for a number of different scenarios based on your specialty or type of facility. Since this testing program is web based, online testing tools offer flexibility to be used anytime.

The professional provider testing tool consists of scenarios that are clinical narratives used for ICD-10 coding to detect valid and invalid codes. You can view results and compare your answers to other providers in your specialty.

The institutional provider testing tool consists of medical record numbers that represent high dollar and high volume scenarios from previously processed ICD-9 claims. Providers can recode and compare the associated claims based on ICD-10 coding guidelines.

We welcome you to take advantage of the additional time to test since the ICD-10 compliance date has been extended.

Check the ICD-10 page on our website http://www.**bcbst**.com/providers/icd-10.page for upcoming changes and access to the ICD-10 testing tools. For questions about the tools and to test with us, please send email to ICD10_GM@bcbst.com.

Reminder: Claims filing guidelines

BlueCare Tennessee and CoverKids contracted and non-contracted providers are required to submit all medical service claims within 120 days of the date of service, or for facilities, within 120 days from the date of discharge, **or** within 60 days from the date of the rejection notice, whichever is later. For claims submitted by physicians and other suppliers that include span dates of **service (i.e., a "From" and "Through" date on the claim), the "From" date will be used for determining timely filing.**

In the case of retroactive eligibility determinations, claims must be submitted within the latter of 120 days from the date of service or, for facilities, within 120 days from the date of discharge, or 120 days from the date notification of the enrollee's eligibility/enrollment.

Corrected bills are also required to be submitted **within 120 days of the date of the remittance.** For more information on filing corrected bills, see the *BlueCare Tennessee Provider Administration Manual* located on the company websites, www.bluecare.bcbst.com and www.bcbst.com.

If BlueCare, TennCare*Select* or CoverKids is secondary to a commercial insurer or Medicare, claims must be submitted within 120 days from the date the primary insurer's remittance was produced.

Reminder: Coding Requirements

A valid HCPCS/CPT® Code is required when billing certain revenue codes (RC) as indicated in the *BlueCross BlueShield of Tennessee Provider Administration Manual*. These CPT®/HCPCS Codes should always be billed on a CMS-1450 in Form Locator 44. Without the correct RC and CPT®/HCPCS Codes, BlueCross will not accept the claim for consideration of benefits. If a required CPT® /HCPCS Code is missing, the claim may be denied and/or returned to the facility for proper coding.

BlueCross uses the Uniform Billing Editor published by Optum (or its successor) Appendix 3, "Numeric List of HCPCS Codes with Recommended RC Assignments," as a guide to determine appropriate billing services rendered.

iCES billing update

Durable medical equipment network providers for BlueCare Tennessee and CoverKids may bill for diabetic pump supplies on a monthly basis. These supplies can be on one line of the claim. Example: A4221 can now be billed with four units.

Reminder: Commercial prior authorization requirements update for hyperbaric treatments

Effective June 30, 2014, **hyperbaric treatments** were added to the list as requiring prior authorization for commercial plans in an inpatient or outpatient setting. The updated list is located on the company website at <http://www.bcbst.com/providers/utilization-management-resources.page>.

Authorization is not a confirmation of coverage or benefits. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member's eligibility at the time services are rendered.

Contact information to request prior authorization:

Behavioral Health
1-800-888-3773
Diagnostic Imaging/Radiology
1-888-693-3211
Durable Medical Equipment
1-866-558-0789
Medical & Surgical
1-800-924-7141
Musculoskeletal Management
1-800-388-8978

BlueCare Tennessee

ADMINISTRATIVE

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus℠ (DSNP)

Reminder: TENNderCare medical record documentation requirements

Network practitioners are expected to maintain medical records in detail consistent with good medical/ professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care practitioner.

Clinical personnel review medical records of Primary Care Practitioners that provide preventive care to members under the age of 21 to evaluate compliance with Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) requirements and share additional education and resources. Reviews are performed every two years, but may also be requested anytime by the Clinical Risk Management Department. Reviews are conducted according to TennCare Audit Instructions-Medical Record Review Instructions that are published in the *Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual* unless more current published American Academy of Pediatrics (AAP) guidelines are available. The AAP manual provides detailed information for each EPSDT element and is available at http://www.tnaap.org/EPSDT/EPSDTmanual.htm.

Age appropriate elements, identification of risk factors, periodicity for procedures and immunizations should be provided at each TENNderCARE encounter based on the most current *American Academy of Pediatrics Recommendations for Pediatric Health Care*. Documentation should provide reasons for not performing any element, or member refusal of any or all elements of this exam. Additional information regarding EPSDT elements and documentation requirements is available in the *BlueCare Tennessee Provider Administration Manual* at www.bcbst.com.

Reminder: Reporting home health missed shifts

Home health agencies are reminded to notify BlueCare Tennessee of any missed shifts for hourly skilled and aide services. If ***missed shift*** is for the same day or you know in advance that a shift will be missed please report this information immediately by calling 1-800-423-0131 for BlueCare members and 1-800-711-4104 for TennCare*Select* members. All other ***missed shifts*** must be reported by faxing the missed shift information to 1-423-535-5254, or 1-865-588-4663. Please remember all missed shifts should be reported within 24 hours.

If the home health agency is not able to staff a shift after normal business hours, the agency should call the BlueCare Tennessee NurseLine at one of the following numbers:

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

Additionally, home health agencies are required to notify BlueCare Tennessee in advance if aware of the following:

- Any planned missed shift
- A nurse/aide is going to be late
- The agency is unable to staff the shift

Note: It is considered a missed shift if the home health agency is authorized to provide a shift, but no services are provided for that shift. The home health agency should only submit claims for services actually rendered.

BlueCard

ADMINISTRATIVE

Prior authorization review for inpatient facility services required for out-of-state members*

Beginning July 1, 2014, all Blue Plans will require participating providers to obtain prior authorization review for out-of-state members to receive inpatient facility services. Participating providers obtaining prior authorization review for inpatient facility services should:

- Notify the appropriate Home plan within 48 hours of a change to the original prior authorization
- Notify the appropriate Home plan within 72 hours for emergency or urgent admissions

If prior authorization is required and is not obtained for inpatient facility services, the facility will be financially

responsible for their services and the member will be held harmless.

As a reminder, *Electronic Provider Access (EPA) Out-of-Area Pre-service Review* is now an available tool to request an authorization from a member's Home plan. This tool is located in the BlueCard/FEP section of BlueAccess.

For more information, please contact us at 1-800-705-0391.

Medicare Advantage

ADMINISTRATIVE

This information applies to BlueAdvantage HMO/PPO plans, excluding dual-eligible BlueCare Plus℠ (DSNP)

New CMS requirement for non-covered services/supplies*

In accordance to notification from the Centers for Medicare & Medicaid Services (CMS), the Advanced Beneficiary Notice (ABN) used in the original Medicare program is **not** applicable to Medicare Advantage programs. Therefore, when informing a BlueAdvantage member that a service is not covered or is excluded from their health benefit plan, the decision is considered an organization determination under 42 CFR, 422.566(b) and requires the appropriate CMS notice of denial of coverage (CMS-10003). A "waiver" is no longer sufficient documentation of this notification. BlueChoice HMO or BlueAdvantage Plan network providers should request a pre-determination from BlueAdvantage on the member's behalf before any non-covered service/supply is provided.

For additional information and to download the Denial of Coverage Notice, see the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html.

Expanded Population Health/Condition Management Program (previously Disease Mgt.)

Starting on **July 7, 2014**, BlueCross BlueShield of Tennessee Medicare Advantage plans are pleased to announce an expansion of our Condition Management Programs for members with:

- Diabetes
- CHF/CAD/Hypertension/High Cholesterol
- Asthma/COPD
- ESRD on Hemodialysis

These programs include information about the member's diagnosis and health coaching to encourage compliance with your plan of care and prescription adherence. The latest techniques of motivational interviewing and readiness to change assessments are built into the health coaching models. If you have a member with one of these diagnoses and you would like to refer them for enrollment, please contact Julie Thomas, Medicare Products Case Management and Population Health Supervisor at (423) 535-6827.

Starting Sept. 1, 2014, BlueAdvantage (PPO) and BlueChoice (HMO) programs will introduce several care management programs for members in acute inpatient care settings.

Medicare Advantage Readmission Reduction Program

In conjunction with the Centers for Medicare & Medicaid Services' (CMS) Hospital Readmissions Reduction Program, beginning **Sept. 1, 2014**, BlueCross Medicare Advantage Plans will reimburse for readmissions to acute care hospitals that occur within 31 days from the index admission discharge as follows:

- A same or similar diagnosis readmission occurring within three (3) to 31 days from a complication of the original hospital stay or admission resulting from a modifiable cause relating to the acute care facility's discharge diagnosis to the same or similar facility, or facility operating under the same contract, is not eligible for two DRG inpatient payments. The facility will be reimbursed for a single inpatient DRG (the higher weighted of the two admissions) only. All other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for Medical Necessity.

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

BlueCross readmission guidelines have been developed to be less stringent than the Readmission Reduction Program guidelines for original Medicare by not penalizing a facility for all diagnoses that could lead to a readmission or adjusting all Medicare payments, but rather applies the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the individual member that is readmitted. The goal of this program is to engage providers and facilities in addressing transition of care options.

CMS considers 31 day readmissions to be an indicator of quality of care.

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

Medicare Advantage Inpatient Level of Care Management Program

Starting **Sept. 1, 2014**, and consistent with the criteria in MCG (formerly Milliman Care Guidelines®), BlueCross BlueShield of Tennessee will reimburse for higher acuity level of care beds (critical care level of care) during acute inpatient hospitalizations as follows: MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with a higher acuity level of care bed and nursing care. This review is performed by a Plan Medical Director.

- If criteria are not met, then the day may be approved as Medically Necessary, but the intensity of care will be reimbursed at an acute level of care rather than critical care level of care.
- This review can occur during any portion of the hospitalization, including during the initial Diagnosis Related Group (DRG) period.

Note:
1. The Member cannot be held liable for payment of services received when not approved.
2. Standard facility appeal remedies are applicable.

Inpatient DRG Day Outlier Management Program

Starting **September 1, 2014**, and consistent with the criteria in MCG, BlueCross BlueShield of Tennessee will reimburse acute inpatient hospitalization days outside of the initial DRG day approval as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur during the time period after which the DRG days have elapsed, and are subject to the facility providing concurrent clinical information for review as contractually required.
- If clinical information is requested three (3) times using at least two (2) different notification methods, then the days will be denied for a lack of clinical information necessary to establish ongoing Medical Necessity. In situations where no clinical information has been provided for the days in question, these denied days will not be eligible for reconsideration review or peer to peer discussion and the facility can follow standard facility appeal remedies.

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

Revenue Code 510 (Hospital-Based clinic services) *

Effective **Oct. 1, 2014**, and consistent with reimbursement guidelines of other payers as well as current BlueCross BlueShield of Tennessee Commercial and BlueCare Tennessee contracts, Medicare Advantage will no longer reimburse for charges under revenue code 510 (hospital-based clinic setting as defined in 42 CFR 410.2) when provided in conjunction with an E&M professional service charge.

Breast cancer screening: Patients say they're waiting on you

According to focus group results, over half of the members questioned said they wait for their doctors to tell them it is time for them to get a mammogram. Please recommend your patients have their mammograms as appropriate. As you know, early detection saves lives.

New member engagement program available

Join BlueCross BlueShield of Tennessee in leading your BlueAdvantage (PPO)SM and BlueChoice (HMO)SM patients down the path to better health with the new **My Healthpath Program** described on the company website at http://www.bcbst.com/providers/quality-initiatives/My-Healthpath-Member-Engagement-Program.page?

Medicare Advantage Quality Care Rewards Program and Tool

On June 1, 2014, Blue Cross Blue Shield of Tennessee began a new Physician Quality Program. This program recognizes primary care physician practices that close individual patient's quality gaps in care.

In 2014, a quality bonus payment of up to $125 per attributed patient will be paid when all of an individual patient's quality gaps in care are closed. Your gap closure rate will be used to calculate your practice's star rating and then be applied to your rebased fee schedule in 2015. To find out more about the Quality Care Rewards Program and for resources related to closing gaps in care, please visit the following link: http://www.bcbst.com/providers/quality-initiatives.page.

We know that data is essential to your practice in closing quality gaps in care. As such, you now have the ability to **view and export gaps in care** information, **view financial information** related to the Quality Care Rewards program and **self-report data to directly close gaps in care** on this site. The Medicare Advantage Provider Quality Incentive Program tool is accessible through BlueAccess at https://www.bcbst.com/secure/providers/.

Please contact your eBusiness Marketing Consultant for all of your BlueAccess registration and training needs †.

BlueCross BlueShield of Tennessee offices will be closed July 4 in observance of Independence Day.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*****These changes will be included in the appropriate 3Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare PlusSM **1-800-299-1407**
BlueChoiceSM **1-866-781-3489**
SelectCommunity 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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

August 2014

Bluealert SM

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective Sept. 14, 2014

- Donor Lymphocyte Infusion for Hematologic Malignancies

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

Medical Policy Reminder: Please remember to utilize the following policy: <First-Trimester Detection of Down Syndrome Using Fetal Ultrasound Markers Combined with Maternal Serum Assessment>.

ADMINISTRATIVE

All Blue 2014 Provider Workshops…

Coming Soon to a City Near You!

The annual state-wide All Blue Workshops are designed to simplify your day-to-day interactions with us. At the workshops, provider staff can talk with BlueCross professionals who will share important information on current issues. While you are there, visit our Resource Centers and take advantage of one-on-one discussions with BlueCross representatives.

Watch for your invitation in the mail! For additional information including dates, times, locations and easy online registration, please visit our website at www.bcbst.com/providers/workshops.

Get Ready to Get Paid

Why perform ICD-10 testing now?

BlueCross is offering free online testing tools to assist providers in preparing for the ICD-10 coding change. The tools provide a way for you to use your clinical and coding knowledge and test it against the new coding regulations.

Test now to take advantage of the opportunity to identify possible areas of improvement. Testing now also provides time to ensure you are prepared, to mitigate issues and, of course, to get paid accurately after the transition date.

Go to our website for more information on the testing process and other ICD-10 resources to assist in your successful transition to ICD-10. <http://www.bcbst.com/providers/icd-10.page>.
For questions regarding ICD-10 or testing, email us at ICD10_GM@bcbst.com.

Enhanced phone features allow providers to check status of prior authorization requests

The fastest way to get a prior authorization request reviewed and approved is by submitting the request online at bcbst.com in the secure BlueAccess[SM] portal. Many requests submitted online are approved automatically – with no wait time.

Some providers prefer to call our automated phone system to gain authorization requests or check on the status of a request. Those providers may notice a few changes to the process. Being prepared with key details up front will help ensure you get the information you need quickly.

When using the automated phone system for prior authorizations, you will be asked to enter your provider ID number, a phone number, the member's ID number, and the member's date of birth. If you are calling about a new

prior authorization, you will also need to enter the facility ID number.

You can now check the status of a prior authorization through our automated system as well. Again, you will need to enter your provider ID number, a phone number, the member's ID number, the member's date of birth and the reference number for the original authorization request.

If necessary, you will be transferred to a representative who will assist you with the request.

Remember, entering this same information online through BlueAccess will provide you with a much faster response or approval from BlueCross. Get started today at www.bcbst.com/providers.

Reminder: Group NPI Requirements

In the May 2013 *BlueAlert*, BlueCross advised of upcoming changes to professional claims editing that would reject claims not following ANSI 5010 standard for group NPI submissions: "The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity."

BlueCross is currently targeting Sept. 1, 2014, to enable electronic editing that will *reject* any claims being filed with incorrect billing provider NPI information per this rule. If you have not already done so, please take this opportunity to engage with your vendors and clearinghouses on any necessary changes you may need to make to help ensure your claims will not be rejected so your revenue cycle will not be impacted. For questions on these changes, please contact eBusiness Technical Support†.

Tennessee Health Care Innovation Initiative

The State of Tennessee launched the Tennessee Health Care Innovation Initiative in May 2014. This initiative is meant to help transform the payment system from fee-for-service to value-based models of care. BlueCross BlueShield of Tennessee posted the first round of reports for asthma exacerbation, perinatal and total joint replacement (hip and knee) to principal accountable providers (or quarterbacks) in the BlueAccess secure portal on May 12, 2014.

New reports for asthma exacerbation, perinatal and total joint replacement (hip and knee) for dates of service calendar year 2013 will be available in BlueAccess during the first week of August, 2014. These reports are still within the six-month period where there will be no change in reimbursement. Lines of business included in these episodes are State of Tennessee, BlueCare, TennCare*Select*, Commercial, CoverKids and fully-insured.

If you have any questions related to these reports, please contact our Provider Service Line at 1-800-924-7141 and choose Option 4.

Quality Interactions® - A new round of valuable training courses for ALL lines of business

Due to overwhelmingly positive responses from our provider network, BlueCross BlueShield of Tennessee is offering an additional opportunity to experience Quality Interactions, a program designed to help health care providers treat an increasingly diverse patient population. Developed by the Manhattan Cross Cultural Group, Quality Interactions programs are available for physicians, nurses, and non-clinical staff.

Quality Interactions is based on the conceptual framework that personal accounts are the most effective source in obtaining information for true cultural perspectives. Rather than deploying pre-conceived assumptions about various cultural groups, Quality Interactions teaches a set of concepts and skills that assist in working successfully in cross-cultural situations.

Participants will improve their ability to:

- Respect and value cultural diversity
- Communicate clearly in cross-cultural interactions
- Understand and explore cultural differences
- Effectively engage an individual in a cross-cultural interaction

The training program uses a case-based format supported by evidence-based medicine and peer-reviewed literature. It is accredited for up to 2.5 hours of CME, CEU, or CCM credits.

There is **no cost** to BlueCross BlueShield of Tennessee and BlueCare Tennessee providers. A limited number of licenses are available for these courses, so please register quickly to take advantage of this valuable learning opportunity. The deadline is **Dec. 31, 2014**.

To register, please visit the Provider page of the company website, bcbst.com and click on the "Quality Interactions Cross Cultural Training" link which will provide instructions to register for the class. The BlueCross organizational code is **88750**.

The training course offers a great way to get valuable professional credits, at no cost, and to gain useful knowledge to work with the culturally diverse population of Tennessee.

Reminder: Commercial prior authorization requirements

As of June 30, 2014, **hyperbaric treatments** require prior authorization for commercial plans in an inpatient or outpatient setting. A listing of specific services that require prior authorization is available on our company website at <http://www.bcbst.com/providers/utilization-management-resources.page>.

Remember, you can submit authorization requests through BlueAccess. Please contact your eBusiness Marketing Consultant for all of your BlueAccess registration and training needs †.

Contact information to request prior authorization:

Behavioral Health
1-800-888-3773
Diagnostic Imaging/Radiology
1-888-693-3211
Durable Medical Equipment
1-866-558-0789
Medical & Surgical
1-800-924-7141
Musculoskeletal Management
1-800-388-8978

Reminder: Multi-page claims

When filing claims with multiple pages on a CMS-1500 claim form, please remember:

- List diagnosis code(s) for all conditions related to the patient's illness on **each** page.
- Place the total amount **only on the last page of the claim**. The total on the last page should reflect the sum of the line items for all pages.
- Use the words "Continued on the next page" or "Page X of X") in Block 28 on each page (except on the last page, which reflects the total charge in Block 28).
- Staple each page of the multi-page claim together. (This will help us identify multi-page claims.)
- Staple only the pages of the individual claim together as one. **Do not** staple several multi-page claims together as one.

This information can be found in the Billing and Reimbursement section of the provider administration manuals.

Tobacco cessation: What every clinician should know

Given the many deaths caused by smoking, clinicians should offer evidence-based treatment to every patient who uses tobacco which includes asking patients about tobacco use at every visit and offering a combination of counseling and medication to support patients in quitting. An estimated 85 to 90 percent of Chronic Obstructive Pulmonary Disease (COPD) deaths are caused by smoking.

The Centers for Medicare & Medicaid Services guidelines for meaningful use of electronic health records (EHR) systems now require documentation of every patient's tobacco use status, as well as evidence that patients who smoke are being offered counseling and/or medication.

Because clinic and physician reimbursement are tied to compliance with these guidelines, larger numbers of patients should be offered cessation counseling. Practitioners can encourage cessation efforts by implementing a three-minute, evidenced-based assessment:

- Ask patients about their tobacco use at every visit;
- discuss the benefits of quitting and encourage the use of nicotine replacement therapy when appropriate; and
- connect them to follow-up care, which can be easily done by faxing a referral to the Tennessee Tobacco QuitLine, 1-800-646-1103.

Physicians may receive reimbursement for tobacco counseling lasting three to10 minutes and additional reimbursement for counseling lasting longer than 10 minutes (see codes 99406, 99407, G0436, G0437). Smoking cessation is the most effective way of preventing or slowing the progression of COPD and other tobacco-associated diseases. Tobacco cessation saves lives and increases quality of life.

Resource: Carrie Harrill-Smith, Carol Ripley-Moffitt, Adam O. Goldstein, N C Med J. 2013; 74(5):401-405.

BlueCare Tennessee

ADMINISTRATIVE

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

TENNderCare Medical Record Documentation Requirements- COMPREHENSIVE PHYSICALS

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

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

Please refer to Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual at <http://www.tnaap.org/EPSDT/EPSDTmanual.htm> for the required components of the TENNderCare exam as well as required medical record documentation criteria.

Reminder: Billing Vaccines for Children codes with modifier 32

Modifier 32 should only be used when notification is received from the Centers for Disease Control and Prevention (CDC), Vaccines for Children (VFC), or the Bureau of TennCare stating that there is a shortage of the vaccine. Providers who normally receive influenza vaccine through the VFC program may use their purchased supply when this happens and submit claims using a Modifier 32 to receive fee for service reimbursement. If your VFC supply becomes low, and no official shortage has been communicated, be sure to order sooner to restock instead of using your private stock.

Prior authorization update for allergy testing

As of Sept. 1, 2014, the following allergy testing codes will no longer require prior authorization for BlueCare Tennessee members:

- 95017
- 95018
- 95076
- 95079

BlueCard
ADMINISTRATIVE

Quick tips for a smooth out-of-area claims experience

At BlueCross BlueShield of Tennessee we strive to process claims quickly and accurately. Did you know that you can make a difference in how quickly claims are processed?

Following these helpful tips will improve your claims payment experience:

- **Include the member's complete identification number** when you submit the claim. This includes the three-character alpha prefix.
- **Ask members for their *current* member ID card** and regularly obtain new photocopies of it (front and back). While new identification numbers can be issued at any time during the year, January and July are especially heavy months for this activity. Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- **Check eligibility and benefits** electronically at www.bcbst.com or by calling 1-800-676-BLUE(2583). Be sure to provide the member's alpha prefix.
- **Verify the member's cost sharing amount** before collecting payment. Please do not collect full payment up front.
- **Indicate on the claim any payment you collected from the member.** In cases where there is more than one payer and a Blue Cross and/or Blue Shield Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim.
- **Do not send duplicate claims.** Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- **Check claim status** by submitting an electronic HIPAA 276 transaction (claim status request) to BlueCross BlueShield of Tennessee or by contacting us at 1-800-705-0391.
- If you have any questions about claims filing for Blue members, refer to *BlueCross BlueShield of Tennessee Provider Administration Manual* or:
  - Talk to your Provider Relations Consultant
  - Visit us online at: <http://www.bcbst.com/providers/bluecard/>
  - Contact us at 1-800-705-0391†

Medicare Advantage
ADMINISTRATIVE

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

Reminder: Beginning Sept. 1, 2014, BlueAdvantage (PPO) and BlueChoice (HMO) programs will introduce several care management programs for members in acute inpatient care settings.

Reminder: Medicare Advantage Readmission Reduction Program

In conjunction with the Centers for Medicare & Medicaid Services' (CMS) Hospital Readmissions Reduction Program, beginning **Sept. 1, 2014**, BlueCross Medicare Advantage Plans will reimburse for readmissions to acute care hospitals that occur within 31 days from the index admission discharge as follows:

- A same or similar diagnosis readmission occurring within three (3) to 31 days from a complication of the original hospital stay or admission resulting from a modifiable cause relating to the acute care facility's discharge diagnosis to the same or similar facility, or facility operating under the same contract, is not eligible for two DRG inpatient payments. The

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

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

BlueCross readmission guidelines have been developed to be less stringent than the Readmission Reduction Program guidelines for original Medicare by not penalizing a facility for all diagnoses that could lead to a readmission or adjusting all Medicare payments, but rather applies the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the individual member that is readmitted. The goal of this program is to engage providers and facilities in addressing transition of care options. CMS considers 31 day readmissions to be an indicator of quality of care.

Note:

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

Reminder: Medicare Advantage Inpatient Level of Care Management Program

Starting **Sept. 1, 2014**, and consistent with the criteria in MCG (formerly Milliman Care Guidelines®), BlueCross BlueShield of Tennessee will reimburse for higher acuity level of care beds (critical care level of care) during acute inpatient hospitalizations as follows: MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with a higher acuity level of care bed and nursing care. This review is performed by a Plan Medical Director.

- If criteria are not met, then the day may be approved as Medically Necessary, but the intensity of care will be reimbursed at an acute level of care rather than critical care level of care.

- This review can occur during any portion of the hospitalization, including during the initial Diagnosis Related Group (DRG) period.

Note:

1. The Member cannot be held liable for payment of services received when not approved.
2. Standard facility appeal remedies are applicable.

Reminder: Inpatient DRG Day Outlier Management Program

Beginning **Sept. 1, 2014**, and consistent with the criteria in MCG, BlueCross BlueShield of Tennessee will reimburse acute inpatient hospitalization days outside of the initial DRG day approval as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur during the time period after which the DRG days have elapsed, and are subject to the facility providing concurrent clinical information for review as contractually required.

- If clinical information is requested three (3) times using at least two (2) different notification methods, then the days will be denied for a lack of clinical information necessary to establish ongoing Medical Necessity. In situations where no clinical information has been provided for the days in question, these denied days will not be eligible for reconsideration review or peer to peer discussion and the facility can follow standard facility appeal remedies.

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

Reminder: Revenue Code 510 Hospital-Based clinic services *

Effective **Oct. 1, 2014**, and consistent with reimbursement guidelines of other payers as well as current BlueCross

BlueShield of Tennessee Commercial and BlueCare Tennessee contracts, Medicare Advantage will no longer reimburse for charges under revenue code 510 (hospital-based clinic setting as defined in 42 CFR 410.2) when provided in conjunction with an E&M professional service charge.

BlueCare Tennessee launches quality program to improve physical health of members with behavioral needs

Individuals with mental health and substance abuse problems often have poorer physical health status and outcomes as well. In studying data of our own members, BlueCare Tennessee found that those with behavioral problems also had significantly more gaps in care especially in the areas of breast and cervical cancer screening and comprehensive diabetes care.

In collaboration with its Community Mental Health Center and other behavioral health provider partners, BlueCare Tennessee has implemented a statewide program to fill those gaps in medical care. BlueCare Tennessee will furnish behavioral providers with information about needed screenings and services for members who are also receiving Community Case Management services. Case managers will then use this information to encourage members to get the services they need, and when needed, will assist them in making and keeping appointments. Providers will receive an incentive payment for every gap in care that is closed with the appropriate screening or service.

During a pilot program in 2013, this approach- which builds on strong relationships between members and their case managers - produced impressive outcomes. In a number of cases, practitioners confirmed that as a result of screenings, serious medical conditions were identified in time to successfully initiate treatment.

BlueCare Tennessee partners with Million Hearts® in preventive campaign

BlueCare Tennessee has partnered with Million Hearts®, a national initiative that was launched by the Department of Health and Human Services to prevent one million heart attacks and strokes by 2017. As part of its commitment to help Million Hearts® reach its goal, BlueCare Tennessee will:

(1) Adopt and report on the Million Hearts® Clinical Quality Measures: Controlling High Blood Pressure and Low Density Lipoprotein Cholesterol Control to help measure and report progress on heart disease and stroke prevention.

(2) Help find those at risk of heart attacks and stroke by implementing a member outreach campaign places preventive reminder calls to members identified with gaps in care. A postcard reminder will be mailed to members who are not reached telephonically.

(3) Implement a campaign to promote smoking cessation to BlueCare Tennessee adult members who smoke or use smokeless tobacco products. Members will receive messages on targeted topics including available options to quit smoking and improve member health outcomes. BlueCare Tennessee will identify members who have stopped taking smoking cessation agents and these members will be contacted and encouraged to resume treatment and/or discuss other smoking cessation options.

As a health care provider, you play a key role in helping patients reduce their risk for heart disease and stroke and lead longer, healthier lives.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*****These changes will be included in the appropriate 3Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

---

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CHOICES	**1-888-747-8955**
BlueCare PlusSM	**1-800-299-1407**
BlueChoiceSM	**1-866-781-3489**
SelectCommunity	**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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

PROVIDER NEWS FLASH

of Tennessee

September 2014

Bluealert SM

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective Oct. 11, 2014

- Ultrafiltration for Decompensated Heart Failure

Effective Nov. 19, 2014

- Certolizumab Pegol

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

ADMINISTRATIVE

Reminder: Electronic Claims Submission

BlueCross BlueShield of Tennessee continues its efforts to encourage greater use of electronic processing tools, including greater adoption of electronic claims submissions. Submitting claims electronically produces faster payments, more efficient claims processing, guaranteed record of receipt of claims and more efficient claims tracking. Conversion to electronic claims includes initial claims submissions, secondary claims and corrected bills.

BlueCross is currently working with the provider community to understand why paper claims are being submitted today and determine what we can do to help achieve a fully electronic claims environment. New tools have been developed to address gaps in some existing processes that can lead to paper claim submission.

Please contact eBusiness Support at (423) 535-5717, option 2, to discuss how your organization can continue moving from paper to electronic claims submission. More information is available on the company website at <http://www.bcbst.com/providers/ecomm/> or you can contact us via email at eBusiness_Service@bcbst.com.

Department of Health and Human Services finalizes ICD-10 compliance date

On July 31, 2014, the Department of Health and Human Services (HHS) supplied the final ruling and the Centers for Medicare & Medicaid Services (CMS) announced the ICD-10 effective date as **Oct. 1, 2015**. This ruling applies to all entities covered under the Health Insurance Portability and Accountability Act (HIPAA).

One of the reasons cited in extending the ICD-10 compliance date was to allow time for provider preparedness. Several stakeholders argue a delay was necessary in order to give practices more time to prepare for financial and administrative requirements.[1] With the revised implementation dated issued, time to prepare is now.

BlueCross BlueShield of Tennessee provides resources to assist providers in their process towards ICD-10 compliance. Provider testing tools are available on the Provider page of our website, at <http://www.bcbst.com/providers/icd-10.page> along with links to implementation guides and training resources from professional organizations.

Contact ICD10_GM@bcbst.com for additional testing information.

1 <http://www.ama-assn.org/ama/pub/news/news/2014/2014-02-12-icd10-cost-estimates-increased-for-most-physicians.page>

BlueHealth Solutions offers wellness programs for our members

Members who have coverage through BlueCross BlueShield of Tennessee Commercial plans have access to a variety of wellness-related programs and services through BlueHealth Solutions, our comprehensive wellness program.

While some of the programs we offer vary by plan, many of our wellness

benefits are available for all our members. Those include:

- Our Wellness Portal, available through BlueAccess℠, houses self-directed health courses, health logs, trackers and more.
- BluePerks℠ provides discounts on health and wellness-related goods and services – including eyeglasses and prescriptions.

Encourage your patients who have coverage through BlueCross BlueShield of Tennessee to improve their health by engaging with a wellness program.

Reminder: Earn CEUs at absolutely NO COST!

Address Health Care Disparities through FREE Quality Interactions® online training courses

Quality Interactions, a training program designed to help health care providers treat an increasingly diverse patient population, is currently available for physicians, nurses, and non-clinical staff.

Quality Interactions teaches a set of concepts and skills that assist in working successfully in cross-cultural situations. The training program uses a case-based format supported by evidence-based medicine and peer-reviewed literature and is accredited for up to 2.5 hours of CME, CEU, or CCM credits.

There is **no cost** to BlueCross or BlueCare Tennessee network providers, however a limited number of licenses are available for these courses, so please be sure to register quickly to take advantage of this valuable learning opportunity. The deadline for registration is Dec. 31, 2014.

Registration information is available on the Provider page on the company website, bcbst.com. Enter the BlueCross organizational code, 88750.

Reminder: ANSI claim filing guidelines

To better protect patient data and adhere to ANSI claim filing guidelines, BlueCross will begin **rejecting** claims submitted with the member ID number as a Social Security Number (SSN). The member ID is located within loop 2010BA in the NM1 segment.

This change will affect ANSI 837 Professional, Institutional, and Dental transactions submitted on or after **Oct. 1, 2014**. When filing claims to BlueCross, be sure to use the identification number found on the member ID card. For questions about this change, please contact eBusiness Technical Support†.

Reminder: Filing appropriate "place of service" on durable medical equipment claims

Providers are reminded to report the appropriate place of service (POS) code on claims when distributing durable medical equipment (DME), prosthetics/orthotics and/or supplies. The POS should identify where the equipment or supplies will be used, not where they are dispensed. Refer to the DME Billing and Reimbursement Guidelines found in the provider administration manuals located on the company websites, www.bcbst.com and http://bluecare.bcbst.com/.

Reminder: Group NPI Requirements

Effective Sept. 1, 2014, BCBST began rejecting any claim filed with incorrect billing provider NPI information per the following 5010 guideline: "The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity."

Reminder: New CMS requirement for non-covered services/supplies

In accordance with notification from the Centers for Medicare & Medicaid Services (CMS), the Advanced Beneficiary Notice (ABN) used in the original Medicare program is **not** applicable to Medicare Advantage programs, including BlueCare Plus℠ (our plan for special needs members with dual coverage of Medicare and Medicaid.) Therefore, when informing a BlueAdvantage or BlueCarePlus member that a service is not covered or is excluded from their health benefit plan, the decision is considered an organization determination under 42 CFR, 422.566(b) and requires the appropriate CMS notice of denial of coverage (CMS-10003). A "waiver" is no longer sufficient documentation of this notification. BlueAdvantage BlueChoice℠ and BlueCare Plus℠ network providers should request a pre-determination from BlueAdvantage on the member's behalf before any non-covered service/supply is provided.

For additional information and to download the Denial of Coverage Notice, see the CMS website at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html>.

BlueCare Tennessee

ADMINISTRATIVE

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

Are you seeing your assigned members?

We all know how important it is for Primary Care Providers (PCP) to help coordinate our members' health care needs. As a BlueCare/TennCare*Select* PCP, it is your responsibility to verify our members are on your patient listing as assigned to you *or* to another

participating PCP in your group. Check the member ID card or check the patient listings on BlueAccess to confirm assignment. Look for future articles in *BlueAlert* concerning upcoming changes for PCPs in 2015.

Best Practice for primary care providers - Antidepressant medication management

Major depression often occurs with physical conditions such as heart disease, diabetes and high blood pressure. Patient visits to their Primary Care Provider (PCP) offer an opportunity to discuss symptoms of an undiagnosed mental illness. PCPs are now using screening tools as a way to diagnose depression and other mental-health conditions during routine visits.

The "Whooley Depression Screen," a simple two-question tool, is an easy and reliable way to identify a depressed patient within the primary care arena. The *Major Depression Medication Adherence Tool Kit*, which includes this screening tool, is available on our company website at <www.bcbst.com/providers/behavioral_health/Major_Depression_Medication_Adherence_Tool_Kit.pdf>

If you feel your patient may benefit from behavioral health services, you may call the BlueCare Tennessee PCP Referral Line, 1-800-367-3403, Monday through Friday, 8 a.m. to 5 p.m. (ET).

Additionally, telephone consultation services are provided by Board Certified Psychiatrists and are available to discuss all aspects of mental health and substance abuse treatment, including medications.

Call 1-877-241-5575, Monday through Friday, 9 a.m. to 5 p.m. (ET). Identify yourself as a TennCare PCP seeking psychiatric consultation services.

Reminder: Breast Pump Program

Breast pumps are covered for BlueCare Tennessee members choosing to breastfeed their baby. This includes both manual and electric pumps. No prior authorization is required. To facilitate a BlueCare Tennessee mother in obtaining a breast pump, please refer them to any in-network Durable Medical Equipment (DME) provider. Refer to our website at http://bluecare.bcbst.com or contact Member Service at 1-800-468-9736 for assistance in locating an in-network provider for breast pumps.

TENNderCare medical record documentation for lab tests

In accordance with the most current *American Academy of Pediatrics Recommendations for Pediatric Health Care*, evidence that appropriate lab tests are addressed according to age specific guidelines should be present in a member's medical record as part of the TENNderCare check-up. Listed below are some of the tests that may be required:

- Newborn metabolic screening
- Hematocrit or Hemoglobin
- Lead testing
- Cholesterol test
- Tuberculin test
- Sexually transmitted disease testing

If there are medical reasons to support not performing specifics lab tests, be sure to document the information in the medical record. Please refer to *Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual* at <http://www.tnaap.org/EPSDT/EPSDTmanual.htm> for detailed medical record documentation criteria.

Medicare Advantage

ADMINISTRATIVE

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

Reminder: New Care Management Programs for Medicare Advantage plans

As of Sept. 1, 2014, BlueAdvantage (PPO)℠ and BlueChoice (HMO)℠ plans have initiated several care management programs for members in acute inpatient care settings. See the July and August issues of BlueAlert for details of each of the following programs.

Readmission Reduction Program

In conjunction with the Centers for Medicare & Medicaid Services' (CMS) Hospital Readmissions Reduction Program, BlueCross BlueShield of Tennessee has updated guidelines for readmissions to acute care hospitals occurring within 31 days from the index admission discharge.

Inpatient Level of Care Management Program

Consistent with the criteria in MCG (formerly Milliman Care Guidelines®), BlueCross will reimburse for higher acuity level of care beds (critical care level of care) during acute inpatient hospitalizations.

MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with a higher acuity level of care bed and nursing care.

Inpatient DRG Day Outlier Management Program

In accordance with the criteria in MCG, BlueCross will reimburse acute inpatient hospitalization days outside of the initial DRG day.

Reminder: Revenue Code 510 Hospital-Based clinic services *

Effective **Oct. 1, 2014**, and consistent with reimbursement guidelines of other payers as well as current BlueCross BlueShield of Tennessee Commercial and BlueCare Tennessee contracts, Medicare Advantage will no longer reimburse for charges under revenue code 510 (hospital-based clinic setting as defined in 42 CFR 410.2) when provided in conjunction with an E&M professional service charge.

QUALITYCARE REWARDS

Read important emails about the Medicare Advantage Quality Incentive Program

BlueCross BlueShield of Tennessee is e-mailing providers enrolled in the Medicare Advantage Provider Quality Incentive Program. Look for the address "BlueCross BlueShield of Tennessee <esend.bcbst.com>," as these e-mails contain important program information and the rewards available to you as a participant, by closing gaps in your patients' plan of care. If your e-mail is current for your BlueAccess ID, check your junk e-mail file. Be sure to open and read the e-mails to learn more about the program and enhancements to the Pay for Performance web tool.

Don't miss the opportunity to improve your Stars Rating and earn rewards! If you have not received these e-mails and are interested in taking full advantage of being a program participant, please send your local eBusiness Marketer your updated e-mail address. Past e-mails can be found on the Quality Bonus Program Resources page.

Debbie Angner - West TN
P: (901) 544-2285
E-mail: Debbie_Angner@bcbst.com

Faye Mangold - Middle TN
P: (423) 535-2750
E-mail: Faye_Mangold@bcbst.com

Faith Daniel - East TN
P: (423) 535-6796
E-mail: Faith_Daniel@bcbst.com

eBusiness Technical Support† is also available for questions.

10 new enhancements added to the Provider Quality Incentive Program web tool

A number of new resources and easy-to-use functions are available on the Medicare Advantage Quality Care Rewards website. Details of these updates were presented in an e-mail blast sent on Aug. 5, 2014.

Information to help you with closing care gaps is also available on our Quality Care Rewards website. Some significant new additions are the "Best Practices" documents, which contain important information, including:

- Definitions of each measure
- How to close care gaps associated with each measure
- Coding guides
- Common barriers
- Best practices

Best Practices documents are available for measures such as Adult BMI, Colorectal Cancer Screening, Diabetes LDL Screening, and more. Additional preventive health resources are also available to your patients, helping them take an active role in closing their own gaps.

For questions about the Provider Quality Incentive Program, consult the Quality Care Rewards page, which links to resources for the Attribution process, Patient Assessment Form, My HealthPath, and many other program resources.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

***These changes will be included in the appropriate 3Q or 4Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141
(includes CoverTN; CoverKids)
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-888-747-8955
BlueCare Plus℠ 1-800-299-1407
BlueChoice℠ 1-866-781-3489
SelectCommunity 1-800-292-8196
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 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

October 2014

BlueAlert SM

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective Nov. 8, 2014

- Multi-biomarker Testing for Rheumatoid Arthritis

Effective Nov. 19, 2014

- Ado-Trastuzumab
- Genetic Testing, including Chromosomal Microarray Analysis and Next-Generation Sequencing Panels, for Prenatal Evaluation and Evaluation of Children with Developmental Delays/Intellectual Delays or Autism Spectrum Disorder
- Proton or Helium Ion Beam (Charged Particle) Radiation Therapy

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

Changes to commercial drug formulary

The following changes will be made to the Commercial Drug Formulary as of Oct. 1, 2014.

- **Roche Accu-Chek[TM] diabetic testing products will no longer be preferred for most of our plans.** We will continue to have Bayer's Contour® and Breeze® products as preferred and are adding the Lifescan One Touch® products. Letters are being sent to all Accu-Chek users who may be affected by this formulary change. Coupons for free testing meters and diabetic strips will be offered. Members are being directed to speak to their physicians and pharmacists about this change.

  After Oct. 1, 2014, members will not be able to get an Accu-Chek product without first trying – and not succeeding on – one of the preferred products. If you have clinical rationale supporting continued use of an Accu-Chek product by a BlueCross member, you may submit an appeal by faxing a letter to 1-888-343-4232.

- **Monodox will no longer be on BlueCross' drug formulary.** The generic immediate-release doxycycline will continue to be available for BlueCross members, saving them substantial out-of-pocket expenses.

  If a BlueCross member in your care still needs doxycycline, you can notify his or her pharmacy to switch to the **generic product. The member may want** to continue to obtain Monodox, however after Oct. 1, this drug will no longer be covered by the member's pharmacy benefit plan. BlueCross members currently taking Monodox will receive a letter notifying them of this change.

If you have questions about this formulary policy change, please call our Provider Service line†.

Clinical Practice Guidelines Adopted August 2014

BlueCross BlueShield of Tennessee has adopted the following guidelines as practice resources:

2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines
<http://circ.ahajournals.org/content/127/4/e362.full>

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society
<http://www.annals.org/content/147/7/478>

Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack. A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association (2014)
<https://stroke.ahajournals.org/content/early/2014/04/30/STR.0000000000000024.full.pdf+html>

Guide to Clinical Preventive Services
<http://www.uspreventiveservicestaskforce.org/recommendations.htm>

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents — Third Edition (2008)
<http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html>

Periodic table
<http://brightfutures.aap.org/pdfs/Guidelines_PDF/20-Appendices_PeriodicitySchedule.pdf>

2012 ACCF/AHA Focused Update of the Guideline for the Management of Patients With Unstable Angina/Non - ST-Elevation Myocardial Infarction (Updating the 2007 Guideline and Replacing the 2011 Focused Update): A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines
<http://circ.ahajournals.org/content/126/7/875.full.pdf+html>

Seventh Report of the Joint National Committee (JNC) on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
<http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf>
Use in correlation with: JNC 7 Express
<http://www.nhlbi.nih.gov/health-pro/guidelines/current/hypertension-jnc-7/express-report.htm>

2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines
<http://circ.ahajournals.org/content/early/2013/06/03/CIR.0b013e31829e8776.full.pdf>

Hyperlinks to these guidelines are also available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company website at <http://www.bcbst.com/providers/hcpr/>.

Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

New drugs added to commercial specialty pharmacy listing

Beginning Oct. 1, 2014, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
- Beleodaq (PA)
- Ruconest (PA)

Self-administered via pharmacy benefit:
- Cerdelga(PA)
- Plegridy
- Triumeq
- Zydelig (PA)

Providers can obtain PA for:
- **Provider-administered drugs** that have a valid HCPCS code by logging onto BlueAccess℠, the secure area of www.bcbst.com, selecting Service Center from the main menu, followed by Authorization/Advance Determination Submission. If you are not registered with BlueAccess or need assistance, call eBusiness Technical Support†.
- **Provider-administered specialty drugs** that do not have a valid HCPCS code by calling 1-800-924-7141.
- **Self-administered specialty drugs** by calling Express Scripts at 1-877-916-2271.

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

Health care for adults with intellectual and developmental disabilities

The Intellectual/Developmental Disabilities (IDD) Toolkit is available on the Vanderbilt Kennedy Center website at www.iddtoolkit.org and provides information for the primary care of adults with intellectual and developmental disabilities.

The Toolkit offers health care providers best-practice tools and information regarding specific medical, mental and behavioral health concerns of adults with intellectual and developmental disabilities, including resources for patients and families. The toolkit is also accessible on smart phones and tablets.

Toolkit Contents
- General Issues
  - Communicating Effectively
  - Informed Consent
  - Informed Consent Checklist
  - Office Organizational Tips
  - Today's Visit Forms
- Physical Health Issues
  - Cumulative Patient Profile
  - Female Preventive Care Checklist
  - Male Preventive Care Checklist

- Checklists-Disability Specific (Autism, Down syndrome, Prader-Willi, Fragile X, 22q11.2 deletion syndrome)
- Behavioral and Mental Health Issues
- Resources

If you have questions or suggestions for the Toolkit, please contact Janet Shouse, IDD Toolkit program coordinator, at janet.shouse@vanderbilt.edu or at (615) 875-8833.

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming modifications to select Utilization Management Guidelines. The *Modified Utilization Management Guidelines* can be viewed on the Utilization Management Web page at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm>.

Effective November 19, 2014

The following as relates to inpatient and surgical care:

- *Ambulatory Surgery Complications: Observation Care*
- *Bone Excision*
- *Prostatectomy, Radical*

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

FDA changes dispensing regulations for hydrocodone products

Effective **Oct. 6, 2014**, medications containing hydrocodone (e.g., Lortab, Vicodin, Vicoprofen, et al.) are moving from Schedule III to the more restrictive Schedule II of the Controlled Substances Act.

What this means for patients who use hydrocodone combination products:

- Per Tennessee state law, prescribers may write a prescription for a maximum of a 30-day supply for these medications.
- Refills are not allowed for these medications.
- Prescribers cannot call in or fax prescriptions for these medications. Patients are required to obtain a new paper prescription each time these medications are needed.

ADMINISTRATIVE

Importance of clinical documentation with ICD-10

BlueCross BlueShield of Tennessee is updating its processes and systems to accept provider claims containing the new code sets in preparation for the ICD-10 compliance date, Oct. 1, 2015.

Supporting clinical documentation will be an important foundation to substantiate the ICD-10 code as well as, facilitate communication for proper patient treatment, support medical necessity, reduce claim denials and minimize external audits.

Visit the company website at www.bcbst.com/providers/icd-10.page, for more information about preparing for ICD-10. For more information on clinical documentation guidelines visit AHIMA. Email us at ICD10_GM@bcbst.com if you have further questions about ICD-10.

2014-2015 Reimbursement for influenza vaccine

The timing of flu is very unpredictable and can vary from season to season. Flu activity most commonly peaks in the U.S. in January or February. However, seasonal flu activity can begin as early as October and continue to occur as late as May. Please encourage your patients to get their flu shot and address any fears or misconceptions that they may have in regards to this vaccine. Most, but not all health care plans, cover flu immunizations with no member cost share. Some grandfathered plans may not cover flu immunizations, or may cover them subject to member cost share. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

Each year the formulation of the "seasonal flu vaccine" is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC). This vaccine contains different "strains" of flu expected to be active for that year. The following influenza immunization guidelines apply for BlueCross BlueShield of Tennessee.

Commercial

- ***Vaccine and administration***
  The influenza vaccine, including intradermal and nasal administered, are covered if offered under the member's health care plan.

BlueCare or TennCare*Select*

- ***Vaccine and administration***
  Covered.
- ***Nasal administered vaccine***
  (recommended for healthy individuals ages 2-49)
  Covered.

  Note: The nasal administered vaccine is available under the Vaccines for Children (VFC)

Program for children ages 2 through 18 years.

- ***Intradermal administered vaccine*** (recommended for persons 18 through 64 years of age)

Note: The intradermal administered vaccine is not available under VFC.

Tobacco cessation for commercial members

Your patients who have coverage through BlueCross BlueShield of Tennessee Commercial plans have access to smoking cessation resources through BlueHealth Solutions℠. Resources to help members leave their unhealthy smoking habit behind include:

- **Lifestyle health coaching** – Support through a one-on-one relationship with a qualified health coach
- **Nicotine replacement therapy** – Free nicotine replacement for four weeks
- **Individualized action plan** – A personalized plan for each member

Encourage your BlueCross Commercial members who use tobacco products to check their plan materials or call Member Service to see if they're eligible for help kicking the habit.

CAQH streamlines the credentialing process *

BlueCross BlueShield of Tennessee has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners Universal Provider Datasource (UPD), a universal credentialing application tool. With a single, uniform online application, practitioners can enter their information free of charge to access, manage and revise that information at their convenience.

Beginning Jan. 1, 2015, BlueCross will require new credentialing applications from licensed health care professionals to be submitted through CAQH. The UPD Quick Reference Guide, available on the CAQH website, <http://www.caqh.org/pdf/UPDbrochure.pdf>, provides step-by-step instructions for online registration and how to get started using UPD.

Note:

- Credentialing for participation in all BlueCross networks, except CHOICES, is available through the CAQH credentialing tool.
- Facilities are not eligible for credentialing through CAQH at this time.

New prior authorization requirements tool

Look for a new "Prior Authorization Search by Code" tool on the BlueAccess Service Center in fourth quarter, 2014. The tool will be available on the Patient Information page and will allow you to enter a procedure code and diagnosis code for a specific patient and quickly check if prior authorization is required.

For assistance using BlueAccess, please contact eBusiness Technical Support†.

Reminder: Electronic claims submission

BlueCross BlueShield of Tennessee continues its efforts to encourage greater use of electronic processing tools, including greater adoption of electronic claims submissions. Submitting claims electronically produces faster payments, more efficient claims processing, guaranteed record of receipt of claims and more efficient claims tracking. Conversion to electronic claims includes initial claims submissions, secondary claims and corrected bills.

BlueCross is currently working with the provider community to understand why paper claims are being submitted today

and determine what we can do to help achieve a fully electronic claims environment. New tools have been developed to address gaps in some existing processes that can lead to paper claim submission.

Please contact eBusiness Technical Support† to discuss how your organization can continue moving from paper to electronic claims submission. More information is available on the company website at <http://www.bcbst.com/providers/ecomm/> or you can contact us via email at eBusiness_Service@bcbst.com.

Reminder: Earn CEUs at absolutely NO COST!

Address Health Care Disparities through FREE Quality Interactions® online training courses

Quality Interactions, a training program designed to help health care providers treat an increasingly diverse patient population, is currently available for physicians, nurses, and non-clinical staff.

Quality Interactions teaches a set of concepts and skills that assist in working successfully in cross-cultural situations. The training program uses a case-based format supported by evidence-based medicine and peer-reviewed literature and is accredited for up to 2.5 hours of CME, CEU, or CCM credits.

There is **no cost** to BlueCross or BlueCare Tennessee network providers, however a limited number of licenses are available for these courses, so please be sure to register quickly to take advantage of this valuable learning opportunity. The deadline for registration is Dec. 31, 2014. Registration information is available on the Provider page on the company website, bcbst.com. Enter the BlueCross organizational code, 88750.

BlueCare Tennessee

CLINICAL

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

Reminder: Complete the TENNderCare Checkup when Performing Sports Physicals

With the beginning of the school year and many children playing sports, it is a good opportunity to provide the TENNderCare checkup while conducting the sports physical.

To be considered a TENNderCare checkup, the following should be completed at the visit:

- Health history
- Complete physical exam
- Lab tests as needed
- Shots as needed
- Vision/hearing screening
- Developmental/behavioral screening as appropriate
- Advice on how to keep healthy

For more information about TENNderCare checkups and billing, please refer to http://www.tnaap.org/.

ADMINISTRATIVE

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

Are you seeing your assigned members?

We all know how important it is for Primary Care Providers (PCPs) to help coordinate our members' health care needs. As a BlueCare/ TennCare*Select* PCP, it's your responsibility to verify any member you see is assigned to your patient listing for you or another participating PCP in your group.

Check the member ID card or the patient listings on BlueAccess to confirm assignment. Look for future articles in your BlueAlert newsletter concerning upcoming changes for PCPs in 2015.

Reminder: TennCare member appeal poster must be displayed

The Bureau of TennCare requires the Member Appeal Poster be displayed in a visible location within all provider offices in the event the member has a grievance with the managed care organization or the provider. The poster is available on the company websites, <http://www.bcbst.com/providers/forms/Member_Appeal_Poster.pdf> and <http://bluecare.bcbst.com/forms/Provider%20Information/Member_Appeal_Poster.pdf>.

Please be sure to display this poster in your office for BlueCare and TennCare*Select* members.

Behavioral health update *

Beginning Jan. 1, 2015, BlueCare Tennessee will assume responsibility for behavioral health contracting for the BlueCare, TennCare*Select*/ CoverKids, and BlueCare Plus (HMO SNP) SM networks. Credentialing for BlueCross BlueShield of Tennessee will be handled by utilizing CAQH, Universal Provider Datasource.

Please keep in mind these important dates for **facility contracts**:

- Oct. 1, 2014 – Deadline for returning signed contract with fee schedule
- Jan. 1, 2015 – Earliest network effective dates

Please keep in mind these important dates for **professional contracts**:

- Oct. 1, 2014 – Deadline for returning signed contract/OWDC form
- Jan. 1, 2015 – Earliest network effective date

New guidelines, MCG (formerly, Milliman Care Guidelines) will go into effect Jan. 1, 2015.

- Save the date of Nov. 12, 2014 for a webinar presentation that will highlight the new guidelines as well as introduce our web authorization tool that will be available on BlueAccess beginning Jan. 1, 2015. Email invitations will be sent for this event.

Please contact your local Behavioral Health Provider Network Manager with any questions.

Welcome back middle Tennessee providers

Effective Jan. 1, 2015, BlueCare Tennessee is excited to again be serving TennCareSM members in the Middle Grand Region. We want to make sure you are aware of our programs, services and guidelines, and to help ensure there is no service disruption for your patients who are BlueCare Tennessee members.

Things to do:
The Tennessee Medical Association (TMA)Workshop will be held on Oct. 28, 2014, at the Nashville Marriott Airport where you will be able to speak with BlueCare Tennessee representatives. To attend, please register online with TMA at <http://www.tnmed.org/professional-development/insurance-workshops/>.

Check out the provider section of our BlueCare Tennessee website which has a lot of information to help familiarize you with regulations, guidelines, newsletters, and Electronic Data Interchange. This page also includes the *BlueCare Tennessee Provider*

Administration Manual. Refer to the Newsletters, Announcements section of the website for important information, including the BlueCare Middle Region provider letter mailed to you on Aug. 7, 2014.

If you would like to contract with BlueCare Tennessee or are already contracted but need to add an additional location or make changes to your current location, please call 1-800-924-7141 and choose Option 2 or say "Network Contracts or Credentialing" when prompted. Representatives will assist you with all your contracting requests and location changes.

We look forward to working with you to provide quality health care to our members.

TENNderCare medical record documentation – vision testing

In accordance with the most current American Academy of Pediatrics Recommendations for Pediatric Health Care, evidence that appropriate vision testing is addressed according to age-specific guidelines should be present in a member's medical record as part of the TENNderCare check-up.

Vision acuity should be documented at each visit beginning at age 3 (if child is cooperative) and subsequently at ages 4, 5, 6, 8, 10, 12, 15, and 18 years of age (or at the *in-between* year, up to age 20, if not done at the specified year). Medical record documentation should include all screenings and results. Note: If the child is uncooperative during the objective testing, subjective testing would be appropriate to be included in the record for documentation. Please refer to the *Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual* at <http://www.tnaap.org/EPSDT/EPSDTmanual.htm> for detailed medical record documentation criteria.

Federal PCP Rate Bump ending in December

Beginning Jan. 1, 2013 through Dec. 31, 2014, qualified primary care physicians (PCPs), as detailed by CMS regulation, have been receiving a rate change for eligible CPT® Codes. This rate change is also referred to as the "PCP Bump" and the "PCP Rate Enhancement Payment." The PCP Rate Bump is scheduled to end as of Dec. 31, 2014.

Look for future BlueAlert articles or visit our website at http://bluecare.bcbst.com/ for more information.

Tennessee health care innovation initiative

BlueCross BlueShield of Tennessee participates in the effort launched in May by the State of Tennessee for retrospective episode-based payment strategy that will reward providers for high-quality and efficient care for acute medical conditions in three episodes:

- Total joint replacement (hip and knee);
- Acute asthma exacerbation; and
- Perinatal.

Episode reports are available on BlueAccess, our secure web portal on www.bcbst.com. These reports were developed based upon standards and guidelines issued by the State informing you about your cost and quality levels based on comparisons with your peers. The second round of reports is now available on BlueAccess. Log on and scroll to the link "Tennessee Health Care Innovation Initiative." Next select the reporting period and line of business you want to review.

Our initial reports included data from our Medicare Advantage product, but in the future this data will be excluded. As a result, you will see a change in the weights and factors for the commercial total joint replacement bundles.

If you would like additional information on the Tennessee Health Care Innovation Initiative, BlueAccess provides some Frequently Asked Questions and a guide to help you understand how to read the reports. You can also find more information at <http://www.tn.gov/HCFA/strategic.shtml>.

Inpatient hospice services update*

Inpatient hospice claims should be billed with Revenue Code 0658, with only one line to indicate the date span unless there is a break in the member's stay. Billing a line item for each date of service is not necessary.

Also, please make sure you submit your provider indicator number (PIN) in the CLM*NTE segment when filing electronically or in Form Locator 80 of the CMS-1450. The PIN should be submitted without dashes, spaces or other verbiage in the segment.

Medicare Advantage

ADMINISTRATIVE

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

New CMS requirement for non-covered services/supplies*

In accordance with notification from the Centers for Medicare & Medicaid Services (CMS) in **May 2014**, the Advanced Beneficiary Notice (ABN) used in the original Medicare program

is **not** applicable to any Medicare Advantage programs. Therefore, when informing a BlueAdvantage (PPO)SM or BlueChoice (HMO)SM member that a service is not covered or is excluded from their health benefit plan, the decision is considered an organization determination under 42 CFR, 422.566(b) and requires a formal organizational determination denying coverage.

An "ABN waiver" is no longer sufficient documentation of this notification. BlueChoice or BlueAdvantage Plan network providers should request a pre-determination from BlueAdvantage/BlueChoice on the member's behalf before any non-covered service/supply is provided, or the provider may be responsible for the cost of the service or supply.

Diabetic testing supplies

Beginning **Jan. 1, 2015**, BlueAvantage is making it more convenient for our members to get diabetes testing supplies from a retail pharmacy or mail order pharmacy (Express Scripts® or DrugSource, Inc.) where they obtain their routine medications. After Jan. 1 all members' diabetes testing supplies should be obtained through the pharmacy.

The plan covers preferred products for glucometers, test strips and calibration solutions: Johnson & Johnson (Lifescan®, OneTouch®) and Bayer (Contour®, Breeze2®). Any other products will not be covered by the plan, unless there is a medical necessity reason for an exception. Lancets and lancet devices are not limited to these brands, and up to 300 per month will be allowed. Diabetes testing supplies are available as a 90-day prescription that can save members money, and are not subject to the Donut Hole benefit under Medicare Part D, as they are covered as a Part B benefit at a zero-dollar copayment. Please note diabetes testing supplies will not be covered outside the pharmacy setting.

Negative pressure wound therapy *

Starting **Nov. 1, 2014**, negative pressure wound therapy devices and supplies will be authorized per Local Coverage Determination (LCD) criteria on a two-week basis. After the initial approval, the program will review the wound progress and evaluate medical necessity per the LCD every two weeks, which will be handled by a nurse case manager to decrease turnaround times for authorization requests.

Home health nursing *

All Medicare Advantage members can receive a home health nursing evaluation without an authorization request. On **Nov. 1, 2014**, BlueAdvantage will be implementing a protocol for home health nursing services that will allow for up to eight visits in a 30-day range if medical necessity criteria are met. Any additional services after the 8 visits (even if within the 30-day time period) would require a separate request and updated clinical information to evaluate for ongoing medical necessity.

Reminder: Revenue Code 510*

Hospital-Based clinic services

Effective **Oct. 1, 2014**, and consistent with reimbursement guidelines of other payers as well as current BlueCross BlueShield of Tennessee Commercial and BlueCare Tennessee contracts, Medicare Advantage will no longer reimburse for charges under revenue code 510 (hospital-based clinic setting as defined in 42 CFR 410.2) when provided in conjunction with an E&M professional service charge.

As a reminder, on Sept. 1, 2014, BlueAdvantage (PPO) and BlueChoice (HMO) programs introduced a DRG outlier day review program and a readmissions reduction program for members in acute inpatient care settings. The outlier day program is based on a medical necessity review of the days relative to MCG criteria. The readmission program has an administrative penalty for same or similar diagnosis readmissions within 31 days. Please see last month's BlueAlert or the Provider Administrative Manual for more details on these programs.

Reminder: Expanded population health programs

As a reminder, in July, BlueCross BlueShield of Tennessee Medicare Advantage plans expanded its Condition Management Programs for members with:

- Diabetes
- CHF/CAD/Hypertension/High Cholesterol
- Asthma/COPD
- ESRD on Hemodialysis

These programs include information about the member's diagnosis and health coaching to encourage compliance with your plan of care and prescription adherence. The latest techniques of motivational interviewing and readiness to change assessments are built into the health coaching models. If you have a member with one of these diagnoses and you would like to refer them for enrollment, please contact Julie Thomas, Medicare Products Case Management and Population Health Supervisor at (423) 535-6827.

*****These changes will be included in the appropriate 4Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

AccessTN/Cover Kids **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-888-747-8955**
BlueCare PlusSM **1-800-299-1407**
BlueChoiceSM **1-866-781-3489**
SelectCommunity **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–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

November 2014

Bluealert SM

BlueCross BlueShield of Tennessee, Inc.

(Applies to all lines of business unless stated otherwise)

CLINICAL

Clinical Practice Guidelines Adopted September 2014

BlueCross BlueShield of Tennessee has adopted the following guidelines as practice resources:

Treatment of Patients with Panic Disorder, Second Edition
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_9.aspx>

Helping Patients Who Drink Too Much: A Clinician's Guide, Updated 2005 Edition
<http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>

Treatment of Patients with Major Depressive Disorder, Third Edition
<http://psychiatryonline.org/data/Books/prac/PG_Depression3rdEd.pdf>

Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder
<http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709621821.pdf>

Hyperlinks to these guidelines are also available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company website at http://www.bcbst.com/providers/hcpr/

Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Medical Policy updates/changes

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

Effective Dec. 13, 2014

- Molecular Panel Testing of Cancers to Identify Targeted Therapies

Effective Dec. 17, 2014

- Brentuximab Vedotin

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

Medical Policy Reminder: Please remember to utilize the following policy: <First-Trimester Detection of Down Syndrome Using Fetal Ultrasound Markers Combined with Maternal Serum Assessment>.

ADMINISTRATIVE

Easily find a specialist with our online tool

Quarterly distribution of the Provider Referral Directory is being replaced by our "Find a Doctor" tool on bcbst.com. This online tool is a quick and easy way to find a specialist.

As soon as you open "Find a Doctor", simply type in any specialty in the search bar.

Or, find and print provider directories by network online at <http://www.bcbst.com/providers/directory/pdfview/>. Should you still need a complete hardcopy of the Provider Referral Directory, please contact your local Provider Relations Consultant.

Please remind your patients to get their flu shot!

With the flu season upon us, we encourage you to remind your patients of the importance of getting their flu shots. We also encourage you to address any fears or misconceptions

that they may have regarding this vaccine. Most, but not all health care plans, cover flu immunizations with no member cost share. Some grandfathered plans may not cover flu immunizations, or may cover them subject to member cost share. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

New prior authorization features

Watch for the new prior authorization features coming to BlueAccess℠

Durable Medical Equipment (DME) will be added to the prior authorization submission options and will allow attachment uploads. Also, the Clinical Update page will be updated to allow additional details based on the authorization type.

You spoke; we listened!
A new "Prior Authorization Search by Code" tool will be available on the Patient Information page under Patient Inquiry and will allow you to enter a procedure code and diagnosis code for a specific patient and quickly check if prior authorization is required.

For assistance using BlueAccess, please contact eBusiness Technical Support.

Provider dispute resolution process for Medsolutions

When submitting reconsiderations and retrospective reviews for commercial business to Medsolutions:

The following should be sent directly to Medsolutions:

- **Reconsiderations** (additional medical records submitted after initial denial) must be submitted **within 90 days** of the date of denial.
- **Retrospective reviews** must be submitted **within 180 days** from the date of the original decision. If authorization was approved for a service and another service was billed, providers have up to 180 days to have the case reviewed for medical necessity.
- Submit retrospective reviews to Medsolutions via fax to 1-888-693-3210 or by emailing Clientservices@medsolutions.com. See www.medsolutions.com to locate the required fax form.

Send the following to BlueCross BlueShield of Tennessee:

- **Appeals –** if submission is more than 90 days from the original denial, submit to BlueCross as an appeal.
- **Reconsideration** for decisions remaining denied after reconsideration by Medsolutions, submit the denial letters from Medsolutions and specific reason you are appealing the denial along with medical records.
- Submit to BlueCross BlueShield of Tennessee, Commercial Appeals, 1 Cameron Hill Circle, Suite 0017, Chattanooga, TN 37402 or fax to (423) 591-9451.

Updated physician quality information available

The bi-annual update to Physician Quality Information will be available on Nov. 11, 2014, for private physician review on our secure BlueAccess Web portal. Physicians have a 60-day review period, during which they can submit self-report information at patient level to help improve their rating. After the 60-day review period, provider ratings will be updated to reflect the self-reported submissions. The updated provider ratings are also included in our provider directories that are available online for our members.

Reminder: Guidelines for requesting reconsideration and appeal of adverse determination/denial

The Inquiry/Reconsideration Level is the first step in the Provider Dispute Resolution Procedure (PDRP).
A written request for a standard reconsideration of the denial must be submitted with all pertinent information including prior correspondence, medical records, and all documentation you wish to have reconsidered.

If dissatisfied with the outcome of the reconsideration review, providers can file an appeal request within thirty (30) days of receipt of the reconsideration response.

The appeal request should state:

- The reason for the appeal
- Why the provider is dissatisfied with the reconsideration response
- Any additional information the provider would like considered in support of the appeal request

For more information see our company websites www.bcbst.com and http://bluecare.bcbst.com.

- Guidelines for requesting a reconsideration or appeal are outlined in the PDRP which is available in our provider administration manuals.
- The **Provider Dispute Form** is available in the Forms section of the Provider page.

Reminder: Appropriate billing guidelines for authorized Orally Administered Enteral Nutrition

Published codes for enteral formulae contain the phrase "administered through an enteral feeding tube" in their full code description. Enteral formulae

being administered by mouth must have the BO modifier (i.e. Orally administered nutrition, not by feeding tube) appended to the formulae code(s) to indicate this route of administration. Billing authorized oral enteral nutrition without appending the BO modifier is incorrect coding and failure to submit these authorized services correctly will result in denial or recoupment of reimbursement.

Orally administered enteral formulae should be billed with spanned dates of service. One unit for each 100 calories should be billed, with units/calories matching the quantity dispensed and physician ordered amount, for the submitted date of service span. No feeding supplies should be billed with orally administered nutrition.

Reminder: Billing guidelines for Avastin

Providers are reminded that prior authorization for bevacizumab (Avastin) is not required for use in treatment of eye disorders; however, prior authorization is required for bevacizumab (Avastin) in the treatment of neoplastic conditions/ diseases.

Billing guidelines for compound drugs are available in the billing and reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual* found online at www.bcbst.com.

Reminder: Electronic claim submission

BlueCross BlueShield of Tennessee continues its efforts to encourage greater use of electronic processing tools, including greater adoption of electronic claims submissions. Effective Jan. 1, 2015, BlueCross will begin executing the electronic claims submission requirement pursuant to the BlueCross Minimum Practitioner Network Participation Criteria.

Please contact eBusiness Support at (423) 535-5717, option 2, to discuss how your organization can continue moving from paper to electronic claims submission. More information is available on the company website at <http://www.bcbst.com/providers/ecomm/> or you can contact us via email at eBusiness_Service@bcbst.com.

BlueCare Tennessee

ADMINISTRATIVE

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

Diabetic Retinal Exams

Diabetic Retinal Exams are a covered medical benefit for TennCare℠ members including BlueCare Plus℠ who are diagnosed with diabetes. Diabetes is the leading cause for new cases of blindness among adults between the ages of 20 and 74. Recommending a retinal exam for diabetic patients can lead to early detection and treatment of diabetic retinopathy and can help prevent vision loss. The American Diabetes Association recommends an annual retinal exam for patients with diabetes.

We encourage you to order an annual retinal exam for your diabetic patients. As their health care provider, these members trust you to direct them in their health care needs. For more information, please contact the BlueCare, TennCare*Select* or BlueCare Plus Provider Service Line†.

Authorization requirements to avoid non-compliance

Failure to comply with the following prior authorization requirements, within specified timeframes, will result in a denial due to non-compliance:

- Non-urgent services without notification/authorization prior to services being rendered are considered “non-compliant.”
- Emergencies resulting in an inpatient admission require prior authorization within 24 hours or one business day after inpatient admission/conversion from observation.
- Ongoing services beyond previously approved dates require re-notification/re-authorization review within 24 hours or one business day from the last approved date of service.
- Services rendered without obtaining authorization prior to services being rendered are considered “non-compliant.”
- All inpatient hospital admissions require prior authorization.
- If a member is admitted into the hospital directly from the physician’s office, the authorization for inpatient admission should be obtained by the admitting physician before the member arrives at the hospital.

Submission of outpatient claims following audit

BlueCare Tennessee has contracted with a recovery audit vendor to perform post payment coding, utilization and medical necessity audits. In accordance with CMS ruling 1455-R issued on March 13, 2013, BlueCare Tennessee will accept outpatient claims from facilities for the outpatient services (emergency room visits, observation services, etc.) performed prior to an

inpatient admission when our recovery audit vendor has determined that the inpatient admission was not medically necessary. BlueCare Tennessee will process the outpatient claims according to our normal processing and reimbursement rules.

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it is the result of a vendor audit, and submit it within 120 days of the date of our remittance advice reflecting recovery of the inpatient claim. If a hospital has appealed an audit decision and received a denial, the outpatient claim should be submitted within 120 days of the date of the appeal decision. A copy of the appeal decision should also be submitted to ensure proper handling of the claim. Additionally, hospitals must maintain documentation to support the services billed on the outpatient claim.

Primary care providers get web enhancement support to manage their members

Effective Jan. 1, 2015, primary care providers (PCPs) will be able to access their BlueCare/TennCare*Select* member's admission, discharge, and transfer data from applicable hospitals under the authorization inquiry section online. PCPs will also have access to any related pharmacy claim data for their assigned members under the claim section online. A training tutorial will soon be available within BlueAccess under Service Center for reference on how to access.

Prior authorization no longer required for outpatient hysterectomy*

Effective Nov. 1, 2014, outpatient hysterectomy codes will no longer require prior authorization for BlueCare Tennessee members. However, these procedures will be retrospectively reviewed based on MCG (formerly Milliman Care Guidelines) and all state and federal requirements prior to reimbursement. All inpatient hysterectomy procedures will continue to require prior authorization.

Individualized Education Plan therapy services

To facilitate the receipt of therapy services reflected on the Individualized Education Plan (IEP), BlueCare Tennessee accepts requests for a number of visits over a longer period of time not to exceed the IEP end date.

For additional information see the *BlueCare Tennessee Provider Administration Manual.*

Reminder: Are you seeing your assigned members?

We all know how important it is for Primary Care Providers (PCPs) to help coordinate our members' health care needs. As a BlueCare/TennCare*Select* PCP, it's your responsibility to verify any member you see is assigned to your patient listing either for yourself or another participating PCP in your group. Check the member's ID card or the patient listings on BlueAccess to confirm assignment. Members listed incorrectly can be easily reassigned by emailing the member name, identification number and date of birth to IO-BluecarePCP_GM@bcbst.com.

Transition of contracting and credentialing for behavioral health providers*

Effective Jan. 1, 2015, BlueCare Tennessee will assume responsibility for behavioral health contracting and credentialing for the BlueCare, TennCare*Select*, CoverKids, and BlueCare Plus networks. Our intent is to contract with providers directly under the same terms and rates that currently exist with ValueOptions, Inc.

For providers from whom a **contract has not been received**, please keep in mind these important dates:

- **Nov. 15, 2014**: Last date for BlueCross BlueShield of Tennessee to receive provider contracts to avoid mailing notification to members of non-participating status.
- **Dec. 1, 2014**: Members will receive notification of provider's non-participating status.
- **Jan. 1, 2015**: Earliest network effective date. Providers begin receiving reimbursement at out-of-network rates.

New Guidelines: MCG (formerly, Milliman Care Guidelines) will go into effect Jan. 1, 2015.

- Save the date of Nov. 12, 2014, for a webinar presentation highlighting the change in guidelines as well as introduce the online authorization tool available through BlueAccess beginning Jan. 1, 2015. Watch for an email invitation for this event.

Please contact your local Behavioral Health Provider Network Manager with any questions.

Focus on improving overall health of members with mental health needs

Individuals with mental health and substance abuse problems often have poorer physical health status and outcomes. BlueCare Tennessee is focused on improving the overall health of our BlueCare/TennCare*Select*, CoverKids and BlueCare Plus members with behavioral health needs, and primary care providers (PCPs) have a central role in that mission. Here is what we are doing and how you can help:

- Community mental health centers and other behavioral provider partners – with the consent of members – are required to inform the assigned PCP when behavioral care has been initiated. When you receive this notification, please respond by returning information about the member's current medical problem(s) and medication(s).
- A statewide program has been initiated to fill gaps in medical care by furnishing community mental health case managers with information about members who are not current with recommended screenings and services. Case managers encourage these members to get the services they need and, when necessary, assist them in making and keeping appointments. Mental health case managers can be a great resource in helping your patients stay healthy.
- Resources are available for PCPs who are treating members with behavioral issues. Our *PCP Consultation and Referral Line* can put you in direct contact with a licensed psychiatrist when you have questions about mental health or substance abuse treatment and medications. This help line is staffed by people familiar with local resources who can arrange for care and save you or your office staff valuable time. Call 1-800-367-3403, Monday through Friday, 8 a.m. to 5 p.m. (ET).

TENNderCare
ADMINISTRATIVE

TENNderCare billing and documentation reminders

When a patient's primary reason for a visit is a well-child TENNderCare exam and a significant abnormality is discovered that will need additional evaluation and management, such as an ear infection in a well-baby exam, the office visit code can be billed in addition to the preventive service. A modifier 25 should be attached to the evaluation and management office visit code. Conversely, when a patient presents with symptoms such as an ear infection and is due for a well-child exam and the complete well child exam is performed, then both codes may be billed using the modifier 25 added to the office visit code. Remember: All seven components of the TENNderCare exam must be completed and documented in the patient's medical records, including documentation of the nutritional assessment and physical activity portion of the exam as well.

Medicare Advantage
ADMINISTRATIVE

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

As a reminder, on Sept. 1, 2014, BlueAdvantage (PPO) and BlueChoice (HMO) programs introduced a DRG outlier day review program and a readmissions reduction program for members in acute inpatient care settings. The outlier day program is based on a medical necessity review of the days relative to MCG criteria. The readmission program has an administrative penalty for same or similar diagnosis readmissions within 31 days. Please see previous BlueAlerts or the BlueCare Tennessee Provider Administrative Manual for more details on these programs.

Diabetic testing supplies*

Beginning **Jan. 1, 2015**, BlueAdvantage is making it more convenient for our members to get diabetes testing supplies from a retail pharmacy or mail order pharmacy (Express Scripts® or DrugSource, Inc.) where they obtain their routine medications. After Jan. 1, all members' diabetes testing supplies should be obtained through the pharmacy.

The plan covers preferred products for glucometers, test strips and calibration solutions: Johnson & Johnson (Lifescan®, OneTouch®) and Bayer (Contour®, Breeze2®). Any other products will not be covered by the plan, unless there is a medical necessity reason for an exception. Lancets and lancet devices are not limited to these brands, and up to 300 per month will be allowed. Diabetes testing supplies are available as a 90-day prescription that can save members money, and are not subject to the Donut Hole benefit under Medicare Part D, as they are covered as a Part B benefit at a zero-dollar copayment. Please note diabetes testing supplies will not be covered outside the pharmacy setting.

Reminder: New CMS requirement for non-covered services/supplies

In accordance with notification from the Centers for Medicare & Medicaid Services (CMS) in **May 2014**, the Advanced Beneficiary Notice (ABN) used in the original Medicare program is **not** applicable to any Medicare Advantage programs. Therefore, when informing a BlueAdvantage (PPO)℠, BlueChoice (HMO)℠ or BlueCare Plus member that a service is not covered or is excluded from their health benefit plan, the decision is considered an organizational determination under 42 CFR, 422.566(b) and requires a formal organizational determination denying coverage.

An "ABN waiver" is no longer sufficient documentation of this notification. Providers should request a pre-determination from

BlueAdvantage, BlueChoice or BlueCare Plus on the member's behalf before any non-covered service/supply is provided, or the provider may be responsible for the cost of the service or supply.

Transplant benefits and authorizations*

Beginning Nov. 1, 2014, all requests for transplant benefit verification and authorizations for Medicare Advantage members should be obtained by calling 1-800-841-7434. If you have questions concerning facility benefits, such as member copays, please call Medicare Advantage Customer Service† and a referral will be created to our Medicare Advantage transplant services case management team. The case manager will contact the provider or facility to assist with care coordination and authorizations. The case manager will also review any additional benefits available to the member, including travel benefits.

QUALITYCARE REWARDS

Cancer screening postcards encourage members to close care gaps

In October, Medicare Advantage members who have not had screenings for breast cancer and/or colorectal cancer were identified through claims data. In November, these members will receive postcards emphasizing the importance of these screenings. Be advised that our members may call your office for a referral and/or appointment to complete one or both of these screenings. Members who receive these screenings can earn a $15 gift card for each service after we receive and process the claim.

The My HealthPath Member Engagement Program rewards Medicare Advantage members for receiving breast and colorectal cancer screenings, two of five preventive care procedures which also include bone density tests, annual wellness exams, and medication therapy screenings. These screens close members' care gaps as well, which provides you an opportunity to receive increased payments as a participant in the Physician Quality Incentive Program.

More information about the Physician Quality Incentive Program is available online at the Quality Care Rewards page, which links to helpful resources. The Member Resource Materials page links to mailings and other information for members related to closing care gaps and addressing common health concerns.

New enhancements added to Physician Quality Incentive Program web tool

As of Sept. 30, 2014, even more enhancements have been added to the Physician Quality Incentive Program web tool for Medicare Advantage members. The web tool is available by logging in to BlueAccess. Please see the Oct. 14, 2014 email blast for details.

Additionally, the Patient Assessment Form (PAF) has been streamlined and can now be submitted online through the web tool. For more information about these new web tool enhancements, see the Quality Care Rewards page, or the updated Quick Reference Guide in BlueAccess.

*****These changes will be included in the appropriate 4Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

AccessTN/Cover Kids **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-888-747-8955**
BlueCare PlusSM **1-800-299-1407**
BlueChoiceSM **1-866-781-3489**
SelectCommunity **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–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

DECEMBER 2014

BlueAlert℠

Marketplace

Marketplace resources available

Tennesseans seeking health insurance through the Health Insurance Marketplace can learn more through local community "meet-ups" and special events. For a complete list of locations and times, go to bcbst.com.

Open enrollment on the Marketplace is now through Feb. 15, 2015. People can apply for Marketplace plans on Healthcare.gov by calling the Marketplace Call Center at **1-800-318-2596** or by visiting an enrollment center.

Visit our provider web pages for updated resources about the Marketplace – bcbst.com/providers/health-insurance-marketplace.page.

New network naming conventions

To help our individual members better understand our provider networks, we have recently added short descriptions to networks that are paired with Marketplace plans.

Blue Network P℠ – Preferred

Our Preferred Network – Available for plans purchased on (Multi-State Plans only) and off the Health Insurance Marketplace.

Blue Network S℠ – Select

Our Standard Network – Available for plans purchased on and off the Health Insurance Marketplace.

Blue Network E℠ – Essential

Our Most Basic Network – Available for plans purchased on the Health Insurance Marketplace. It is only available in four service regions which include Tennessee's major cities: Chattanooga, Knoxville, Memphis and Nashville.

BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/ changes

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

Effective Jan. 10, 2015

- Autologous Fat Grafting to the Breast and Adipose-Derived Stem Cells
- Genetic Testing for Mitochondrial Disorders
- Serum Biomarker Tests for Multiple Sclerosis (MS)
- Transcranial Magnetic Stimulation, Cranial Electrotherapy Stimulation and Navigated Transcranial Magnetic Stimulation

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

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming modifications to select Utilization Management Guidelines. The Modified Utilization Management Guidelines can be viewed online at bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm.

Effective Jan. 1, 2015

The following has been updated as it relates to Inpatient and Surgical Care:

- BlueCross modifications related to Psychiatric Observation in the Medical Setting: Observation Care will be removed.

Beginning Jan. 1, 2015, BlueCross will use MCG 18th edition for its behavioral health guidelines.

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

Managing your COPD and asthma patients

As we head into the colder months and flu season, it is important to keep your COPD and Asthma patients as healthy as possible and out of the emergency department and hospital.

A few simple steps can help:

1. Encourage your patients to obtain flu and pneumonia vaccines as applicable.
2. Educate your patients on the importance of taking both rescue/short-term medications and controller/long-term medications for better symptom and exacerbation control.
3. Recommend the use of COPD and Asthma action plans. (For more information contact the American Lung Association at Lung.org)
4. Assure your members are prescribed appropriate drug therapy upon discharge from the emergency department or hospital.

For additional information see the following:

Guidelines for the Diagnosis and Management of Asthma (EPR-3 – 2007) (Asthma: 2008 edits to the 2007 guideline) nhlbi.nih.gov/guidelines/asthma/epr3-errata.htm

Global strategy for the diagnosis, management and prevention of COPD (Updated January 2014) goldcopd.org/uploads/users/files/GOLD_Report2014_Feb07.pdf

Ebola educational materials available

Though the risk of Ebola appearing in Tennessee is low, BlueCross knows our members may have concerns. We have shared educational information about Ebola on our website and have directed members to additional resources for more information.

To see information available to our members, click here: bcbst.com/ebolafacts/index.page.

For more relevant provider information about Ebola developed by the CDC, click here: cdc.gov/vhf/ebola/pdf/ebola-factsheet.pdf or here: cdc.gov/vhf/ebola.

ADMINISTRATIVE

Continued focus on improved quality care and service

BlueCross BlueShield of Tennessee's enterprise Quality Improvement Programs continue to focus on improving the quality and safety of clinical care and service received by our commercial, BlueCare, TennCare*Select*, Cover Tennessee and Medicare Advantage members. BlueCross clinical quality and outreach teams have been working closely with providers to educate our members about the importance of seeking preventive care, including offering member and provider incentives to help improve key quality measures.

The following HEDIS® 2014 results show continued efforts are needed to improve rates for the measures below.

While we continue to promote these screenings to our members, you play the most essential role in actively encouraging patients to undergo appropriate screenings. For more information and resources – including incentive opportunities – please visit bcbst.com/providers/quality-initiatives.page and bluecare.bcbst.com.

Middle Grand Region Providers

BlueCare Tennessee is excited to serve TennCare members in the Middle Grand Region beginning Jan. 1, 2015. Information in a Nov. 11, 2014 letter mailed to Middle Tennessee Providers will help in the transition to BlueCare Tennessee.

If you would like to contract with BlueCare Tennessee or check on your current contract status, please call our Provider Service line†. To help with questions related to this transition, Frequently Asked Questions (FAQs) are available on the BlueCare Tennessee website located in the "2015 Statewide / Health Plan Changes" section or you can contact the BlueCare Tennessee Provider Service Line†.

Remind your patients of the importance of the flu shot

The cooler weather is a reminder that the flu season is upon us. National statistics indicate that more than half of eligible Americans fail to get their flu shot, often due to fear and misunderstanding. We encourage you to remind your patients of the importance of getting their flu shots. We also encourage you to address any fears or misconceptions regarding this vaccine with your patients. Most, but not all health care plans, cover flu immunizations with no member cost share. Some grandfathered plans may not cover flu immunizations, or may cover them subject to member cost share. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

Tennessee Health Care Innovation Initiative

BlueCross BlueShield of Tennessee participates in the effort launched in May with retrospective episode-based payment strategy that will reward providers for high-quality and efficient care for acute medical conditions in three episodes: total joint replacement (hip and knee), acute asthma exacerbation and perinatal.

Beginning in November 2014 the Tennessee Health Care Innovation Initiative (THCII) reports include the Acceptable and Commendable Thresholds for total joint replacement, acute asthma exacerbation and perinatal episode bundles. The reports show your potential gain/risk share eligibility as the quarterback. The gain/risk share eligibility will be based on data collected in 2015 with rewards and/or financial payouts in 2016.

BlueCare Tennessee contract amendments for the Tennessee Health Care Innovation Initiative program will be sent to BlueCare and TennCare*Select* contracted providers in fourth quarter 2014.

For additional information about the Tennessee Health Care Innovation Initiative program see our website at bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html or the State of Tennessee website at tn.gov/HCFA/strategic.shtml.

HEDIS Measure (%)

PRODUCT	Diabetes Care/ Retinal Eye Exam	Diabetes Care/ Kidney Disease Monitoring	Diabetes Care/ HbA1c Screening	Breast Cancer Screening/ Mammogram	Cervical Cancer Screening/ PAP Test	Colorectal Cancer Screening	Childhood Immunizations Combo 10	Adolescent Immunizations (Combo 1)	ADHD – Initiation Phase	ADHD - Continuation & Maintenance Phase	Chlamydia Screening - Total
BlueCare - East	39.05%	75.36%	77.55%	58.29%	67.15%	NA	37.23%	63.74%	42.07%	47.64%	47.93%
BlueCare - West	39.05%	72.63%	76.28%	55.33%	70.32%	NA	20.44%	61.70%	35.61%	50.70%	63.49%
TennCare*Select*	66.22%	57.19%	79.26%	67.61%	58.69%	NA	27.25%	60.76%	34.56%	38.04%	49.74%
Commercial	45.44%	81.39%	90.69%	70.11%	75.67%	57.32%	52.55%	61.48%	39.96%	45.69%	36.19%
CoverKids	NA	NA	92.35% (5-17yrs)	NA	80.92%	NA	39.42%	62.84%	44.73%	56.77%	32.49%
AccessTN	40.93%	81.73%	87.77%	72.49%	63.67%	44.99%	NA	NA	NA	NA	22.22%
BlueAdvantage	63.26%	90.02%	92.46%	75.23%	NA	64.20%	NA	NA	NA	NA	NA

Billing specific modifiers for distinct procedural services*

Beginning Jan. 1, 2015, the Centers for Medicare & Medicaid Services (CMS) is establishing four new modifiers to define specific subsets of the -59 modifier.

- **XE** – Separate Encounter, occurring during a separate encounter
- **XP** – Separate Practitioner, performed by a different practitioner
- **XS** – Separate Structure, performed on a separate organ/structure
- **XU** – Unusual Non-Overlapping Service, does not overlap usual components of the primary service

These new modifiers are collectively referred to as –X{EPSU} modifiers and are more selective versions of the -59 modifier. It would be incorrect to bill one of these modifiers in conjunction with the -59 modifier on the same line item.

BlueCross will follow CMS guidelines regarding utilization of the –X{EPSU} modifiers and will initially accept either a -59 modifier or one of the –X{EPSU} modifiers as correct coding; however, migration to utilization of the more specific modifiers is encouraged.

Reminder: When utilized to indicate a distinct procedural service, either the -59 modifier or one of the –X{EPSU} modifiers should be appended only to the Column 2 (component) code of the NCCI edit pair. Appending one of these modifiers to both the Column 1 (comprehensive) and Column 2 (component) codes of the pair is incorrect coding and may result in errors and/or delay in reimbursement.

Evaluation and Management Service reminder

Based on the Centers for Medicare & Medicaid Services (CMS) guidelines for Evaluation and Management (E&M) Services (100-4, Chapter 12, 30.6), it is inappropriate for therapists to bill E&M services. The guidelines require therapy (PT, OT, and ST) services including evaluations to be submitted with the appropriate code according to the Special Otorhinolaryngologic or Physical Medicine and Rehabilitation sections. Inappropriate billing is subject to post-payment audit review and recoupment.

Dental Coding Changes*

Per current guidelines set by the American Dental Association (ADA), the following CDT® codes will be deleted as of Jan. 1, 2015: D6053, D6054, D6078, D6079 and D6975.

The following CDT® codes will be added as of Jan. 1, 2015, and will be covered under the standard DentalBlue contract: D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117 and D6549.

If a deleted code is filed beginning with date of service Jan. 1, 2015 or after, that line item will not be processed and you will be advised to file the most current ADA code. For questions contact Dental Customer Service at **1-800-523-1478**, Monday through Friday, from 8 a.m. to 5:15 p.m. (ET).

Atypical antipsychotics side effects

Atypical antipsychotics, or second generation antipsychotics, are antipsychotic medications that came to market in the 1990's and afterwards.

The term "atypical" refers to the fact that these medications have less frequent extrapyramidal side effects such as stiffness, tremor, and tardive dyskinesia. These were troublesome side effects that were more common with first generation antipsychotics and were a barrier to patients adhering to the medications. Atypical antipsychotics have these side effects as well, but at lower rates.

Atypical antipsychotics include medications such as risperidone, olanzapine, quetiapine, ziprazadone, and others. They are frequently used for conditions that may have psychotic symptoms such as schizophrenia, bipolar disorder, or depression. Some are also indicated for behavioral abnormalities associated with autistic disorder.

One of the most troublesome side effects to emerge from the atypical antipsychotic medications is weight gain and metabolic syndrome. Metabolic syndrome includes insulin resistance, hyperglycemia, hypertension, diabetes, and dyslipidemia. These conditions contribute to the early death of people with chronic mental disorders. The additional medical problems require additional medications, and additional sophistication to navigate through the medical care system. In order to prevent and mitigate metabolic side effects of atypical antipsychotics, measurements of weight, abdominal circumference, and lab work including fasting glucose and lipids are recommended at baseline and periodically.

For consultation about and medical monitoring of these medications with a board certified psychiatrist, please call **1-800-367-3403**.

Dual-network health care plans now available in Middle Tennessee

Some BlueCross members in the Middle Tennessee area have dual- network health care plans that enable them to make a network choice each time they seek medical care. BlueCross has partnered with MissionPoint, to offer members in the Middle Tennessee area the opportunity to seek care from providers that participate in both Network M and Network P.

Members that choose this plan will have access to MissionPoint's clinically-integrated support services at no charge to them. The result of providing these services should decrease future costs by reducing repeat hospital and emergency room visits and better managing chronic conditions.

Member ID cards for those that choose this plan will have both provider networks listed on the card. Reimbursement to the provider for services to these members will be based on the terms of the network that is listed first on the member ID card.

REMINDER: CAQH streamlines the credentialing process

BlueCross BlueShield of Tennessee has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners Universal Provider Datasource (UPD), a universal credentialing application tool. With a single, uniform online application, practitioners can enter their information free of charge to access, manage and revise that information at their convenience.

Beginning Jan. 1, 2015, BlueCross will require new credentialing applications from licensed health care professionals to be submitted through CAQH. The UPD Quick Reference Guide, available on the CAQH website at caqh.org/pdf/UPDbrochure.pdf, provides step-by-step instructions for online registration and how to get started using UPD.

Note:

- Credentialing for participation in all BlueCross networks, except CHOICES, is available through the CAQH credentialing tool.
- Facilities are not eligible for credentialing through CAQH at this time.

Weight management intervention for children and adolescents

Did you know Body Mass Index (BMI) percentile assessment and counseling for nutrition and physical activity is recommended yearly for children and adolescents 3-17 years of age? Good Nutrition and Physical Activity is the foundation for a healthy future. These healthy behaviors can result in improved health, positive self-image, and prevention of chronic conditions later in life. During a yearly visit primary care physicians (PCPs) or obstetricians/gynecologists (OB/GYNs) can help by completing the following steps:

- Discuss current nutritional status and activity behaviors
- Provide nutritional and physical activity educational materials when necessary
- Provide guidance for nutritional and physical activity recommendations
- Consider weight or obesity counseling if necessary

Completing these activities is an essential component of quality health care. Please remember to address these important topics with all your patients yearly. Early weight management interventions for children and adolescents will instill the positive behaviors needed for healthy outcomes as adults.

REMINDER: Earn CEUs at absolutely NO COST!

Address Health Care Disparities through FREE Quality Interactions® online training courses

Quality Interactions, a training program designed to help health care providers treat an increasingly diverse patient population, is currently available for physicians, nurses and non-clinical staff.

Quality Interactions teach a set of concepts and skills that assist in working successfully in cross-cultural situations. The training program uses a case-based format supported by evidence-based medicine and peer-reviewed literature and is accredited for up to 2.5 hours of CME, CEU, or CCM credits.

There is **no cost** to BlueCross/BlueCare Tennessee network providers, however a limited number of licenses are available for these courses, so please be sure to register quickly to take advantage of this valuable learning opportunity. The deadline for registration is Dec. 31, 2014.

Registration information is available on the Provider page on the company website, bcbst.com. Enter the BlueCross organizational code, 88750.

REMINDER: Electronic claim submission

BlueCross continues its efforts to encourage greater use of electronic processing tools, including greater adoption of electronic claims submissions. Effective Jan. 1, 2015, BlueCross will begin executing the electronic claims submission requirement pursuant to the BlueCross Minimum Practitioner Network Participation Criteria.

Please contact eBusiness Support at **(423) 535-5717**, option two, to discuss how your organization can continue moving from paper to electronic claims submission. More information is available on the company website at bcbst.com/providers/ecomm or you can contact us via email at eBusiness_Service@bcbst.com.

REMINDER: Physician Quality Information Portal available until January

The Physician Quality Information Portal on BlueAccess® will be available for physician review and self-reporting until Jan. 11, 2015. After this deadline, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available to our members on the company website.

BlueCare Tennessee

ADMINISTRATIVE

Articles apply to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless otherwise stated.

Provider Audit Alert: Medical Records Submission

When requested, facilities are required to furnish all medical records and encounter data in electronic or hardcopy format in a timely manner. According to the Contractor Risk Agreement (CRA), BlueCare Tennessee is required to have all medical records for claims reviewed, regardless of findings, to ensure the accuracy of the review process for the Bureau of TennCare.

For your convenience, medical records may be submitted via our secure file transfer portal (SFTP) that is fully HIPAA compliant and requires minimal set up. To obtain access to SFTP call our Provider Audit Department at **1-888-423-9493**, Monday through Friday, 8 a.m. to 5 p.m. (ET).

Community health events boost preventive screening rates

BlueCare Tennessee providers can help improve preventive screening rates for BlueCare and TennCareSelect members by participating in BlueCare Tennessee-sponsored community health events featuring onsite screening clinics. Providers who conduct screenings at these events are eligible for reimbursement at their contracted rates. Providers can also host outreach events for their BlueCare and TennCareSelect patients at their practice location.

REMINDER: Behavioral health provider update

Beginning Jan. 1, 2015, BlueCare Tennessee will assume responsibility for behavioral health contracting and credentialing for BlueCare, TennCare*Select*, CoverKids and BlueCare Plus℠ networks. Our intent is to contract directly with providers, under essentially the same terms and rates that currently exist with ValueOptions, Inc.

Please keep in mind these important dates:

- **Dec. 1, 2014** – Members receive notification of provider's non-participating status if provider **did not** return a signed contract by early November.
- **Jan. 1, 2015** – Earliest network effective date. Providers who **did not** return a signed contract will begin receiving reimbursement at out-of-network rates.

Please contact your local Behavioral Health Provider Network Manager with any questions.

REMINDER: Notification no longer required for outpatient hysterectomy for in-network providers

As of Nov. 1, 2014, outpatient hysterectomy codes, for in-network providers and facilities, will no longer require notification for BlueCare Tennessee members. These procedures are still 100 percent retrospectively reviewed based on MCG (formerly Milliman Care Guidelines) and all state and federal requirements prior to reimbursement. All inpatient hysterectomy procedures will continue to require prior notification.

Are you seeing your assigned members?

We all know how important it is for primary care physicians (PCPs) to help coordinate our members' health care needs. As a BlueCare/TennCare*Select* PCP, it's your responsibility to verify any member you see is assigned to your patient listing for you or another participating PCP in your group.

Please be sure to check the member's ID card or check the patient listings on BlueAccess to confirm assignment. PCPs that are currently receiving a paper remittance advice (RA) will see the following message at the bottom of their RA as a general reminder:

> **Are you seeing your assigned members?**
> As a BlueCare/TennCare*Select* PCP, it is your responsibility to verify any member you see is assigned to your patient listing for you or another participating PCP in your group. Please be sure to check the member's ID card or check the patient listings on BlueAccess to confirm assignment.

BlueCare Tennessee will be conducting an analysis to identify high volume PCPs who are seeing members not on their patient listing. We will be providing outreach and education to those high volume PCPs.

Medicare Advantage

ADMINISTRATIVE

These articles apply to BlueChoice (HMO)℠ and BlueAdvantage (PPO)℠ plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.

REMINDER: New CMS requirement for non-covered services/supplies

In accordance to notification from the Centers for Medicare & Medicaid Services (CMS) in May 2014, the Advanced Beneficiary Notice (ABN) used in the original Medicare program is not applicable to any Medicare Advantage programs. Therefore, when informing a BlueAdvantage or BlueChoice℠ member that a service is not covered or is excluded from their health benefit plan, the decision is considered an organization determination under 42 CFR, 422.566(b) and requires a formal organizational determination denying coverage.

An "ABN waiver" is no longer sufficient documentation of this notification. BlueChoice or BlueAdvantage Plan network providers should request a pre-determination from BlueAdvantage/BlueChoice on the member's behalf before any non-covered service/supply is provided, or the provider may be responsible for the cost of the service or supply.

Copays based on place of service

Starting Jan. 1, 2015, Medicare Advantage members will be responsible for the following Lab, Diagnostic Test and X-Ray copays based on the place of service:

- Free-Standing Lab - $0
- Primary Care Physician (PCP) - $0
- Specialist - $10
- Free-Standing Facility - $10
- Outpatient - $25

Provider billing will not be affected, but could affect where members choose to get their services. Additionally, copays for testing and diagnostic services may be separate to office visit copays.

Refraction reimbursement

As of Sept. 17, 2014 BlueCross began reimbursing in-network providers the allowed amount for CPT® 92015 (Determination of Refractive State). Any cost over the allowed amount will be considered provider write off. Although, traditional Medicare does not cover this service, BlueCross has elected to provide this benefit to our Medicare Advantage members.

For questions about this change please call our BlueAdvantage Provider Service Line†.

REMINDER: Revenue Code 510

Hospital-Based clinic services

Effective **Oct. 1, 2014**, and consistent with reimbursement guidelines of other payers as well as current BlueCross BlueShield of Tennessee Commercial and BlueCare Tennessee contracts, Medicare Advantage will no longer reimburse for charges related to an E&M Code (using HCPCS Code G0463) when billed for the same member, on the same date of service, by the same rendering provider and without a separately identifiable service provided, under revenue code 510 (hospital-based clinic setting as defined in 42 CFR 410.2).

REMINDER: Diabetic testing supplies

Beginning **Jan. 1, 2015**, BlueAvantage is making it more convenient for our members to get diabetes testing supplies from a retail pharmacy or mail order pharmacy (Express Scripts® or DrugSource, Inc.) where they obtain their routine medications. After Jan. 1, all members' diabetes testing supplies should be obtained through the pharmacy.

The plan covers preferred products for glucometers, test strips and calibration solutions: Johnson & Johnson (Lifescan®, OneTouch®) and Bayer (Contour®, Breeze2®). Any other products will not be covered by the plan, unless there is a medical necessity reason for an exception. Lancets and lancet devices are not limited to these brands, and up to 300 per month will be allowed. Diabetes testing supplies are available as a 90-day prescription that can save members money, and are not subject to the Donut Hole benefit under Medicare Part D, as they are covered as a Part B benefit at a zero-dollar copayment. Please note diabetes testing supplies will not be covered outside the pharmacy setting.

In-Home health assessments improve preventive care availability

Annual wellness exams are very important, and highly encouraged, for our Medicare Advantage members.

Transportation or ambulation are concerns for many Medicare Advantage members, therefore BlueCross has partnered with CenseoHealth, an independent company that provides in-home health exams by a physician on our behalf. These visits will include annual wellness exams and basic preventive services (i.e LDL check, fecal occult blood test (FOBT), diabetic HbA1c test and diabetic urine microalbumin test).

CenseoHealth's physicians do not replace members' primary care physicians (PCPs). CenseoHealth encourages members to follow up with their PCPs for continued coordination of care. All test results are sent to the members' PCP, and all preventive care gaps closed as a result will be credited to the PCP. These in-home services can be obtained by calling CenseoHealth at **1-877-868-5351**.

*These changes will be included in the appropriate 4Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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

Bluealert℠

of Tennessee

Provider Service Lines†

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "Network Contracts or Credentialing" when prompted, to easily update your information.

Commercial Lines **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

AccessTN/Cover Kids **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**

TennCare*Select* **1-800-276-1978**

CHOICES **1-888-747-8955**

BlueCare Plus℠ **1-800-299-1407**

BlueChoice℠ **1-866-781-3489**

SelectCommunity **1-800-292-8196**
Monday – Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueAdvantage **1-800-841-7434**

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

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: eBusiness_service@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbst.com