BlueCross BlueShield of Tennessee, Inc.

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

Medical Policy Updates/Changes

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

Effective Sept. 1, 2017
• Keratoprosthesis (Revision)

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

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

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

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

If you are providing this service and have reimbursement questions, please contact the facility or your BlueCross Network Manager.
Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

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

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

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

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

Reminder: Availity Coming Soon

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

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

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

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

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

Further Updates to Claims Editing Process Aim to Increase Payment Accuracy

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

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

While these updates will not completely eliminate overpayments or the need for recovery, our efforts in 2017 help ensure a more accurate and efficient payment process to our providers.
Reminder: Refer Your Patients with BlueCross Plans to Network Providers

Our members get the most from their health benefits when they visit participating network providers. As one of our network providers, please remember you are contractually obligated to refer your patients with BlueCross BlueShields of Tennessee health insurance plans to contracted network providers. This is especially important when referring our members to hospitals, for lab work, DME and any other ancillary service. Our “Find a Doctor” tool on bcbst.com can be used to easily locate other participating network providers. Please keep in mind that genetic testing not performed by a network provider requires prior authorization, and other out-of-network services may require review.

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

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

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

Reminder: Split Billing

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

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise

Submitting Evaluation and Management with Injection Services

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

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

BlueCare Tennessee

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

See the New BlueCare Tennessee Website

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

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

Community Outreach Events Bridge Gaps in Patient Care

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

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

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

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

Reminder: Provider Satisfaction Survey Coming Soon

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

Reminder: Coordinating Therapy for Your School-Age Patients

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

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

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

Reminder: Filing an Appeal on Behalf of Your Patient

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

TennCare Solutions Medical Appeals
P.O. Box 593
Nashville, TN 37202-0593
Fax (toll-free) 1-888-345-5575

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

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

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

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

In-Home Bone Density Screenings Available for BlueAdvantageSM and BlueChoiceSM Members

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

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

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

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

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

Earn Bonus by Sending Your Provider Assessment Forms

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

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

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

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

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

Hospice Prescription Drugs Review

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

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

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

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

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

You can find these guidelines on the CMS website.

Medicare Advantage Members Electing Hospice Services

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

Medicare Advantage members who select hospice care may revoke this option at any time. However, claims will continue to be paid by the appropriate A/B MACs as if the beneficiary was covered under original Medicare until the first day of the month following the month in which hospice was revoked.

Please note that certain medications not related to the admitting hospice diagnosis may be covered under the Medicare Advantage Part D benefit.

You can find these guidelines on the CMS website.

Please Comply with ArroHealth Documentation Requests

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

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

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

New Medicare Advantage PCP Change Request Form

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

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

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

Home Health Administrative Approvals Updates

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

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

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

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

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

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

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

Correct LOIN Codes for Closing Hemoglobin A1c Gap in Care Measure

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

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

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

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

Reminder: Audit Procedures for PCMH and QCPI Practices

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

Here are additional details:

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

Thank you for your help with this process.
BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not to discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCareSelect. For TTY help call 771 and ask for 888-418-0008.

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

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

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

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### Provider Service Lines

**Featuring “Touchtone” or “Voice Activated” Responses**

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

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the “touchtone” option or press 1. Then, press 1 again and follow the prompts to reach Network Contracts or Credentialing to update your information; and

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

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<thead>
<tr>
<th>Service Line</th>
<th>Phone Number</th>
<th>Operating Hours</th>
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<tbody>
<tr>
<td>Commercial Service Lines</td>
<td>1-800-924-7141</td>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td>Commercial UM</td>
<td>1-800-924-7141</td>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)</td>
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<tr>
<td>Federal Employee Program</td>
<td>1-800-572-1003</td>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td>BlueCare</td>
<td>1-800-468-9736</td>
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<tr>
<td>TennCareSelect</td>
<td>1-800-276-1978</td>
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<tr>
<td>CoverKids</td>
<td>1-800-924-7141</td>
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<td>CHOICES</td>
<td>1-888-747-8955</td>
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<td>ECF CHOICES</td>
<td>1-888-747-8955</td>
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<td>BlueCare PlusSM</td>
<td>1-800-299-1407</td>
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<tr>
<td>BlueChoiceSM</td>
<td>1-866-781-3489</td>
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<tr>
<td>SelectCommunity</td>
<td>1-800-292-8196</td>
<td>Available Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<td>BlueCard</td>
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<td>Benefits &amp; Eligibility</td>
<td>1-800-676-2583</td>
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<tr>
<td>All other inquiries</td>
<td>1-800-705-0391</td>
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<tr>
<td>Monday–Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td>BlueAdvantage</td>
<td>1-800-841-7434</td>
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<td>BlueAdvantage Group</td>
<td>1-800-818-0962</td>
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<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td>eBusiness Technical Support</td>
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<tr>
<td>Phone: Select Option 2 at</td>
<td>(423) 535-5717</td>
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<tr>
<td>Email:</td>
<td><a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
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