Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/medical-policy-manual/index.page under the “Upcoming Medical Policies” link.

Effective Feb. 22, 2017

• Varicose Vein Treatments for the Lower Extremities (Revision)

Effective April 13, 2017

• Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Individuals with Non-Small Cell Lung Cancer (NSCLC) (Revision)
• Hematopoietic Stem Cell Transplantation for Miscellaneous Solid Tumors in Adults (Revision)
• Positron Emission Tomography (PET) for Oncologic Applications (Revision)

Implantable Ventricular Assist Devices and Total Artificial Hearts

BlueCross will continue to address total artificial hearts within its current medical policy; however, the implantable ventricular assist devices portion of this medical policy will be archived (i.e., no longer active) as the company transitions to MCG- Formerly Milliman Care Guidelines to address ventricular assist devices. This action will take place in April/May of 2017. Link to policy

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

All Blue Workshops

The dates for the 2017 All Blue provider workshops are April 5 in Chattanooga, April 18 in Johnson City and April 19 in Knoxville. We will announce more details and dates for Memphis, Jackson and Nashville on our website soon!
New Process Aims to Increase Payment Accuracy, Reduce Administrative Burden on Providers

BlueCross will begin a new process that will help reduce the administrative burden put on providers when we recover overpayments on your patients’ claims. Beginning in April, our claims payment process for all lines of business, including BlueCare Tennessee and BlueAdvantage (PPO), will more carefully analyze claims with the goal of delivering payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability.

This process will not reduce provider reimbursement rates, your patients’ benefits or the speed at which we pay your claims. In fact, this addition to our system will increase efficiency and compliance with standards set by the Centers for Medicare & Medicaid Services and other governing organizations.

While this system 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.

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 requirement went into effect Jan. 1, 2017, and applies even if nurse practitioners and physician assistants are employed by a physician or group already contracted with BlueCross.

Important Notes:

- Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form.
- Once this process is complete, nurse practitioners and physician assistants must submit bills under those/their specific specialties.
- Nurse practitioners and physician assistants are not permitted to bill as a delegated service and claims will be denied beginning May 1, 2017.
- Claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants will be considered out of network beginning May 1, 2017.

Please contact your local Provider Relations Consultant (PRC) with any questions. If you don’t know who your PRC is, visit http://www.bcbst.com/providers/mycontact/ to locate your BlueCross contact.

Changes to Moderate Conscious Sedation Codes

In keeping with current coding standards BlueCross is making changes to payment rates for codes related to Moderate Conscious Sedation. Please review this important information for each line of business.

BlueCross’ changes are in response to the Centers for Medicare & Medicaid Services (CMS) modification of procedure codes and corresponding payment rates for the Medicare Physician Fee Schedule, based on the American Medical Association’s (AMA’s) CPT® coding changes for Moderate Conscious Sedation services.

- CMS reduced the Relative Value Units (RVUs) for procedure codes listed in the Appendix G Summary of CPT® Codes that include Moderate Conscious Sedation last published in the 2016 AMA CPT® Manual.
- CMS changed the RVUs for certain codes included in Appendix G that now correspond with the seven new Moderate Conscious Sedation procedure codes, for which payment may be made.

For more information see our website at www.bcbst.com/sedationcode.
Reminder: Billing Assistant-at-Surgery Services for Commercial Plans

Assistant-at-surgery services provided by a physician assistant (PA) or nurse practitioner (NP) should include the Level II HCPCS AS modifier. Eligible assistant-at-surgery services provided by a PA or NP credentialed as an assistant-at-surgery will be based on the lesser of total covered charges or 13.6 percent (i.e., 85 percent of 16 percent) of the maximum allowable fee schedule amount. The maximum allowable for assistant-at-surgery services provided by a physician assistant who is not credentialed as an assistant at surgery will be $0.00.

Assistant-at-surgery services by a PA or NP must be billed using the unique provider number and/or NPI. Refer to the Billing and Reimbursement section of the BlueCross BlueShield of Tennessee Provider Administration Manual for more information.

Note: Assistant-at-surgery charges will only be reimbursed if filed with the appropriate taxonomy code.

Reminder: All-Inclusive Reimbursement for MRI/MRA/CT Scans

Reimbursement for MRI/MRA/CT scans is an all-inclusive rate that includes pharmacy, anesthesia, and/or supplies used in conjunction with these radiology services for Commercial and Medicare Advantage plans. Supplies incidental to radiology (RC 0621) and supplies incidental to other diagnostic services (RC 0622) should be filed accordingly with the appropriate HCPCS/CPT® code(s), but will not be reimbursed in addition to the MRI/MRA/CT scan payment.

For more information see the Billing and Reimbursement section of the BlueCross BlueShield of Tennessee Provider Administration Manual.

BlueCare Tennessee

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

Encourage Mothers to Get Postpartum Care

The American Congress of Obstetricians and Gynecologists (ACOG) recommend that all women undergo a comprehensive postpartum visit within the first six weeks (42 days) after giving birth.

For some new moms, self-care is not a priority. If postpartum care during maternity visits isn’t part of your normal discussion, please let your patients know it’s an important part of their health care. This visit should include a complete assessment of the mother’s physical and emotional health, a plan for continued well-woman care, as well as a discussion regarding contraception.

Note: The CoverKids program wants to encourage providers to schedule the mother’s postpartum visit within 21-56 days of delivery. This service is part of the CMS Quality Core measures for CHIP.

Immunizations Save Lives

Children turning 2 years old often miss several vaccines needed to keep them healthy. The three most common vaccines missing from most 2-year-olds’ immunization records are influenza, rotavirus and hepatitis B.

Influenza – A child needs two shots before age 2, the first of which is recommended after the child is 6 months old. Note: Flu mist is no longer recommended by the Centers for Disease Control and Prevention (CDC).

Rotavirus – Administer the two- or three-dose series beginning 42 days after birth.

Hepatitis B Shot – Three doses are required before the child turns two, one of which can be the dose given in the hospital after birth.

Reimbursement for Vaccines Given in Your Office

You can receive a payment for the administration of vaccines under the federal Vaccines for Children (VFC) program. To receive this reimbursement, the claim must be filed with the administration and vaccine procedure codes for each vaccine. The reimbursement applies to all immunizations under the VFC program. All providers are eligible to receive this reimbursement, even non-VFC providers. Information about VFC and the administrative fee reimbursement is available in the Preventive Care Section of the BlueCare Tennessee Provider Administration Manual.
Coordinating Patient Care is Key

The coordination of a patient’s care is essential for healthy outcomes. If you are a primary doctor/primary care provider (PCP), remember to ask if your patient has been seen by any other providers (specialists, urgent care, emergency room or received durable medical equipment, physical therapy services, etc.) since you last saw them. Encourage the discussion of treatment plans they have received elsewhere and request information from the other provider(s).

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

Tips for Coding Preventive Care for TennCare Kids

The Tennessee Chapter of The American Academy of Pediatrics offers free training and resources to help providers with coding preventive care services for TennCare Kids. Proper coding of all preventive care is not only practical when caring for your patients, but also helps ensure you are paid for the care you provide. Solid records maintenance also makes the process of external reviews and medical audits much easier and more effective.

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

Model of Care Training

BlueCare PlusSM offers Model of Care (MOC) training for all PCPs. The training is required annually by CMS and describes the framework for BlueCare Plus, our dual eligible special needs plan. PCPs completing the MOC training between Jan. 1 to March 31, 2017, will receive a 1 percent bonus to their base rate of reimbursement.

CHOICES Incident Examples: Proper Reporting to Adult Protective Services and BlueCare Tennessee

The reporting of incidents to Adult Protective Services (APS) is an important part of your role as a BlueCare Tennessee CHOICES provider. Any unexpected member death reported to APS should also be reported to BlueCare Tennessee as a critical incident. APS requires reporting of all incidents specifically related to abuse, neglect or exploitation.

The following are examples of incidents that ALWAYS require you to file a CHOICES critical incident report, and WOULD also require a report to APS:

- A member breaks a bone as the result of an HCBS worker transferring the member improperly.
- An HCBS worker arrives for shift and discovers the member did not receive any care from family since the last shift.
- A member reports unauthorized use of a debit card by an HCBS worker.

Submit APS reports to by phone or fax:

- Phone: 1-888-277-8366
- Fax: 1-866-294-3961

Submit CHOICES reports by email or fax:

- Email: CHOICESQuality@bcbst.com
- Fax: 1-855-292-3715

Reminder: Billing Requirements for Behavioral Health Providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering the service to BlueCare Tennessee, BlueCare Plus or CoverKids members is different than the billing provider. In the case of an agency billing for services not provided by a licensed clinician, the medical director or other supervising professional may be entered on the claim as the rendering provider.

Failure to provide this information could result in a denial or reduction in reimbursement.
Medicare Advantage

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

New Colorectal Screenings Fulfill CMS Criteria

Having regular screenings for colorectal cancer is a critical part of a healthy lifestyle for patients 50 years of age or older. Now you have more options for fulfilling the CMS requirement for providing this potentially life-saving screening for your Medicare Advantage patients.

In 2017, both a CT Colonography and a FIT-DNA test, in addition to the services traditionally accepted by CMS, will satisfy the clinical requirement if a member is eligible for a colorectal screening. The CT Colonography satisfies the screening requirement for five years, and the FIT-DNA test for three.

Please remember you must document in your patient’s chart the specific test you perform in order to get credit for the clinical service that satisfies the quality measure.

Reminder: Per HEDIS® definitions, digital rectal exams and fecal occult blood tests (FOBT) performed in the office or performed on a sample collected from a digital rectal exam, cannot be used to close the colorectal cancer gap in care.

Updated Authorization Codes for Spinal Surgery, Occupational and Physical Therapy

Several codes related to spinal surgery, occupational therapy and physical therapy have been added or removed from the authorization list for OrthoNet, our musculoskeletal vendor. The codes removed include:

- 62310
- 62311
- 62318
- 62319

Please visit the BlueCross website for a complete list of codes including any added to the prior authorization list.

You may submit authorization requests via fax to OrthoNet at 1-866-747-0587 or online via BlueAccess℠ at https://www.bcbst.com/secure/public/login.asp.

Reminder: Last Month to Get Maximum Provider Assessment Form Bonus for 2017

In 2017, physicians are again eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage℠ and BlueChoice℠ members.

Note: The CPT® code that should be used to file a PAF claim has changed. The new code, as of Jan. 1, 2017, is 96160. CPT® code 99420 is no longer valid.
BlueAdvantage and BlueChoice will continue to reimburse the service as E/M Code 96160, with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2017
- $200 for dates of service between April 1 and June 30, 2017
- $175 for dates of service between July 1 and Sept. 30, 2017
- $150 for dates of service between Oct. 1 and Dec. 31, 2017

To receive reimbursement, you must complete and submit the form electronically via BlueAccess or complete the writable Provider Assessment Form and fax to 1-877-922-2963. The form should also be included in your patient’s chart as part of his or her permanent record per guidelines set by CMS.

Reminder: Annual CAHPS Survey Includes Questions about Member Experiences with Physicians

CMS conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey every year which contains several questions directly related to the member’s experience with their doctor. The specific questions are:

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

The responses CMS receives from our Medicare Advantage members become part of BlueCross’ network contracted physician’s annual STAR quality rating score. This year, the member experience measures account for 50 percent of the total score, making these survey results very important.

For more information about the CAHPS survey, please see the Quality Care Rewards page on our website.

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member’s health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member’s condition. The MA plan follows Medicare policy. According to 42 U.S.C. §1395y(b)(2), Medicare may not pay for a beneficiary’s medical expenses when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” According to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.24(e) and (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

As with Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

Reminder: Peer-to-Peer and Re-Evaluation Process Changes

Beginning Jan. 1, 2017, BlueCross has made changes to the provider peer-to-peer and re-evaluation processes for our Medicare Advantage products per guidance received from CMS.

These processes have been updated in the Medicare Advantage section of the BlueCross BlueShield of Tennessee Provider Administration Manual.
Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. Reimbursement will not be considered for dialysis clinic claims in a given calendar year if a completed CMS-2728-U03 form is not on file with BlueCross. The initial and subsequent claims will be denied requesting you to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002


BlueCross has partnered with Magellan Healthcare National Imaging Associates (NIA) radiology benefit management program to perform authorization review for non-emergent outpatient advanced imaging and cardiac imaging services for BlueCross’ Medicare Advantage and BlueCare Plus members. Emergency room, observation and inpatient imaging procedures do not require prior authorization. If an urgent/emergent clinical situation exists outside of a hospital emergency room, please call 1-888-258-3864.

Procedures requiring prior authorization:
- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging
- Muga Scan
- Stress Echocardiogram

You may request prior authorization from Magellan by logging in to BlueAccess at http://www.bcbs.com and clicking “Submission” by the section for Medicare Advantage or BlueCare Plus, or by calling 1-888-258-3864. Magellan does not accept authorization requests via fax.

Reminder: 2017 Member Incentive Information Now Available Online

An annual wellness exam is an important first step to a healthy 2017, and it can qualify your patients for wellness rewards from BlueCross. It is also a good time for you to complete a Provider Assessment Form and get extra reimbursement. You can help your BlueCross Medicare Advantage patients earn rewards for their healthy living by scheduling a check-up early in the year.

In 2017, BlueCross Medicare Advantage members will need to take two steps to be eligible for rewards:

1. Opt in to the rewards program with OnLife Health, our new rewards partner. Each member received a welcome kit in January detailing opt-in instructions.
2. File an annual wellness claim so members can receive any additional rewards in 2017 for other needed screenings. File annual wellness exams with CPT® 96160, 99385, 99386, 99387, 99395, 99396, 99397, or HCPCS GO402, GO438, GO439, plus appropriate E/M codes for the visit.

The Member Wellness Incentive FAQ is now available on the Quality Care Rewards website with more information about the member program.

Note: The annual wellness exam is a calendar-year benefit, which means each member is entitled to one in 2016, one in 2017, etc. regardless of the number of days between each exam. It is not necessary to wait 365 days between exams.

Quality Care Rewards

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

Deadline for Commercial Pay for Gaps Claim Submission

The 2016 Commercial Pay for Gaps program is coming to a close. The deadline has passed for completing attestations, but claims can be submitted and processed by March 31, 2017, to document the clinical service that satisfies the quality measure.
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.

*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 http://www.bcbst.com/providers/newsletters/index.page

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HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

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

Provider Service Lines

Featuring “Touchtone” or “Voice Activated” Responses

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

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

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

Commercial Service Lines 1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 p.m. (ET)

BlueCare 1-800-468-9736

TennCareSelect 1-800-276-1978

CoverKids 1-800-924-7141

CHOICES 1-888-747-8955

ECF CHOICES 1-888-747-8955

BlueCare PlusSM 1-800-299-1407

BlueChoiceSM 1-866-781-3489

SelectCommunity 1-800-292-8196

Available Monday-Friday, 8 a.m. to 6 p.m. (ET)

BlueCard

Benefits & Eligibility 1-800-676-2583

All other inquiries 1-800-705-0391

Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434

BlueAdvantage Group 1-800-818-0962

Monday-Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support

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

Email: eBusiness_service@bcbst.com

Monday-Thursday, 8 a.m. to 6 p.m. (ET)

Friday, 9 a.m. to 6 p.m. (ET)