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:

Treatement of Patients with Panic Disorder, Second Edition


Treatment of Patients with Major Depressive Disorder, Third Edition

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/PIS0890856709621821.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℠ /TennCareSelect 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 BlueAccessSM

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.

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.bcbs.com and http://bluecare.bcbs.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.

**BlueCare Tennessee**

**ADMINISTRATIVE**

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

**Diabetic Retinal Exams**

Diabetic Retinal Exams are a covered
medical benefit for TennCareSM
members including BlueCare PlusSM
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, TennCareSelect 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/TennCareSelect 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/TennCareSelect 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, TennCareSelect, 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.

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

BlueCross BlueShield of Tennessee, Inc. is an Independent Licensee of the BlueCross BlueShield Association
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 BlueAdvantageSM HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM 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 (Contour®, 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)SM, BlueChoice (HMO)SM 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...
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.

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.

†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 SM 1-800-299-1407
BlueChoice SM 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)