



November 2015

Blue⁺ealertSM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

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

Effective Dec. 12, 2015

- Amniotic Membrane and Amniotic Fluid Injections (New)
- Electronic Brachytherapy for Non-melanoma Skin Cancer (New)

Effective Dec. 16, 2015

- BRCA1, BRCA2 and PALB2 Testing for Breast, Ovarian and Other Cancers (New)

Note: These effective dates also apply to BlueCare /TennCareSelect pending State approval.

New Prior Authorization Needed for CPT® Codes 64581 and 64590*

Starting Jan. 1, 2016, prior authorization will be required for codes 64581 and 64590 related to neurostimulator implantation for occipital nerve stimulation as well as fecal and urinary incontinence. Previously, medical records were reviewed by a nurse after claims were submitted. If the claims did not meet the appropriate guidelines, they were denied and the provider was financially liable. This new prior

authorization requirement will reduce claims issues related to these codes. If you have questions, please contact the Provider Service Line†.

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Dental Predetermination

We are pleased to announce that we have recently updated the form required to submit a dental predetermination request to us. These revisions were made to provide additional information in regard to any charges that are disallowed. The updated form will provide you with an improved estimation of patient responsibility and provider contractual write off. Please note this does not apply to CoverKids or BlueCare Tennessee lines of business.

GeoBlue® offers BlueCross coverage for International Members

GeoBlue, in partnership with BlueCross BlueShield of Michigan, began serving more than 3,000 internationally based General Motors members on Jan. 1, 2015. Many of these members are enrolled in a BlueCross product, have full access to the BlueCard provider network and will present the GeoBlue identification card when seeking care in the U.S.

If a member calls for an appointment and states they have GeoBlue insurance:

- Verify eligibility and benefits by calling GeoBlue Customer Service at 1-855-282-3517 or
- Go online and verify benefits through the BlueExchange BlueCard system.
- Process claims as you would any other BlueCard claim.

GeoBlue members also have BlueDental® coverage with access to dental providers who participate in the BlueCross dental network or on a per-claim basis. To verify dental benefits, call 1-877-891-3326 and submit claims through the regular dental claims process.

Reminder: Avoid Claim Denials by Following Prior Authorization Guidelines

Services rendered without obtaining authorization prior to services being rendered are considered “non-compliant.” Prior authorization reviews can be initiated by the member, designated member advocate, practitioner or facility. However, **it is ultimately the facility and practitioner’s responsibility to contact BlueCross to request an authorization.**

When a request for authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross’s non-payment is applicable to both facility and practitioner rendering care. The member is held harmless if the member is eligible at the time services are rendered and the covered services are received from a network provider.

When prior authorization is required, providers must obtain authorization prior to scheduled services and within 24 hours or the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. **BlueCross members cannot**

be billed for services denied due to non-compliance by the provider.

Help Your Patients Overcome Depression

Major depression is often excessively misdiagnosed and can lead to over prescribing of medications. The American Psychiatric Association advises that physicians only use a diagnosis of major depression if their patient has experienced at least five of the nine symptoms listed below for two weeks or more, almost every day or if their symptoms are a change from their prior level of function. Consider using alternative diagnoses for your patient’s depression, such as seasonal affective disorder, bipolar disorder, situational depression or atypical depression, for your patients who do not ascribe to these symptoms.

- Depressed or irritable mood for children and adolescents
- A significantly reduced level of interest or pleasure in most or all activities
- A considerable loss or gain of weight when not dieting and/or an increase or decrease in appetite
- Difficulty falling or staying asleep or sleeping more than usual
- Agitated or slowed down behavior that others can observe
- Feelings of fatigue or diminished energy
- Thoughts of worthlessness or extreme guilt
- Reduced ability to think, concentrate or make decisions
- Frequent thoughts of death or suicide or suicide attempt

Members ages 18 or older that have recently been diagnosed with major depression and are currently being treated with antidepressant medications for major depression should be encouraged to remain on their prescribed medications for at least 84 days when acute treatment is administered and for at least 180 days during periods of continuation treatment. The biggest barrier to successful treatment of depression is medication non-adherence. Members who receive extra support from their provider, such as counseling or written materials, are typically more compliant.

Formulary Changes for Fourth Quarter

Effective Oct. 1, 2015:

- Tobradex ointment, Tobradex **ST** and Zylet moved to Tier 2 of BlueCross’ Prescription Drug List.
- Bunavil **QL** moved to Tier 3 of BlueCross’ Prescription Drug List.
- Treximet will be excluded from BlueCross’ Prescription Drug List.

ST – Requires step therapy
QL – Quantity limits apply

FDA Investigating Tramadol

The Food and Drug Administration is investigating the use of the pain medicine tramadol in children ages 17 years and younger because of the rare but serious risk of slowed or difficult breathing. This risk may be increased in children treated with tramadol for pain after surgery to remove their tonsils and/or adenoids.

Tramadol is not FDA-approved for use in children, however, data shows it is being used “off-label” in the pediatric population. The agency is asking health care providers to consider prescribing non-tramadol pain relievers for children as it completes its investigation.

ICD-10 Compliant Updates

As of Oct. 1, 2015, all providers must comply with ICD-10 coding requirements established by the federal government. Please take note of these important updates:

- Providers are required to submit ICD-10 codes for dates of service Oct. 1, 2015, and beyond.
- Retrospective prior authorization requests for dates of service before Oct. 1, 2015, should be submitted with applicable ICD-9 codes.
- Prior authorization requests that have already been approved that span the Oct. 1 compliance date will not need to be resubmitted.
- Updated information is available on <http://www.bcbst.com/providers/icd-10.page>.

Reminder: Flu Season Coming Soon

It is important that you take the appropriate preventive care measures to protect your patients during this time of year. Please educate all patients or parents of children older than 6 months of age on the importance of getting the yearly flu vaccine.

Because patients 65 and older are at greater risk for serious complications from the flu, they have the option to receive the standard vaccine or a newer higher-dose vaccine. The higher-dose vaccine is 24 percent more effective for people in this age group, according to *The New England Journal of Medicine*.

Please make every effort to schedule your high-risk patients for a flu shot as early as possible to prepare for the flu season.

The following influenza immunization and reimbursement guidelines apply to BlueCross.

Commercial

- **Vaccine and administration**
 The influenza vaccine, including intradermal and nasal-administered vaccines, is a covered benefit if offered under the member’s health care plan. Verify coverage by calling our Provider Service Line†.

BlueCare or TennCareSelect

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

Note: The intranasal-administered quadravalent, preservative-free vaccine is available under the Tennessee Department of Health’s Vaccines for Children (VFC) Program for children ages 2 through 18.

For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

- **Intradermal-administered vaccine**
 (recommended for persons ages 18 through 64)
 Covered benefit

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

CoverKids

- *Vaccine and administration, Intradermal and nasal-administered vaccines*
Covered benefit

Medicare Advantage

- *Intradermal and nasal-administered vaccines*
Covered benefit

Behavioral Health Network Update

Effective Jan. 1, 2016, BlueCross will assume responsibility for contracting and credentialing behavioral health providers for Medicare Advantage and Commercial lines of business.

Behavioral health providers should have already received necessary contracting documents for participation in the BlueCross behavioral health network.

Under the terms of the provider contract with Magellan, behavioral health providers who are not contracted and credentialed directly with BlueCross by Jan. 1, 2016, are required to continue seeing BlueCross members for 120 days following the Jan. 1 effective date or until members are safely transitioned to participating providers, if less than 120 days. Non-participating providers will be paid at their Magellan contracted rates until the 120 day cut off, when reimbursements will adhere to non-participating rates and increased member payment liability. Visit <http://www.bcbst.com/providers/Behavioral-Health-Network.page> or contact your behavioral health network manager with any questions.

Reminder: High-Tech Imaging Program Changes

On Oct. 1, 2015, you noticed a few changes to the process for submitting prior authorization requests for High-Tech Imaging Services. Beginning on this date, all online prior authorizations must be submitted via BlueAccessSM at www.bcbst.com/blueaccess. You can also request prior authorization for these

services by calling 1-888-693-3211 or by faxing to 1-888-693-3210. Fax forms and the code list are available at <http://www.bcbst.com/providers/hti/>.

All reference materials including a reference guide with step-by-step instructions on the new web submissions process are located within BlueAccess.

Please note that during the timeframe of Oct. 1 to Dec. 31, 2015, these submissions will be limited to one CPT[®] code per authorization number which will increase your volume of correspondence during this time.

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Reminder: Musculoskeletal Management Program Change

Beginning Nov. 1, 2015, prior authorizations for Musculoskeletal (MSK) services can be submitted online via BlueAccess at www.bcbst.com/blueaccess, via phone at 1-866-747-0586 or via fax at 1-866-747-0587. Beginning on this date, BlueCross will be partnering with OrthoNet who will administer MSK management services for Commercial and Medicare Advantage members.

You will find all reference materials, including a code list, fax forms and reference guide with step-by-step instructions, on the new web submissions process located within BlueAccess. Fax forms and the code list can also be found at <http://www.bcbst.com/providers/utilization-management-resources.page>

Marketplace Open Enrollment Begins Nov. 1

Open enrollment on the Health Insurance Marketplace runs from Nov. 1, 2015 through Jan. 31, 2016. Tennesseans seeking health insurance can learn more through local community meetings and special events. More information is available on our website.

Disease Management Program Transitioning to New Care Model

New for 2016, BlueCross will transition to a new care model integrating care management, disease management and wellness. More details on our holistic approach for members will be coming soon.

BlueCare Tennessee

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

Improving Childhood and Adolescent Immunizations is our Top Priority.

The Vaccines for Children Program (VFC) will benefit members and your practice, excluding CoverKids lines of business.

Why should I join VFC?

- Being a VFC provider is a sound investment in your practice and in your patients.
- VFC reduces your up-front costs because you will not have to pay to purchase vaccines for VFC-eligible children.
- You can charge an administrative fee to offset your costs of doing business.
- Your patients benefit since they will not go elsewhere for the vaccines they need and there is no charge to you, the provider.

Who is Eligible?

- Medicaid eligible
- Uninsured
- American Indian or Alaska Native
- Underinsured: Underinsured means your patient has health insurance, but it won't cover the vaccine(s)
- **VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed.**

The VCF Program, Patient Eligibility Screening form is available on www.tn.gov/

How do I become a VFC provider?

Contact a VFC Quality Coordinator at (615) 741-7507 to request a Provider Enrollment Package. More information about becoming a VFC Provider is available on the [CDC website](#).

Correct Coding of VCF is Critical

- It is very important that coding of vaccines for children is accurate. Please use the correct CPT® codes along with the vaccine procedure code.
- Promote the importance of vaccinations that protect our children from serious but preventable illnesses.

Source:

<http://www.cdc.gov/vaccines/programs/vfc/providers/questions/qa-join.html>

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Updated Physician Quality Information Available

The bi-annual update to Physician Quality Information will be available on Nov. 10, 2015, 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 member level to help improve their ratings. 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 on our company website for our members.

DME & Home Health Requests Move Solely to BlueAccess Jan. 1

BlueAccess offers you the ability to serve members by making requests for Durable Medical Equipment (DME) and home health services at any time day or night through BlueAccess, our secure provider portal. Beginning Jan. 1, 2016, BlueAccess will be the required method to submit DME and home health service requests.

BlueAccess can reduce time on the phone and eliminate the need to fax requests. You can also use BlueAccess to find benefit information, claim status, claim estimates and many other self-service resources. If you would like your office staff to learn

more about using our online services, our eBusiness staff is available to provide on-site training. For more information, call eBusiness Technical Support†.

Filing Observation Charges with Outpatient Surgery

Outpatient surgery all-inclusive rates include up to six hours of post-surgery observation time. Additional observation charges (revenue code 0762) may not be billed unless the member’s time in observation is longer than six hours. This charge will be allowed if the surgery claim also includes a claim for the observation room charge.

When multiple surgeries are filed on the same claim form with observation, the highest level code is reimbursed at 100 percent of the outpatient surgery fee schedule. Each additional surgical code is reimbursed at 50 percent of the outpatient surgery fee schedule. The highest level code is not determined by the greatest total charge, but by the highest allowed.

BlueCare Tennessee and CoverKids Payment Error Rate Measurement Program

The Centers for Medicare & Medicaid Services (CMS) will be performing an audit of BlueCare Tennessee and CoverKids providers’ medical records as part of the Payment Error Rate Measurement (PERM) program. The PERM program measures improper payments made by Medicaid and the Children’s Health Insurance Program (CHIP/CoverKids). CMS will review a random sample of payments with original dates of payment from Oct. 1, 2015 through Sept. 30, 2016. Medical record requests for the PERM review will begin in first quarter 2016.

Tennessee Health Care Innovation Initiative

Tennessee Health Care Innovation Initiative (THCII) November reports will be available by Nov. 7. To review your November THCII reports, please log into BlueAccess at www.bcbst.com by clicking

the Log In/Register link at the top right corner of the page. If you have not registered for BlueAccess, the link will guide you through registration.

Wave 1 BlueCare, TennCareSelect and CoverKids Episode of Care reports for Asthma Exacerbation, Perinatal care and Total Joint Replacement (hip and knee) are currently in the Performance Period which runs from Jan.1 to Dec. 31, 2015. Gain or Risk Sharing will be applied to providers after the 2015 calendar year has ended.

Wave 2 Episode of Care reports for Acute COPD Exacerbation, Screening and Surveillance Colonoscopy, Cholecystectomy, and Acute and Non-Acute PCI are Preview Reports intended to provide information regarding your performance against quality and efficiency measures. The November reports also include thresholds for these Episodes of Care. BlueCare, TennCareSelect and CoverKids Wave 2 Episodes of Care will move into the Performance Period on Jan. 1, 2016 and will reflect all Episodes of Care which end in the 2016 calendar year, with Gain or Risk Sharing applied in 2017.

The Wave 2 THCII BlueCare Contract Amendments will be mailed to BlueCare contracted acute care facilities, cardiologists, gastroenterologists, general surgeons and colon and rectal surgeons in early November 2015. If you are a BlueCare contracted provider in one of these specialties and do not receive an amendment, please contact your Network Manager. If you do not know who your network manager is, you can find them by using the My BlueCross Contact tool at www.bcbst.com/providers/mycontact/?nav=alltoaction.

For more information about the THCII Episodes of Care, visit the State of Tennessee website at www.tn.gov/hcfa/section/strategic-planning-and-innovation-group

National Drug Code Claim Filing

The Deficit Reduction Act (DRA) of 2005 required states to collect rebates on provider-administered drugs. Providers must include the National Drug Code (NDC) of the drug(s) administered, along

with the correct quantity and unit, for all provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format and facilities filing outpatient UB claims on a CMS-1450 claim form or submitted electronically in the ANSI-837 Institutional version format with exceptions of vaccines and inpatient claims.

All other Providers should submit claims with the NDC information for "J" codes only. Any missing element may result in the claim being returned unprocessed. Please refer to the Provider Administration Manual for all data elements required. http://www.bcbst.com/providers/manuals/BCT_PAM.pdf

Provider Satisfaction Survey

We are listening and your input is valuable to us. An online Provider Satisfaction Survey is now on the BlueCare PlusSM website at: https://www.bcbst.com/forms/anon/org/app/9c4d4280-dc57-45e0-8dd9-f6a97e09de50/launch/index.html?form=F_Form1. The survey offers providers another opportunity to submit suggestions, ideas and opportunities and to rate your experience with BlueCare Plus. Visit us today!

Medicare Advantage

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

Notification Approval for Home Health Allows up to Seven Visits in One Month

To allow time for home health agencies to complete all documentation required by the Centers for Medicare & Medicaid Services (CMS) without a delay in patient care, BlueAdvantage allows up to a maximum of seven visits over a one-month period when home health requests are submitted for notification in a timely manner. This notification approval will allow for the initial evaluation and treatment plus six additional visits without any care

management review. If more than seven visits are needed, or the timeframe exceeds one month, additional medical management review will be necessary with required clinical documentation to support the request.

Oxygen Authorizations Now Limited to a Calendar Year

Beginning Jan. 1, 2016, BlueAdvantage members will no longer receive lifetime, or multi-year approval for oxygen equipment rentals.

Because plan benefits can change at the beginning of each calendar year, a new authorization will be required at the beginning of the new year and will be valid for a maximum of 12 months.

If an authorization is approved during the year, it will remain in effect through the end of the calendar year and need to be re-certified for continued approval in the new year.

The annual request will need a certification of medical necessity completed by the requesting physician and dated within two months of the request. Please remember, oxygen rental is only covered for 36 months in accordance with CMS regulations.

Reminder: Refer Lab Work to a Participating Provider

Providers are reminded to use in-network options for all laboratory services requested for BlueAdvantage members, unless the specific laboratory test is not available from a participating lab provider. This includes genetic testing that is covered by Medicare. If the provider refers testing to a non-participating lab and the test was available through a participating provider, the cost may be the provider's, not the member's, responsibility through reconciliation.

Diabetes Measures that Can Affect Your Quality Score

November is American Diabetes Month and a good opportunity to take a few minutes to make sure you are aware of the various quality measures the Centers for Medicare & Medicaid Services (CMS) has in place that can affect your quality score.

According to CMS, everyone between the ages of 18 and 75 with a diagnosis of diabetes should receive the following each year:

- HbA1c blood test
- Diabetic retinal eye exam
- Kidney function screening

BlueAdvantage and BlueChoice members should be reminded they may be eligible for a reward from BlueCross for each of these services they complete.

We understand sometimes it can be hard to get elderly members into your office. That's why we offer in-home services for each of these diabetic screenings. Our health partners can mail kits to your diabetic patients for HbA1c, kidney function screenings and schedule in-home eye exams, as well. And if you are the member's attributed provider, you get the quality credit for the service.

Schedule a Bone Density Test for Blue Advantage members within Six Months of a Fracture

As you know, often the first symptom of osteoporosis in an older person is a broken bone. Because seniors, especially senior women, are susceptible to osteoporosis, it is important to schedule a bone density test for those who have suffered a fracture.

Best Practices

- Encourage your patients to include adequate amounts of calcium in their diets.

- Recommend regular weight-bearing exercise like walking or dancing.
- Talk to your patients about risk factors for falls.
- Measure height annually.
- Perform a bone mineral density test on women 65 and older and men 70 and older.
- Prescribe appropriate medication for patients with a documented hip or vertebral fracture.

Reminder: BlueAdvantage In-Home Test Kits Available for Homebound Members

BlueCross now offers in-home test kits for three of the most common annual screenings. With a simple phone call, our partner, Home Access can mail our BlueAdvantage and BlueChoice members an in-home test kit for:

- Fecal occult blood screening for colorectal cancer
- Kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

Following the instructions, the member then mails the kit back to the vendor for lab testing and the written results are then sent to the member and you. The screenings are at no cost to the member and count toward the member’s quality rewards incentive for attributed members.

For more information on how to order an in-home test kit for members, contact Julie Mason at (423) 535-6827.

At-Home Test Kits Now available for Commercial members too!

Colon cancer is the second leading cause for cancer deaths in America. It is also one of the most preventable. To help manage chronic health issues and encourage members to receive colorectal cancer screenings, BlueCross will provide at-home test kits to screen for the disease. Fecal immunochemical test (FIT) kits are being offered through the Colorectal At-Home FIT Kit Program to commercial members ages 50 to 75 that have not received this test based on our medical claims data.

Qualifying commercial members received a program introduction letter and a phone call in September inviting them to officially enroll in the FIT kit program. Those enrolled in the program will receive an at-home FIT kit (collection kit) in the mail. The kit includes instructions, supplies needed to complete the test and a postage-paid return envelope. Providers can also enroll qualifying BlueCross Commercial members.

Members’ and primary care practitioners will receive the lab results we then encourage you to initiate follow-up with members whose test results are positive or inconclusive.

BlueCross BlueShield of Tennessee offices will be closed November 26 and 27, 2015 in observance of Thanksgiving.



Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare.Select 1-800-263-5479.

العربية (Arabic); Bosanski (Bosnian); كوردی – بادینانی (Kurdish-Badinani); کوردی – سۆرانی (Kurdish-Sorani); Soomaali (Somali); Người Việt (Vietnamese); Español (Spanish) call 1-800-758-1638.

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare.Select to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

* These changes will be included in the appropriate 4Q 2015 provider administration manual update.

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

†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 just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the [CAQH Proview™](http://www.caqh.com/CAQH_Proview) website.

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/CoverKids 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

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–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)