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.bcbs.com/providers/mpm_s.html under the “Upcoming Medical Policies” link.

Effective May 14, 2016

- Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening - (New)
- Chromosomal Microarray Testing for the Evaluation of Early Pregnancy Loss and Intrauterine Fetal Demise (Revision)

Auditory and Visual Evoked Potentials – This medical policy will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued.

http://www.bcbs.com/mpmanual/!SSL!/WebHelp/Somatosensory_Evoked_Potentials_Non-intraoperative.htm

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

Changes to Prior Authorization Requirements for High Tech Imaging

Effective immediately, the following codes require prior authorization when providing high tech imaging services for pain management:

Codes: 74712, 74713, 78264, 78265, 78266, G0297

Prior to submitting prior authorization requests for high tech imaging services, please verify member benefits and eligibility through BlueAccessSM, the secure area of our website or by calling the BlueCross Provider Service Line†.

Prior authorization requests can be submitted via fax to 1-888-693-3210 or through BlueAccess. When submitting requests online, the high tech imaging code must be the primary code.

Reminder: Electronic Claims Submission

As of April 1, 2016, network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office’s transition or any barriers that may prevent you from filing electronic claims.

Reminder: Be Aware of Member Rights and Responsibilities

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

BlueCross BlueShield of Tennessee, Inc. is an Independent Licensee of the BlueCross BlueShield Association

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

CPT® is a registered trademark of the American Medical Association
Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and BlueCare Tennessee Provider Administration Manuals, which are available online at www.bcbst.com and http://bluecare.bcbst.com.

BlueAccess Enhancements Ease Prior Authorization Process

You may now send photos in PDF format when submitting outpatient prior authorization requests via BlueAccess for blepharoplasty and varicose vein procedures for our commercial members. Another new capability in BlueAccess is prior authorization for commercial outpatient therapy. This means less time on the phone and elimination of fax requests.

If you would like your office staff to learn more about using our online services, our eBusiness staff can provide on-site training. For more information, email eBusiness_service@bcbst.com.

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Effective immediately, the following prior authorization codes have been updated for Commercial plans.

New codes that require prior authorization for pain management:
22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22849, C1820

Deleted codes that are no longer used for pain management:
S2360, S2361

Revised code for Generator, neurostimulator (implantable), non-high-frequency w/rechargeable battery and charging system: C1820

Prior to submitting prior authorization to the Musculoskeletal Program (administered by Orthonet), please verify member benefits and eligibility through BlueAccess or by contacting the BlueCross Provider Service Line.

Prior authorization requests can be submitted via fax to 1-800-747-0587 or through BlueAccess, our secure area on www.bcbst.com. When submitted via the web, musculoskeletal must be the primary code.

New Online Behavioral Health Toolkit

New tools and resources to help you identify, assess, treat, and refer patients with behavioral health disorders are a click away. The BlueCross Behavioral Health Toolkit gives you easy access to screening tools for a range of conditions, including ADHD, substance use disorder, anxiety and more. The website also provides links to several training resources. An updated section on delivering evidence-based health care also offers resources for providing care in accordance with HEDIS® standards, as well as information you can download for your patients. Send your suggestions for new tools and resources to GM_PCP_BH_Toolkit@bcbst.com.

Have a question about medications, want information about local resources or need a referral for behavioral health services? Speak with one of our medical directors, who are available through our Behavioral Health Consultation and Referral Line (1-800-367-3403) from 9 a.m. to 5 p.m. (ET), Monday through Friday. Learn more in the Behavioral Health Toolkit.

UPDATE: CPT® Code 92250 Clarification

CPT® Code 92250 for Fundus Photography is not typically covered under vision plans insured or administered by BlueCross. However, most commercial BlueCross medical plans cover CPT® code 92250 when medically necessary, subject to member cost share. When filed with various diabetic diagnosis codes, preventive benefits apply; in most plans members will not have any cost share. A list of diabetic ICD-10 diagnosis codes is available on the provider page of our website www.bcbst.com/providers.

BlueCare Tennessee

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

Reminder: TennCare Kids Check-Ups

When a child visits your office for an EPSDT/TennCare Kids exam, be certain the examination includes these key elements and screenings:

- Comprehensive Health (Physical and Mental) and Developmental History
  - Initial and Interval History
  - Developmental/Behavioral Assessment
- Comprehensive Unclothed Physical Exam
- Vision Screening
- Hearing Screening
- Laboratory Tests
- Immunizations
- Health Education/Anticipatory Guidance
If the child is uncooperative or the examination was refused, be sure to include this information in the medical record.

For more information, as well as required medical record documentation criteria, please see the Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual.

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**Tennessee Health Care Innovation Initiative (THCII) Reporting Notification**

Starting Jan. 1, 2015, BlueCross added Medicaid members in the Tennessee middle region. These members have been added to episode reporting as of the February 2016 reports.

As a result, some providers may have seen BlueCare reports for the first time in February or may have noticed an increase in the number of episodes on their BlueCare reports. This potential increase would apply to all episodes with the exception of perinatal.

Due to the extended pre-trigger window for the perinatal wave, we determined not to include Tennessee middle region perinatal episodes since these episodes will be missing data for any services rendered prior to 2015.

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**Closer Review of Reimbursement for Neonatal Services Begins in April**

The Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities set standards for neonatal intensive care units (NICUs) in April 2014. The guidelines state that babies born with certain life-threatening conditions at a standard birth facility should be transferred to the nearest NICU. The facility should code the claim for the care provided and note the baby was transferred to a NICU. Even though these guidelines were established two years ago, the related reimbursement levels have not been enforced. Babies born in distress are often treated at the same standard birth center where they were born and these facilities are reimbursed for NICU-level care.

If your birth facility does not meet the NICU standards in the Tennessee Perinatal Care System Guidelines, please make sure your claims do not include codes for NICU-level care. All claims are subject to a post-payment audit. Payments for claims that do not comply with Tennessee Perinatal Care Guidelines will be recovered.

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**Temporary CoverKids Member ID Cards**

Be aware that beginning in April your patients in the CoverKids plan may present a temporary paper member ID card. The temporary card carries some benefit changes and may require different handling on your part. A permanent card will be issued to these members in July.

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**TennCare Changes PDL Effective April 1**

The Preferred Drug List (PDL) for TennCare has changed effective Apr. 1, 2016. The new PDL is available on the Magellan Health Services Portal at https://tenncare.magellanhealth.com. If you have TennCare patients taking medications that are on the non-preferred drug list, please inform them that switching to preferred drugs will decrease delays in receiving their medicines.

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**Quest Laboratory Exclusion List Update**

The Quest laboratory exclusion list has been updated to reflect the following changes effective Jan. 1, 2016:

- Added Code G0477 - Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, capable of being read by direct optical observation only

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**Update: Medicaid Requirements for Home Health Services, Durable Medical Equipment * **

Effective immediately, the Centers for Medicare & Medicaid Services (CMS) has issued a final ruling that requires providers to document face-to-face encounters with Medicaid beneficiaries for authorization of home health services, as well as medical supplies, equipment and appliances, within certain timeframes.

Providers are not required to submit documentation of face-to-face visits to BlueCross.

Please refer to the following information and updated requirements for these services:

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**Home Health Services:**

- Providers must document face-to-face visits with members for the primary reasons home health services were deemed necessary.
- Visits must have occurred any time from 90 days before to 30 days after home health services were ordered.
Medical Supplies, Equipment and Appliances:
- Providers must document face-to-face visits with members for the primary reason supplies, equipment or appliances were deemed necessary.
- Visits must have occurred no more than 6 months prior to the order of supplies, equipment or appliances.

Telehealth visits are considered as face-to-face visits.

For more information about the requirement to document face-to-face encounters see the CMS website.

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

Members Auto-Enrolled in SilverSneakers® Gym Membership

It’s no secret that remaining physically active is an important part of longevity and quality of life for senior citizens. That’s why BlueCross includes a SilverSneakers membership with every BlueAdvantage and BlueChoiceSM health plan we offer.

SilverSneakers provides access to hundreds of fitness facilities across Tennessee, including:
- Group exercise classes designed specifically for older adults
- A variety of fitness equipment, pools, saunas and more

Guidance and assistance from a program advisor
Access to a variety of social activities with other older adults

Members are automatically enrolled in SilverSneakers when they join BlueCross and will receive a welcome kit from SilverSneakers that outlines the benefits. Members can also check for participating facilities and class schedules online at the SilverSneakers website or by calling 1-866-584-7389.

Changes to Musculoskeletal Prior Authorization Requirements for BlueAdvantage

As of April 1, 2016, prior authorization will be required for CPT® code 27096, injection procedure for sacroiliac joint with anesthetic or steroid.

Prior authorization is also required for a CT or MRI scan associated with the following joint arthrogram procedures (23350, 27095, 27370, G0259, G0260).

Prior authorization requests can be submitted via fax to the Musculoskeletal Program (administered by Orthonet), at 1-866-747-0587 or online via BlueAccess, our secure area on www.bcbst.com. When submitted online, the musculoskeletal code must be the primary code.

Pharmacy Resources

Your BlueAdvantage and BlueChoice patients have access to a suite of tools offered by Express Scripts, Inc. (ESI), our pharmacy vendor, to help ensure they have access to the medications they need and are taking them properly.

Through ESI, BlueCross Medicare Advantage members have access to:
- A specialist pharmacist available 24/7 who can answer questions related to drug interactions and side effects, affordability, dosing and the proper use of devices like inhalers, needles and syringes.
- Mail order fulfillment that offers significant savings on prescription drugs.
- An ESI mobile app that provides instant access to personalized information related to the medications.

Guidelines for Submitting a Provider Assessment Form

In 2016, physicians are eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service as E/M Code 99420 with a maximum allowable charge of:
- $200 for dates of service between April 1 and June 30, 2016
- $175 for dates of service between July 1 and Sept. 31, 2016
- $150 for dates of service between Oct. 1 and Dec. 31, 2016

Note: The incentive will be paid for a claim billed with 99420 only one time in the calendar year for each eligible member.

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the fillable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be placed in your patient’s chart as part of his or her permanent record.
Stars Ratings Now Available; Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality Incentive Program offered providers enhanced reimbursement for closing defined gaps in care through Dec. 31, 2015. Providers may now visit BlueAccess to view their current Stars rating based on the clinical data received from their practice. After logging in to BlueAccess through [www.bcbst.com/providers](http://www.bcbst.com/providers) and accessing the Quality Rewards tool, a home screen will appear with the provider’s Stars rating. Providers can click on the “Financial” tab on the main menu to see their new fee schedules.

Stars ratings, as calculated by the previous year’s performance, will impact each provider’s current reimbursement rates, effective April 1, 2016. Providers should refer to their contract amendments for information about their base rate, the quality escalator and total earning potential.

Reminder: Medical Record Acquisition

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims be supported in medical records. BlueCross has partnered with ArroHealth (formerly known as MedSave USA) to obtain medical records on our behalf to meet this requirement.

ArroHealth will formally request medical records beginning in April. You will soon receive a letter, along with a list of requested member records and instructions on how to send medical records. Please follow the return instructions provided with your letter.

You may send the requested medical records to ArroHealth by:
- Fax: 1-866-790-4192
- Mail: ArroHealth
  Attn: MRR3 Unit – BlueCross BlueShield of Tennessee
  49 Wireless Blvd., Ste. 140
  Hauppauge, NY 11788

Note: Please mark the envelope “Confidential”.

You also may request on-site assistance by calling ArroHealth at 1-855-651-1885 or by calling your Provider Relations Consultant.

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

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted by the Centers for Medicare & Medicaid Services (CMS) every year and contains several questions directly related to a member’s experience with their doctors. 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 it?
- 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 specialists?

The responses CMS receives from our Medicare Advantage members become part of BlueCross’ network contracted physician’s annual Stars quality rating score.

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

Submit Form CMS-2728 as Mandated by CMS for ESRD Patients

For all patients entitled to Medicare benefits with end stage renal disease (ESRD), the Centers for Medicare & Medicaid Services (CMS) requires their Form 2728 to be submitted within 45 days of the start of dialysis services. Instructions are available beginning on page four of the form.

The form can be submitted electronically through CROWNWeb, a web-based data collection system mandated by CMS to enable dialysis facilities to meet the requirements for collecting administrative and clinical data by all Medicare-certified dialysis facilities.

For more information, please contact Jennifer Cross at (423) 535-5969 or email Jennifer_Cross@BCBST.com.

Reminder: Concurrent Review Will Ease Transition of Care

Effective March 1, 2016, facilities that have an approved inpatient DRG are asked to provide clinical updates starting on day six of the hospitalization. This does not change
approval of the base DRG from a reimbursement standpoint. Ongoing concurrent review at this point will assist the facility with transition of care and ensure compliance with the Centers for Medicare and Medicaid Services (CMS) expectation that inpatient care meet medical reasonableness for that level of care, at all times during the inpatient confinement.

Let’s Make a Difference Together

Every day, children are exposed to many harmful diseases without even realizing it. Without recommended vaccinations, these exposures could lead to serious illnesses. The American Academy of Pediatrics (AAP) suggests children receive the initial 10 recommended vaccinations by 23 months of age. Annual wellness visits are the best opportunity to address and administer these vaccinations.

You play an essential role in advising and guiding parents on the best clinical plan for their child. You can help ensure a high level of quality care for your patients 2 years of age and younger by:

1. Scheduling regular wellness visits, and assuring all 10 recommended immunizations are administered by 23 months of age
2. Teaching and advising parents on the importance of immunizations
3. Scheduling appointments in advance and sending reminders to avoid missed appointments and dosages
4. Submitting claims and encounter data quickly and accurately

If you provide care for BlueCare Tennessee members age 18 or younger, you are eligible to participate in the Tennessee Department of Health’s Vaccines for Children (VFC) Program which will benefit your patients and your practice. This program reduces your vaccine cost by providing free vaccine serum for BlueCare Tennessee patients 18 or younger.

For more information or to participate, email VFC Enrollment at VFC.Enrollment@tn.gov or call (615) 253-4072 or (615) 532-8501.

Schedule Follow-Up Visits for Patients with ADD/ADHD

The treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) often includes stimulants. Because these drugs can have serious side effects, quality measures include follow-up recommendations from the American Academy of Pediatric & Adolescent Psychiatry (AACAP).

Following these tips will help your practice meet quality standards:

- Schedule a follow-up visit for your patient within 30 days of the initial diagnosis. Consider scheduling the appointment while the patient is in your office.
- When writing prescriptions for new ADHD medication therapy, consider writing only a 30-day prescription. If prescription refills are written for more than 30 days remember to schedule the two additional required follow-up appointments at the time each refill is due. After the first 30-day follow-up visit, you can conduct one of the two continuation follow-up visits via phone consultation as long as it is coded appropriately when billed.
- Ask the parent what amount of medication they already have on hand if a 90-day prescription is written.
- If you prescribe a 90-day medicine supply after the initial prescription, schedule a follow-up visit before the 90-day prescription runs out. A gap of more than 120 days between follow-up visits will identify your

Encourage Your Patients to be Proactive with Their Health

A yearly preventive exam is necessary, even for your healthiest patients. Because people often live unaware of the state of their health it is important that you schedule all patients for an annual wellness exam.

Patients who complete wellness exams at the beginning of the year are more likely to continue with important tests and screenings throughout the year. At their annual wellness exam, it is important to appropriately document your patient’s body mass index (BMI) value. Offering health counseling can also help them achieve and/or maintain a healthy weight.

According to national guidelines, a healthy weight depends on:
- Body mass index (or BMI)
- Waist measurement
- Risk factors for obesity-related diseases and conditions

Annual wellness exams do not have to be scheduled 365 days apart. Thank you for partnering with us to ensure your patients receive the best quality care this year and every year!
Polycystic Ovarian Disease No Longer Exclusion for Diabetes Quality Measures

Polycystic ovarian disease is no longer considered an exclusion for the 2016 HEDIS® diabetes quality measures. Those quality measures are the HbA1c blood test, kidney function screening and retinal eye exams.

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 TennCareSelect 1-800-263-5479.

†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™ website.

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

* Changes will be included in the appropriate 2Q 2016 provider administration manual update.

Be sure your CAQH Proview™ profile is kept up to date at all times.