BlueCross BlueShield of Tennessee, Inc.
This information applies to all lines of business unless stated otherwise

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/mpm.shtml under the “Upcoming Medical Policies” link.

Effective Jan. 14, 2017:

- Digital Breast Tomosynthesis (Revision)
- Fractional Laser Treatment of Vulvovaginal Atrophy (New)
- Magnetic Resonance Imaging (MRI) of the Breast (Revision)
- Proteogenomic Testing for Individuals with Cancer (New)
- Tumor-Treatment Fields Therapy for Glioblastoma (Revision)

The follow medical policies will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued. This policy document is no longer utilized by BlueCross’ Commercial and BlueCare Utilization Management departments.

- Ultrafiltration for Decompensated Heart Failure
- Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea and Chronic Pelvic Pain

This medical policy will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued. This procedure is rarely performed and the American Medical Association (AMA) has decided to archive the two unique procedure codes associated with this service.

- Optical Coherence Tomography

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

All Provider-Administered Medications Require NDC Codes

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 must include the National Drug Code (NDC) of the drug(s) administered, along with the quantity and unit.
Providers are encouraged to share NDC billing requirement guidelines with their electronic software vendor to assist in the submission of electronic claims and to help ensure accurate placement of data.
http://www.bcbst.com/docs/providers/Supplemental-EDI-Information.pdf

Please note, submitting claims without the appropriate NDC could delay your reimbursement payments.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Expansion to State Employee Health Plan and Fully Insured

BlueCross will be expanding The State of Tennessee’s established Tennessee Health Care Innovation Initiative (THCII) Episodes of Care program to our State Employee Health Plan (SEHP) and Fully Insured members who use Blue Network SSM effective Jan. 1, 2017.

The first effort under this program will focus on episodes of care related to:

- Perinatal
- Total Joint Replacement (hip and knee)
- Screening and Surveillance Colonoscopy
- Outpatient and Non-Acute Inpatient Cholecystectomy
- Acute Percutaneous Coronary Intervention (PCI)
- Non-acute Percutaneous Coronary Intervention (PCI)

The performance period for SEHP will begin Jan. 1, 2017, as preview reports related to performance have been available for review since May of 2014. The performance period for Fully Insured will begin Jan. 1, 2018, with a reporting-only period for calendar year 2017, where Preview reports will be provided for informational purposes only.

More information about this expansion will be available in the coming weeks.

Improving Vaccination Rates Among Children

Children turning 2 years old are often missing several vaccines that are necessary for keeping them healthy. The three most common vaccines missing from most 2-year-olds’ immunization records are influenza, rotavirus and hepatitis B.

**Influenza** – Two shots are needed by the time the child turns 2, the first shot administered after 6 months old. The flu mist is no longer recommended by the Centers for Disease Control and Prevention (CDC).

**Rotavirus** – Either the two or three dose series, administered beginning 42 days after birth.

**Hepatitis B Shot** – Three doses are required before the child turns 2, one of which can be the dose given in the hospital after birth.

Source: http://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
Flu Prevention Starts with a Shot

You know how important it is to educate all patients or parents of children older than 6 months of age on the importance of getting a yearly flu vaccine. Please refer to flu vaccine benefit information we published in previous issues of the BlueAlert Newsletter. Reminder: Because it has concerns regarding the effectiveness of the FluMist Quadrivalent, the Centers for Disease Control and Prevention (CDC) recommends that this vaccine not be used during the 2016 – 2017 flu season.

Blood Pressure Monitor Benefit and Treating Hypertension in Federal Employee Program (FEP) Patients: New Information Available

FEP is taking a stand against heart attacks and strokes by helping its members manage high blood pressure. To make it easier for them, FEP initiated a program to provide free blood pressure monitors to its members over age 18 diagnosed with hypertension or those who have high blood pressure without a hypertension diagnosis.

Members can get the monitor by completing the Blue Health Assessment and answering “yes” when asked if they have been diagnosed with high blood pressure.

Information created by the American Medical Association is also available to help you improve health outcomes for your FEP patients. Click on the following links to access these resources:
- Measure Accurately and Promote Self-Measured Blood Pressure Monitoring at Home
- How to Check a Home Blood Pressure Monitor for Accuracy
- Clinical Competency: Self-Measured Blood Pressure at Home

Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

Providers are often the first point of care for alcohol and drug dependence treatment. Follow these suggestions to improve the chances that an individual will engage in and successfully complete treatment:
- Use screening tools to identify alcohol or other drug dependencies (AOD).
- Refer to a behavioral health provider (BHP) to start treatment within 14 days of diagnosis.
- Provide AOD dependence code to the BHP treatment provider.
- If a referral is not elected, see the patient within 14 days to initiate treatment through education on the potential risks and health outcomes.
- Schedule two follow-up visits within 30 days after starting treatment.
- Educate patients on the importance of follow-up care and keeping all appointments for the treatment of this medical condition, even after they start to feel better.
- For help finding a BHP to whom you can refer your patients, call the number listed on the back of the member’s ID card.
Importance of Collaboration and Communication Between Medical and Behavioral Health Professionals

High-quality care for your patients needing behavioral health treatment is the result of effective collaboration with behavioral health professionals. By working together, your patients benefit through:

- Integrated interventions
- Patient safety (e.g. potential drug interactions, substance use and interaction with prescriptions, psychosocial support in the home for medical interventions)
- Adjustment in the treatment plan if necessary
- Improved effectiveness such as encouraging compliance with other provider recommendations

Collaboration helps you as the medical professional treating your patients who are also being treated for behavioral health concerns by:

- Increasing awareness of what knowledge and skills you both can offer the patient
- Improving decision-making by understanding the whole person and what might be the most realistic and effective intervention(s) for that individual
- Boosting clinical effectiveness and job satisfaction through learning about other professional’s approach to patient care
- Creating and maintaining good relationships with patients and fellow professionals

You can find more information and other resources by visiting [www.ncbi.nlm.nih.gov/books/NBK2637/](http://www.ncbi.nlm.nih.gov/books/NBK2637/).

Antipsychotic Use Has Potential to Impact Patient Health

As a behavioral health provider, it is recommended that you notify the patient’s PCP when an antipsychotic medication is being considered. An assessment of the patient’s health is recommended due to the increased risk for weight gain and Type 2 Diabetes associated with the use of antipsychotics. Targeted assessments should include: weight, waist circumference, and/or BMI, blood pressure, heart rate, blood glucose level and lipid profile. Continued assessment of these factors should occur throughout the course of treatment, and collaboration is encouraged between treating providers. The efficacy and safety of antipsychotics should be monitored proactively.

See [the American Psychiatric Association’s (APA’s) Practice Guidelines](http://www.apa.org/practice/guidelines/antipsychotics.aspx) for more information.

KX Modifier Keeps Professional Claims from Rejecting for Gender Conflict

**Background:** Regulations implementing Section 1557 of the Affordable Care Act prohibit covered entities from denying professional claims for covered services ordinarily appropriate for individuals of one sex that are provided to transgender, intersex or ambiguous-gender individuals based on their recorded gender.

**Situation:** Claim systems may reject professional claims for some members due to gender-specific edits and cause inappropriate denials. For example, a claim filed for a pap smear performed on a male patient would typically reject for a gender conflict correctly. However, if the male patient was a transgender male, then a pap smear may be a medically appropriate service. To ensure BlueCross processes professional claims correctly, the KX modifier should be billed on the detail line, when appropriate, with procedure code(s) that are gender-specific.
Continued from previous page

KX modifier definition: Requirements specified in the medical policy have been met. The KX modifier is a multipurpose modifier for professional claims and can be used to identify gender-specific services provided to transgender, intersex, or ambiguous-gender individuals. Using it also lets us know you performed a service for a patient for whom gender specific editing may apply, and the service should be allowed to continue with normal processing. All benefit/authorization type requirements still apply.

Please Note: The Federal Employee Program (FEP) claims system will not recognize the KX modifier code and using it will not change how FEP claims are handled.

Seeking Timely Response to Requests for Medical Records

Often medical information and/or records are needed to process member claims, to determine reimbursement levels for certain procedures and for audits/reviews by the Bureau of TennCare. In order to reduce delays in claims processing, it is important that providers respond to these requests as quickly as possible. Please note the following guidelines regarding medical record requests:

- Submit the request letter as the first page of your medical record.
- Fax the requested information to the number listed in the letter.
- Submit only the requested information.
- Copies of the claim are not required. If claim copies are included, please attach behind the medical record.

Correction: Billing for Medication Wastage from a Single Dose Vile (SDV)

Effective Jan. 1, 2017, a JW modifier (Drug amount discarded/not administered to any patient) will be required to bill any unused drugs or biologicals from SDVs or packages.

BlueCross will continue to follow the published guidelines found in the Provider Administration Manuals for billing medication wastage from a SDV as follows:

- Documentation of wastage in the medical record is expected.
- The Provider is responsible for using the most economical packaging of medication to achieve the required dosage with the least amount of medication wastage necessary.
- Instances of medication wastage from a SDV should be submitted on a single line item with the JW modifier appended to the appropriate HCPCS Level II code.
- The number of units billed for the SDV using specific HCPCS codes with the JW modifier is inclusive of both the administered and discarded amounts.
- The number of units should be reported as one (1) for unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes billed with the JW modifier appended and dosage administered/wastage should be reported as supplemental information.
Medical Professional Communication May Increase Clinical Effectiveness

Research indicates that collaboration in health care increases team member awareness of each other’s knowledge and skills, leads to integrated interventions for the patient, and improves decision-making. It can be one of the most important factors in clinical effectiveness and job satisfaction. Team members need to share information in a short period of time and structured techniques are available (STCC – Situation Task Intent Concern Calibrate and SBAR – Situation-Background-Assessment-Recommendation). A clinical “champion” who promotes the necessity of team collaboration is an asset. Effective communication is an essential aspect of creating and maintaining good relationships with patients and fellow professionals. Attention to this aspect of practice can pose challenges, but can address patient safety, allows adjustment in the treatment plan and thereby improves effectiveness, and allows for providers to learn in an ongoing manner from one another.

For more information see the National Center for Biotechnology Information website.


BlueCross continues to address the growing national effort toward more appropriate use of opioids. Earlier this year, BlueCross made a policy change requiring your patients who are new to long-acting opioid pain medication therapy and covered by BlueCross commercial plans to have prior authorization (PA) for these drugs. To further promote prescription safety, BlueCross is making other significant changes that will go into effect in January.

### Opioid Prescription Policy Changes Effective Jan. 1, 2017

<table>
<thead>
<tr>
<th>(Applies to your patients with BlueCross commercial, BlueAdvantage (PPO)(^{SM}), BlueChoice (HMO)(^{SM}) and BlueCare Plus (HMO SNP)(^{SM}) plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization required for all long-acting opioid prescriptions</td>
</tr>
<tr>
<td>Quantity limits for both short-acting and long-acting opioids prescriptions</td>
</tr>
<tr>
<td>The combined morphine equivalent dose (MEqD) of all prescriptions cannot exceed 200mg/day</td>
</tr>
</tbody>
</table>

*Note – Opioid treatment for members in hospice care or undergoing cancer treatment will receive approval, but still require a prior authorization request.*

To view the entire policy on the Use of Opioids in Control of Chronic Pain, please visit our website: [www.bcbsmt/mppro既有!SSL!WebHelp/mppromprov.htm](http://www.bcbsmt/mppro既有!SSL!WebHelp/mppromprov.htm)

**Now Accepting Prior Authorization Requests for Jan. 1 Effective Dates**

For your patients taking long-acting opioids, and for whom you expect to need the medicines in January, you may request the prior authorization for a Jan. 1 effective date now. The maximum length of a prior authorization for long-acting opioid is six months. **When you make your request, please inform the PA Desk that the request is for prescriptions obtained on or after Jan. 1, 2017.**

**How to Obtain Prior Authorization for Your Patients**

- For your patients with BlueCross commercial plans, please call 1-877-916-2271 or fax your request to 1-800-837-0959.
- For your patients who are covered by BlueAdvantage, BlueChoice or BlueCare Plus plans, please call 1-844-648-9628 or fax your request to 1-877-328-9799.
Reminder: Improved Prior Authorization Process for Provider-Administered Specialty Medications

Beginning Dec. 1, 2016, BlueCross is partnering with Magellan Rx Management to facilitate the prior authorization process for provider-administered specialty medications under the medical benefit for all lines of business.

Please note that as of Dec. 1, 2016, prior authorization requests for specialty medications are no longer being accepted by fax. Because more detailed information is now being requested through the prior authorization process, and because we want to ensure you get the fastest response possible, authorization requests must be submitted online through BlueAccess™ or by phone. These direct interactions with clinical pharmacists and board-certified physicians will help ensure we receive all required information to make the most informed and timely determination. For assistance with submitting your authorizations online using BlueAccess, please contact your eBusiness Marketing Consultant.

The Provider-Administered Specialty Drug Lists vary by lines of business and are located online:

- BlueCare Tennessee
- BlueCare Plus (HMO SNP)™
- Commercial/CoverKids
- Medicare Advantage

Reminder: Credentialing Required for Nurse Practitioners and Physician Assistants

BlueCross is requiring all nurse practitioners and physician assistants to complete the credentialing process before providing services to our members. Nurse practitioners and physician assistants must be credentialed by Jan. 1, 2017, even if they are employed by a physician or group that is contracted to provide services to BlueCross members. Begin the credentialing process by completing the online Provider Enrollment Form.

Reminder: Improved Provider Reconsideration and Appeals Process Now in Effect

It is now easier for providers to go through the formal process of asking BlueCross to reconsider claims outcomes or denials, and to file formal appeals when necessary. An overview of the process and the two new forms are located online at http://www.bcbst.com/providers/forms/reconsideration-and-appeals.shtml.

A helpful guide offers more details and guidance about when and how to request claims reconsiderations or appeals. Depending on the line of business, there are some variances in the processes which are outlined in this guide.

Important Note: Beginning Jan. 1, 2017, reconsideration and appeals requests submitted on the old provider dispute forms may be returned, directing you to resubmit on the appropriate new forms. Please use the new Provider Reconsideration Form and Providers Appeal Form to prevent delays in processing these requests.
Reminder: Electronic Claims Submission Required

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.

BlueCare Tennessee

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

BlueCare Providers Can Now View Opioid Prescription Risk Reports Online

BlueCare Tennessee is working to promote opioid prescription safety by showing providers their opioid prescribing patterns through a comprehensive online report.

The Risk Identification and Mitigation (RIM) report is an online tool that will offer BlueCare Tennessee providers a deeper insight into the opioids they prescribe, the levels and frequency at which they provide them and how their prescribing patterns compare to other providers in their specialty across the state, as well as their patients who might be at risk when taking opioids.

BlueCare Tennessee providers who prescribe a minimum of six prescriptions during the previous 90 days can access their personalized report through the secure provider section of our website. The report is available through the BlueAccess home page under the heading RxSafetyTN by clicking the link Pain Medication & Care Improvement Program.

Tennessee Health Link and PCMH Programs for Behavioral Health Needs

The State of Tennessee is continuing its growth of the Tennessee Healthcare Innovation Initiative (THCII) through the development of the Tennessee Health Link (THL) and expansion of the Patient-Centered Medical Home (PCMH) model. The State is working with providers to improve integrated and value-based primary care services for all members and behavioral health services for members with the highest behavioral health needs. The THL will launch Dec. 1, 2016. Expanded PCMH will launch Jan. 1, 2017, for 20-30 primary care provider groups who volunteered to be in the first wave of implementation, with additional opportunities in future years.

Please refer to the State’s website for details on the THL and the PCMH programs: https://www.tn.gov/hcfa/article/patient-centered-medical-homes https://www.tn.gov/hcfa/article/tennessee-health-link
TennCare Kids - Healthier by the Dozen

Every child should have 12 TennCare Kids checkups before turning 3 years old. After their third birthday, children should receive TennCare Kids screenings every year until age 21. Recommendations for Preventive Pediatric Health Care, including suggested checkups is available on the American Academy of Pediatrics website.

Get Reimbursed for the Administration of Each Vaccine Given in Your Office

Did you know you can receive a $10.25 payment for the administration of vaccines under the 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.

VFC is a federally funded program operated by the State of Tennessee Department of Health. All TennCare enrolled children 18 years of age and under are eligible for the VFC vaccines. These vaccines are available to any provider who serves eligible members.

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 they were last seen by you. 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.

BlueCare Plus (HMO SNP)SM Annual Evaluation Completed and Available

An evaluation of the 2015 Model of Care (MOC) and Quality Improvement (QI) Program plan has been completed and approved by the BlueCare PlusSM Quality Committee and BlueCare Tennessee Quality and Operational Oversight Committee.

Key accomplishments:
- Member grievance/appeals above goal of 95 percent timeliness
- Utilization Management and Care Coordinator audits above goal of 97 percent
- Provider Satisfaction and Patient Experience Surveys launched
- Increased member engagement with Interdisciplinary Care Teams
- Health risk assessments completed
- Practice pattern analysis established
- Medication review of 29 percent of qualified members
- 53 percent response rate on CAHPS, estimated 5 Stars on member experience with health plan
- Clinical Quality of Care unit developed to review issues

Continued next page
The trends, barriers and planned actions identified are used to develop the 2016 BlueCare Plus QI plan. To see the 2015 report, with goals and performance results of all QI activities, contact the BlueCare Plus Tennessee Clinical Improvement Department at 1-888-433-8221.

New Event Reporting Requirements for ECF CHOICES in 2017 *

Providers in the Employment and Community First (ECF) CHOICES network will have additional reporting requirements for two types of events starting in January. These new requirements are for actions that do not meet the definition of emotional or psychological abuse.

Disrespectful or inappropriate communication like humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts regarding a person receiving support is strictly prohibited. These actions fall into one of two categories.

➢ **Tier 2 Reportable Events** – Any disrespectful or inappropriate communication listed above directed to or within eyesight or audible range of the person receiving support.

➢ **Non-Reportable Events** – Any disrespectful or inappropriate communication listed above about the person receiving support, but not directed to or within eyesight or audible range of that person.

Regardless of an action’s definition as reportable or non-reportable, it must be reported to BlueCare Tennessee’s Non-Discrimination Compliance Coordinator starting Jan. 1, 2017. Providers can report events by mailing details of the event on business letterhead or by calling BlueCare Tennessee.

**Mail:**  BlueCare/TennCareSelect Non-Discrimination Compliance Coordinator
1 Cameron Hill Circle
Chattanooga, Tennessee 37402

**Phone:**  BlueCare: 1-800-468-9736
TennCareSelect: 1-800-276-1978

How to Report a Member Complaint about a CoverKids Provider

When your patients who are covered by a CoverKids plan express a complaint about a provider’s quality of care, please make sure to report it.

The following are examples of quality of care complaints:

- Not satisfied with treatment
- Adverse reaction to medicine
- Pharmacy concerns
- Treatment complications
- Alleged misdiagnosis
- Disagreement with treatment decision

Please report CoverKids member complaints regarding quality of care by calling the provider service line at 1-800-924-7141. Our staff will investigate the complaint to determine if the treating provider followed the standard of care.
Critical Incidents Involving CoverKids Members Must be Reported

Any significant event involving a CoverKids member who is receiving home health services must be reported as a Home Health Critical Incident. A member death is always considered a critical incident, regardless of whether the death occurs during the provision of Home Health Services.

The following are all examples of Home Health Critical Incidents:

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major or severe injury</td>
<td>Broken bones or severe bleeding</td>
</tr>
<tr>
<td>Life-threatening medical emergency</td>
<td>Heart attack or unconsciousness</td>
</tr>
<tr>
<td>Medication error</td>
<td>Member takes too much medicine at one time.</td>
</tr>
<tr>
<td>Safety issues</td>
<td>Member falls due to slippery floor.</td>
</tr>
<tr>
<td>Known or suspected physical, mental or sexual abuse</td>
<td>Agency staff hits, inappropriately touches, yells at or intimidates a member.</td>
</tr>
<tr>
<td>Neglect (a lack of care that could harm the member)</td>
<td>Member fell because staff member did not help member with walking.</td>
</tr>
<tr>
<td>Theft</td>
<td>Worker steals electronic device from member</td>
</tr>
<tr>
<td>Financial exploitation - improper use of funds</td>
<td>Agency staff used member’s debit card for personal use.</td>
</tr>
</tbody>
</table>

Click here to download a copy of the Home Health Critical Incident Report form.

Email completed forms to: BlueCareQOC@bcbst.com. If email is not available, please fax the form to 1-855-339-3022.

Short Wait Times and Ease of Access Encourages Preventive Care

When your patients can easily make an appointment and only have to wait a few minutes to see you, they see the benefit of visiting their regular provider and will do so more often. These are the foundation of the primary care medical home. They help your patients stay current with preventive care screenings and encourage them to seek care before complications occur.

BlueCare Tennessee has specific standards for routine and urgent care, including physical and behavioral health. Provider compliance with wait times is important to ensure your patients receive care in the appropriate setting and at the appropriate time. These standards are monitored via a member survey on office wait time experience.

For additional information on Access and Availability Standards, please refer to the BlueCare Tennessee Provider Administration Manual.
Reminder: Maternity Authorizations for BlueCare, TennCare Select and CoverKids

Prior authorization is not required for an inpatient stay as long as the hospitalization results in the delivery of the newborn, even when the member labors on day one and delivers on day two.

Complications of pregnancy will still require authorization if delivery is not expected during that hospital stay. Medical emergencies do not require prior authorization.

Reminder: Reporting the Death of a CoverKids Member is Required

Providers are required to report all patient deaths if they involve a CoverKids member under the age of 19 or the unexpected death of a member who is not receiving home health services. Deaths should be reported as soon as possible using the Death of a Member Notification Form.

A member death consistent with the medical diagnosis and prognosis would be considered an expected death. Providers should use the following criteria to determine if the death of the member is unexpected:

- Accidental
- Not anticipated
- Suicide
- Mistreatment
- Homicide

Do not use Death of a Member Notification Form if the member was receiving Home Health Services.

The death of a member receiving Home Health Services should be reported using the Home Health Critical Incident Form, even if the member was not receiving care at the time of death. Complete reporting guidelines and definitions are included in the BlueCare Tennessee Provider Administration Manual.

Please submit all forms relating to the death of a BlueCare Tennessee member by email to: BlueCareQOC@bcbs.com. If email is not available, you may fax forms to: 1-855-339-3022.

Medicare Advantage

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

Annual Wellness Exams and 2017 Member Incentives

An annual wellness exam is an important first step to a healthy 2017. Patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. They may also be eligible to earn a reward for completing the exam. You can help your BlueCross Medicare Advantage patients earn additional rewards for their healthy living by scheduling a check-up early.

Continued on next page
In 2017, members will need to take two steps to be eligible for rewards:

1. BlueCross Medicare Advantage members will need to “opt in” to the rewards program with OnLife Health, our new rewards partner. Each member will receive a welcome kit in January detailing opt-in instructions.

2. An annual wellness claim must be on file for members to receive additional rewards in 2017 for other needed screenings. Annual wellness exams should be filed with 99387, 99397, 99385, 99395, 99386, 99396, 96160, GO402, GO438, GO439, plus appropriate E/M codes.

The Member Wellness Incentive FAQs is being revised to reflect the changes to the 2017 program and will be available in January in print or on the Quality Care Rewards website.

High-Tech Imaging Authorization Vendor Changes Effective Jan. 1, 2017

BlueCross BlueShield of Tennessee is partnering 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 www.bcbst.com or by calling 1-888-258-3864. Magellan does not accept authorization requests via fax.

CMS-2728-U03 Required for Dialysis Clinic Claim Reimbursement*

Initial dialysis clinic claims filed with Type of Bill 072X will require submission of a completed CMS-2728-U03 form annually for each patient effective Jan. 1, 2017. 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 that the provider submit the completed form.

You may fax the CMS-2728-U03 form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Cr, Ste 0002
Chattanooga, TN 37402-0002
Guidelines for Oxygen Renewals, Maintenance and Service Repairs, and Replacement Equipment

**Oxygen renewals:** Most oxygen authorizations will expire at the end of 2016 and providers will need to submit a request to continue service for 2017. Please be sure to include the [Certificate of Medical Necessity CMS Form 484](#). The form must be signed by the ordering physician and include the qualifying diagnosis and oxygen saturation.

**Maintenance and service repairs:** Oxygen equipment has a cap rental period of 36 months. After the cap is met, you may bill for maintenance and service repairs every six months from months 37 - 60 or until the equipment is replaced. These services should be billed using the appropriate oxygen code with modifier MS. Maintenance and service repairs do not require prior authorization, however they may be reviewed based on current fee schedules if charges exceed the allowed amount. As a reminder, oxygen contents are a lifetime rental item.

**Replacement equipment after 60 months:** Per [Local Coverage Article A52514 for Oxygen and Oxygen Equipment](#), a member may elect to have their oxygen equipment replaced after the reasonable useful lifetime (RUL). The RUL for oxygen equipment is 60 months. If members elect to have equipment replaced at month 61 or after, their cost share for the new equipment will begin again. Therefore, DME companies should not routinely replace equipment once the RUL has been reached. A new prescription and a face-to-face examination with the ordering provider are required unless there is a non-serviceable issue with the patient’s current oxygen equipment within six months before the order is required. Replacement equipment will not be eligible for administrative approvals.

Non-Eye Care Professionals Conducting Retinal Eye Screenings in Office Must Bill Appropriate Codes

Clinical guidelines for retinal eye screenings in diabetic patients allows for the screening to be conducted by either dilated or digital format. If you perform digital retinal eye screenings in your office and do not have an eye care professional specialty such as ophthalmology or optometry, make sure claims are billed to BlueCross with the appropriate CPT II codes in addition to procedure and diagnosis codes.

Without a CPT II code, such as 2022F, 2024F, 2026F or 3072F, a gap in care for the Comprehensive Diabetes Care – Eye cannot be closed according to NCQA requirements outlined in the HEDIS technical specifications for this measure.

If your office performs these screenings, please let us know by contacting your BlueCross Quality Outreach Consultant.
Submit Chiropractic Request Forms to OrthoNet

All BlueCross Medicare Advantage patients seeking chiropractic services must have a Chiropractic Request Form submitted to OrthoNet. The form must be completed and include supporting clinical documentation.

Supporting clinical documentation may include but not limited to:
- Patient Intake Forms
- Initial or Interim History
- Initial or Interim Exams
- Results of Diagnostic Tests and/or Imaging
- Consultations/Reports
- Daily Progress Notes
- Plan of Treatment
- Informed Consent Forms
- Patient Questionnaires
- Outcomes Assessment Forms
- Other pertinent information to support medical necessity

By rule, Medicare only covers a medically necessary spinal manipulation procedure (e.g., CPT® 98940, 98941, or 98942). Any other chiropractic services, such as evaluations, extremity manipulations and/or therapies/modalities are not payable.

New CPT® Code for Submitting a Provider Assessment Form in 2017

In 2017, you will again be eligible to receive payments for completing and submitting a Provider Assessment Form for your attributed BlueAdvantageSM and BlueChoiceSM members.

Note: The CPT® code that should be used to file a PAF claim is changing. The new CPT® code, effective Jan. 1, 2017, is 96160. The current 2016 CPT® code, 99420, will not be valid in 2017.

BlueAdvantage will continue to reimburse 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 the form and submit 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.

For additional information about the Provider Assessment Form, please visit: http://www.bcbst.com/providers/quality-initiatives.page
Peer-to-Peer and Re-Evaluation Process Changes*

New guidance from the Centers for Medicare and Medicaid Services (CMS) will change some BlueCross BlueShield of Tennessee provider peer-to-peer and re-evaluation processes. BlueAdvantage and BlueChoice have had long-standing processes in place already. Here are some changes that become effective Jan. 1, 2017:

- When there is **insufficient clinical documentation** to support an organizational determination, and after we made three separate attempts to obtain clinical information from the requesting provider, a BlueCross medical director will contact the physician for the documentation. If we cannot reach the physician, we will follow up with a specific “intent to deny” fax. If we still do not receive the needed clinical information within one business day, we will issue the adverse determination for insufficient clinical documentation. There are no additional peer-to-peer options for the requesting physician. Documents submitted after the organizational determination will be treated as a member appeal (reconsideration) according to CMS regulations.

- When an adverse determination was rendered and there was **sufficient clinical information**, the requesting provider can request a peer-to-peer conversation or submit additional clinical documentation. Either will be treated as a member appeal if services have not yet been rendered. There will not be a re-evaluation process because it is not compliant with CMS guidance.

- When requests are treated as member appeals, only the member and rendering provider have appeal rights. Everyone else needs to have an Appointment of Representative (AOR) form on file before the appeal can be processed. **This includes third-party companies acting on behalf of a facility for adverse determinations appealed while the member is still in the hospital.**

- When **services were already rendered** and there was no additional member financial responsibility, these will be processed as provider appeals. One peer-to-peer conversation and one level of provider appeal are permitted during this process, followed by binding arbitration. This process includes inpatient services with adverse determinations and the member was discharged from the hospital.

This process will be updated in the *BlueCross BlueShield of Tennessee Provider Administration Manual* for Medicare Advantage products.
Enhanced Quality Care Rewards Tool Shows All Patients and Their Open Gaps in Care

Soon you will have access to a listing of all BlueCross and BlueCare Tennessee members attributed to your practice and their individual open quality measures. This list provides an easy way to identify patients who could benefit from screenings or other preventive care.

If you’re participating in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Rating System (PQRS) or a BlueCross Quality Care Rewards program, closing these measures may help boost your quality ratings and payments or reimbursements. You still have a few weeks left in 2016 to get your patients scheduled for the preventive care they need.

To find your listing, go to the Quality Care Rewards tool by visiting bcbs.com then logging in to BlueAccess, then clicking on the tab next to your member roster. If you have questions or want to know more about Quality Care Rewards, visit the Quality Initiative Page for contact information.

Decrease Antibiotic Resistance: Avoid Antibiotics for Respiratory Conditions

We are committed to working with you to decrease antibiotic resistance and to support appropriate testing and antibiotic use. This quality improvement initiative focuses on the avoidance of antibiotic treatment in children and adults with the following respiratory conditions.

- Children (ages three months to 18 years) with upper respiratory infection (URI)
- Children (ages three to 18 years) with pharyngitis (CWP)
- Adults (ages 18 to 64 years) with acute bronchitis (AAB)

Remember to use the appropriate codes to indicate a bacterial infection. If the cause of illness is viral consider suggesting over-the-counter medications to help the symptoms.

Quality Improvement Teams at BlueCross are actively engaged in outreach with our provider community regarding this important initiative.

Educational information is available on following websites:

- Centers for Disease Control and Prevention (CDC)
- HealthCare 21 Business Coalition (HC21)

Together, we can make an impact on antibiotic prescribing in Tennessee.
Your Attention to Quality Care Helps BlueCross Plans Earn High Ratings

Several BlueCross BlueShield of Tennessee plans have earned 4-star ratings due to the quality care you provide daily to your patients/our members. Thanks to your efforts and our important partnerships, our Commercial PPO and BlueCare Tennessee East plans earned 4 out of 5 stars for 2016 by the National Committee on Quality Assurance (NCQA). NCQA ratings are based on a plan’s internal quality procedures, customer satisfaction and clinical quality measures of members getting recommended care and their health outcomes.

BlueAdvantage received a 4-star rating (out of 5) from the Centers for Medicare and Medicaid Services (CMS) for a second consecutive year. CMS ratings are based on customer satisfaction, plan operations and quality outcomes.

Several enterprise-wide quality initiatives and programs, including the Medicare Advantage Quality Outcomes program, Quality Care Partnership Initiative (QCPI) and the Clinical Data Exchange, are key components to the improved quality ratings. We appreciate your participation in these important initiatives.

In observance of the holidays, BlueCross BlueShield of Tennessee will be closed Dec. 23 and Dec. 26, 2016
BlueAlert Provider News Flash

December 2016

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.

Information about the civil rights laws can be found at http://www.bcbst.com/ or from the Department of Health and Human Services at http://www.hhs.gov/ocr/index.html.

*Changes will be included in the appropriate 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 press 1. Then press 1 again if you are a provider 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 pm. (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 Plus SM   1-800-299-1407
BlueChoice SM   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
e-mail: eBusiness_service@bcbst.com
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

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