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.html under the “Upcoming Medical Policies” link.

Effective Feb. 20, 2016
- Rituximab (Revised)
- Varicose Vein Treatments for the Lower Extremities (Revised)

Effective March 11, 2016
- Autologous Chondrocyte Implantation (Revised)
- Mechanical Embolectomy for Treatment of Acute Stroke (Revised)
- Percutaneous Tibial Nerve Stimulation (PTNS) (Revised)
- Prostatic Urethral Lift (New)

Reminder: Electronic Claims Submission
As previously communicated, beginning April 1, 2016, network providers (including oral surgeons) will be required to submit all claims to BlueCross electronically.

We have worked to make it easier for you to achieve 100 percent electronic claims submission, which should help eliminate any disruption to your current processes as a result of this transition.

Note: 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 at (423) 535-5717† (Option 2) to discuss your office’s transition and any barriers that may prevent you from filing electronic claims.

2016 HEDIS® Medical Record Review Project to Begin
Each year BlueCross BlueShield of Tennessee and BlueCare Tennessee are required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. Data is collected for Medicaid, Medicare Advantage, Commercial and CHIP/CoverKids products.

We are seeking medical records related to prevention and screening, diabetes care, cardiovascular conditions, access and availability, medication management and utilization measures and will be contacting you soon.

Your cooperation is greatly appreciated and important to the success of the outcome. We will work with you to arrange the most appropriate method for obtaining medical record information, which may include scheduling an onsite review in your office or arranging delivery of records. Oversight audits of our medical record abstraction methodology require that we scan pertinent elements of member charts. If you use a copy service, please ask them to respond promptly to record requests.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows Covered Entities (such as practitioners and their practices) to disclose protected health information (PHI) to another Covered Entity (such as BlueCross and BlueCare Tennessee) without patient authorization as long as both parties have a relationship with the patient and the PHI pertains to that relationship for the purposes of treatment, payment, and health care operations. Additionally, all nurses reviewing charts on behalf of BlueCross and BlueCare Tennessee have signed a HIPAA-compliant confidentiality agreement.
**ArroHealth Medical Records Acquisition**

The Centers for Medicare & Medicaid Services (CMS) requires Affordable Care Act (ACA) individual and small group health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross BlueShield of Tennessee has partnered with ArroHealth, formerly MedSave USA, to obtain medical records on our behalf to meet this requirement.

ArroHealth will begin formal medical records requests over the next two months. We ask that you please follow the return instructions provided with the list of requested records.

Medical records can be returned to ArroHealth by either:
- Faxing to: 1-866-465-0110 or
- Mailing to:
  ArroHealth
  Attn: MRR3 Unit – BCBST
  49 Wireless Blvd, Ste. 140
  Hauppauge, NY 11788

**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:
Codes: 64461, 64462, 64463, C1822

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

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

Prior to submitting prior authorization to the Musculoskeletal Program (administered by Orthonet), please verify member benefits and eligibility through BlueAccessSM 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.

**BlueCare Tennessee**

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

**Tennessee Health Care Innovation Initiative**

New Tennessee Health Care Innovation Initiative (THCII) Provider Reports for episodes of care are available the first week of February. To review your February THCII Provider Reports, please log into BlueAccess at www.bcbst.com by clicking the Log In/Register link found at the top-right corner of the page. If you are not registered for BlueAccess, the site will guide you through registration.


**Make Sure Medical Records Follow TennCare Guidelines**

Maintaining a carefully organized and detailed system of medical records is not only practical for patient care, it’s consistent with best practices. Proper records maintenance also makes the process of external reviews and medical audits much easier and effective.

Medical record reviews of primary care physicians (PCPs) who care for BlueCare Tennessee members under age 21 include evaluation of compliance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, sharing additional educational resources, and helping ensure proper immunization schedules are followed. These reviews take place every two years, but can be requested at any time.

These reviews follow guidelines from TennCare, as well as the American Academy of Pediatrics which are available online at: http://www.tnaap.org/EPSDT/EPSDTmanual.htm.

Additional information regarding EPSDT elements and documentation requirements is available in the BlueCare Tennessee Provider Administration Manual at http://bluecare.bcbst.com/Providers/Provider-Administration-Manual.html.

**Requirements for Ordering Providers for Certain Services**

For claims received on or after March 1, 2016, an Ordering Provider’s NPI will be required on all professional claims submitted for durable medical equipment and medical supplies, home infusion therapy and specialty pharmacy services for BlueCare Tennessee and CoverKids members. The Ordering Provider should be submitted as follows:

- CMS-1500 Paper Claim Form
  - Block 17 – Qualifier DQ should be entered to the left of the vertical, dotted line and the provider’s name should be entered to the right of the vertical, dotted line.
Use of New Sterilization Consent Form Required *

Federal law requires a valid and current consent form for sterilization procedures. Make sure your office is using the most up-to-date sterilization consent form, which was recently updated and is available on the State of Tennessee website. Claims filed with out-of-date forms will be denied.


Instructions for completing the form are available at https://tn.gov/assets/entities/tenncare/attachments/sterilizationconsentform.pdf

Be Aware of Hospital Guidelines for Perinatal and Neonatal Services

Tennessee hospitals providing perinatal and/or neonatal care services must comply with the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. The program is designed to help diagnose and treat certain life-threatening conditions in the perinatal period and decrease the high infant mortality rate and minimize lifelong disabilities in surviving newborns.

Facilities should adhere to all relevant guidelines regarding care, transfer, and discharges for perinatal and neonatal patients. Each facility has designations (Level I, Level II, Level III or Perinatal) that indicate the appropriate level of care that should be available for high-risk conditions.

The current edition, (Seventh Edition) was prepared by the Workgroup on Regionalization Guidelines Revision and the Perinatal Advisory Committee, and can be found at http://www.tnafp.org/documents/Regionalization_Guidelines_Approved_2014.pdf.

Help Your Patients Keep TennCare Coverage

One of the biggest issues the Bureau of TennCare faces is maintaining an accurate database of member addresses. When your BlueCare Tennessee patients schedule office visits, please ask them if TennCare has their current address. If not, please ask them to call 1-855-259.0701 to update their address. It’s free, easy and very important if they want to keep their coverage.

New Process for Submitting CoverKids Applications *

Children who apply for child (non-pregnant) coverage must now apply online at www.healthcare.gov or by calling 1-800-318-2596 toll free.

As of Jan. 1, 2016, pregnant women now have four application options:

- Online at www.healthcare.gov or by calling 1-800-318-2596 toll free.
- In-person application assistance is available at local health departments throughout the state. To find a list of local health departments visit www.tn.gov/health/topic/localdepartments
- Fax a paper application with a signed cover page to CoverKids at 1-866-913-1046
- Mail a paper application with a signed cover page to: CoverKids P.O. Box 305230 Nashville, TN 37230-5230

The paper application and cover page are available at http://tn.gov/coverkids/topic/coverkids-applicationapplication or by calling 1-866-620-8864.
Reporting a CoverKids Birth
Births to women enrolled in CoverKids should be reported by calling 1-855-259-0701.

Registration for Referring Providers Required Soon
Beginning March 1, 2016, all Referring Providers submitted on professional and/or institutional claims for BlueCare Tennessee and CoverKids members must be registered with BlueCross as well as the Bureau of TennCare for all dates of service on the claim. Claims received by BlueCross on or after March 1, 2016, with a referring provider who is not properly registered will be rejected and returned to the provider unprocessed.

If you refer BlueCare Tennessee or CoverKids members for any type of service and have questions on how to register with BlueCross please call our Provider Service Line†. More information concerning registration with the Bureau of TennCare is available at http://tn.gov/tenncare/topic/provider-registration.

Reminder: Treat Medical Record Requests as High Priority
BlueCare Tennessee and CoverKids sometimes need to access the medical records of our members while conducting audits or medical necessity reviews. When your office receives a request to review the medical records of our members, please make them a high priority and submit all requested information as soon as possible.

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

Reminder: Inpatient DRG Day Outlier Management Program
Consistent with the criteria in MCG (formerly Milliman Care Guidelines), BlueCross BlueShield of Tennessee’s Medicare Advantage plan will reimburse acute inpatient hospitalization days outside of the initial inpatient DRG as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the outlier hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review is subject to the facility providing concurrent clinical information for review as contractually required.

- If clinical information is requested three times using at least two different notification methods, the days will be denied after review by a medical director for a lack of clinical information necessary to establish ongoing medical necessity. In situations where no clinical information has been provided at all for the days in question, these denied days will not be eligible for reconsideration review or peer-to-peer discussion, and the facility can follow standard facility appeal remedies.

- This requirement is outlined by CMS as follows: Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.” (Reference: Internet Only Manual (IOM) Medicare QIO Manual Pub 100-10, Ch. 4, Sect 4110)

The member cannot be held liable for payment of services received when not approved.

Vanderbilt Facilities and Doctors Not In-Network for BlueAdvantage and BlueChoice starting Jan. 1, 2016
As of Jan. 1, 2016, Vanderbilt University Medical Center (VUMC) facilities and physicians under Vanderbilt Medical Group (VMG) are not in the BlueCross Medicare Advantage networks for HMO and PPO. Participating providers should not refer or transfer BlueAdvantage and BlueChoice members to any VUMC facility or VMG provider for treatment unless there is not a network provider able to address the medical concern. In middle Tennessee, both St. Thomas Health System and HCA facilities and providers are in-network for these members.
Provider Performance Module: Important Dates and Deadline for 2015 Attestations

The deadline to submit Preventive Screening Attestations for 2015 dates of service is Feb. 13, 2016. Any attestations loaded for 2015 dates of service after this date will not count toward your 2015 quality incentive fee schedule. On Feb. 22, 2016, the 2015 Provider Performance Module (PPM) will transition to read only. You will be able to view your data but no longer able to load attestations. The 2015 PPM will be removed from view on April 30, 2016.

The 2016 PPM will be available for use on Feb. 22, 2016. Attestations and other information can start to be loaded at this time.

New Chronic Kidney Disease Case Management Program Seeks to Remove Barriers to Care, Increase Member Education

BlueCross’ new Case Management program, which began Jan. 1, 2016, for BlueAdvantage and BlueChoice members with Chronic Kidney Disease (CKD) or End-Stage Renal Disease (ESRD) will work to reduce barriers to care and improve member awareness of diet and medication adherence.

The program is designed to help identify when members are in stage four or five CKD. Targeted interventions for the CKD program will increase an at-risk member’s overall understanding about CKD and treatment modalities that include early consultation with a nephrologist, medication adherence, nutritional counseling, dialysis education, vascular access options and transplantation options. Promoting member self-management and compliance with an established treatment plan will result in a decrease in emergency room visits, inpatient admissions and readmissions for worsening of CKD.

Our case management program will offer education and support for our members identified with CKD and ESRD, provide tools and support to promote knowledge and self-management of their CKD and other chronic conditions, and resolve barriers to care.

Updates to Home Health Billing Code

Effective Jan. 1, 2016, home health billing code G1054 has been retired. Services provided by a Registered Nurse should now be coded G0299 and by a Licensed Practical Nurse coded as G0300.


If you have any questions, please contact your MAC at their toll-free number, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - “How Does It Work”.

Concurrent Review Will Ease Transition of Care

Effective March 1, 2016, facilities that have an approved inpatient DRG will be asked to provide clinical updates starting on day six of the hospitalization. Ongoing concurrent review at this point will assist the facility with transition of care and help ensure compliance with the Centers for Medicare & Medicaid Services (CMS) expectation that inpatient care meet medical reasonableness for level of care at all times during the inpatient confinement.

Advance Care Planning Now an Option During Annual Wellness Exam

As of Jan. 1, 2016, the Centers for Medicare & Medicaid Services is including voluntary Advance Care Planning (ACP) as an optional element of a patient’s annual wellness visit. ACP services furnished on the same day, by the same provider and filed on the same claim form as an annual wellness visit are considered a preventative service.

According to the guidelines set by CMS, when ACP services are provided as part of an annual wellness visit, providers should file CPT® code 99497 (plus 99498 for each additional 30 minutes) in addition to either of the annual wellness visit codes. Further, the ACP codes should be filed with modifier 33 for preventive services. Since payment for annual wellness visits is limited to once per year, the deductible and coinsurance for ACP can only be waived once a year.

As this is a new code for 2016, a fee allowance will be added to our system in the next few weeks. All claims from Jan. 16, 2016, forward will then be processed to allow payment for this important service.

ColoGuard™ Multi-target Stool DNA Test Not Accepted by NCQA

The multi-target stool DNA test, or ColoGuard, is not accepted by NCQA
for its HEDIS® standard for colorectal cancer screenings. This is despite Medicare adding the test to its list of covered services in 2014. The test, billed as G0464 through the end of 2015 and currently billed as 81528, is not sufficient to meet NCQA quality standards and will not close the colorectal cancer screening gap in care that is part of the Centers for Medicare & Medicaid Services (CMS) annual STAR quality ratings.

This service will also not earn Medicare Advantage members their member reward through BlueCross’ MyHealthPath® program, which incentivizes members to receive colorectal cancer screenings.

As a reminder, the HEDIS® colorectal measure is satisfied by a fecal occult blood test, such as a 3 card guaiac test (gFOBT) or a 1 card fecal immunochemical test (iFOBT), for one year. Rigid or flexible sigmoidoscopy satisfies the measure as met for 5 years and a colonoscopy satisfies the measure as met for 10 years. Patients who have a history of colon cancer or have had a total colectomy for any reason, are not part of this HEDIS® measure.

The supplier who provides oxygen equipment for the first month should continue to provide any necessary oxygen equipment and all related items and services through the 36-month period. If there is a transition in provider for the same equipment, then the 36-month rental limit for that equipment will still apply and not restart with the new provider.

After 36 monthly rental payments have been made, there is no further payment for oxygen equipment during the 5-year reasonable use lifetime of the equipment.

At any time after the end of the 5-year reasonable use lifetime the beneficiary may elect to receive new equipment and begin a new 36-month rental period, assuming the equipment is not functioning in some way.

**Authorization Now Required for Two Medicare Advantage Specialty Pharmacy Medications**

Effective Feb. 1, 2016 prior authorization is now required for two specialty pharmacy medications for BlueAdvantage and BlueChoice members:

- Darzalex (Daraumumab), J9999
- Dysport (abobotulinumtoxinA), J0586

**Pharmacotherapy Management of COPD**

Let’s make a difference together. COPD mortality is rising. According to the American Lung Association, *COPD is now the third leading cause of death in the United States*. Early diagnosis and aggressive treatment of your patient’s conditions can improve their quality of life and lifespan.

Adequate control of COPD relies on the proper use of both short-acting and long-acting medications. The National Committee for Quality Assurance recommends that after a COPD exacerbation a patient be prescribed and dispensed a systemic corticosteroid within 14 days of discharge, as well as a bronchodilator within 30 days of discharge.

**Tips to help increase COPD medication adherence:**

- Incorporate prescriptions and medication instructions in discharge planning.
- Offer to “call in” prescriptions to your patient’s home pharmacy to make picking up their prescriptions more convenient and increase the likelihood for medication adherence.
- If your hospital has an in-house pharmacy, encourage your patients to fill prescriptions before leaving.
- Explore reasons for non-compliance and initiate Case Management if needed.

**Reminder: Reimbursement for Oxygen Equipment Rental Follows Medicare Guidelines**

Per long-standing Medicare payment guidelines, reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories, delivery, back-up equipment, maintenance and repairs is included in the rental allowance. Oxygen contents are a lifetime rental item.
February is American Heart month.

Healthy Heart

High blood pressure is one of the leading co-morbid causes of heart disease and stroke, which are the first and fourth leading causes of death respectively in Tennessee, according to the Tennessee Department of Health.

Help your patients take control of their heart health and manage their blood pressure. Keeping a blood pressure journal and practicing at-home blood pressure monitoring can help your patients maintain their blood pressure within the following ranges:

- Ages 18-59: <140/90
- Ages 60-85: Diabetic: <140/90
- Ages 60-85: non-Diabetic: <150/90

Helping your patients take control of their blood pressure can decrease the risk of having a second heart attack. Beta-blockers are shown to lower the risk of having a second heart attack as well as helping to prevent sudden cardiac death.

For patients who have recently experienced a heart attack, it is important to encourage them to take the prescribed beta-blocker medication for at least six months following their heart attack.

Encourage the following healthy lifestyle changes:

- Quit smoking.
- Follow a healthy diet.
- Be physically active.
- Lose weight.

Heart Healthy Benefits for BlueAdvantage and BlueChoice Members

February is American Heart month, and BlueCross provides benefits to your BlueAdvantage and BlueChoice patients designed to keep their heart healthy. Talk to them about the importance of physical activity, and let them know about SilverSneakers, a free gym membership included with their BlueCross Medicare Advantage Health Plan. SilverSneakers has hundreds of participating locations across Tennessee.

Reminding your patients about the importance of physical activity, along with taking steps to make sure their blood pressure is under control, and keeping them adherent with their prescriptions for conditions such as high cholesterol or hypertension can help boost your quality scores and earn fee schedule bonuses from BlueCross.

IMPORTANT REMINDER

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

*(Arabic); Bosanski (Bosnian); (Kurdish-Badinani); (Kurdish-Sorani); Soomaali (Somali); Ngữ 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, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

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

* Changes will be included in the appropriate 1Q 2016 provider administration manual update.

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

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.

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)

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

BlueCare 1-800-468-9736

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