Online-Only Provider Enrollment Process Starting Oct. 1

Earlier this year, we launched a new online Provider Enrollment Form to simplify the enrollment process. The new form has reduced omissions, the need for follow-up, phone calls and duplicate applications to the point that we have decided to move to an online-only submission process starting Oct. 1, 2017. This will affect enrollment for professional providers for every line of business.

Please look for further enhancements as we continue to reduce enrollment processing time and improve our service to you.
Medical Policy Updates/Changes

We’re updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, please click here.

Effective Nov. 1, 2017

• Ablation Procedures for Peripheral Neuromas (Revision)
• Human Amniotic Membrane Grafts and Amniotic Fluid Injections (Revision)
• Magnetic Resonance Imaging (MRI) of the Breast (Revision)
• Whole Exome and Genome Sequencing (Revision)

The following medical policies will be archived and no longer active 30 days after this BlueAlert notification.

• Modified Condylotomy for the Treatment of TMJ Disorders – An MCG Care Guideline contains similar clinical indication criteria and will be used as needed.
• Mechanical Embolectomy for the Treatment of Acute Stroke – This procedure is now accepted by health care professionals as standard/conventional practice.
• Beta Amyloid Imaging with Positron Emission Tomography (PET) for Alzheimer’s Disease – The use of PET for Alzheimer’s Disease is addressed as investigational within another BlueCross medical policy titled Positron Emission Tomography for Miscellaneous Applications; thus, the investigational policy position reflected by this policy is redundant.
• Nerve Fiber Density Testing

♦ There is no longer a need to maintain this medical policy for use by our Commercial and BlueCare Tennessee Utilization Management departments.

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

2018 Formulary Changes

Each year BlueCross Formularies are reviewed to determine changes based on a drug’s effectiveness, safety and affordability. While many changes to the BlueCross Formularies occur at the beginning of the year, formulary changes may occur at any time because of market changes such as:

• Release of new drugs to the market after FDA approval
• Removal of drugs from the market by the FDA
• Release of new generic drugs to the market

Please visit the following links to view the 2018 Formulary Changes for each of the formularies listed below:

• 2018 Preferred Formulary Changes
• 2018 CoverKids Formulary Changes
• 2018 Essential Formulary Changes

In November, we’ll begin sending letters to our members whose medications are changing to non-formulary status Jan. 1, 2018. We aren’t sending letters about every change to their formulary, so please remind your patients to check for changes at bcbst.com.
Managing Weight Gain in Children Taking Antipsychotics

In a review of regularly prescribed antipsychotic medications, weight gain is listed as one of the most common side effects. Children on these medications are also at risk for weight gain and other metabolic effects, such as increased total cholesterol and triglycerides.

You can help monitor weight gain by first taking a baseline measurement of:

- Weight (or body mass index)
- Waist circumference
- Blood pressure
- Fasting plasma glucose
- Fasting lipid profile

After the baseline, providers are encouraged to check the child’s weight every three months and other measures at least once a year. If you notice significant increases, you should consider more frequent visits.

Use of antipsychotic medications should only be considered after a thorough assessment of the child’s health, family history and alternative medications and therapeutic interventions.

Prior Authorization Required for Imlygic

Beginning Nov. 1, 2017, Imlygic will be added to the Provider-Administered Specialty Drug Lists and require prior authorization for all lines of business. Imlygic is currently listed on the Commercial, CoverKids, and BlueCare Tennessee Provider-Administered Specialty Drug Lists. Imlygic will also be added to the Medicare Advantage and BlueCare Plus (HMO SNP)SM drug lists requiring a prior authorization beginning Nov. 1, 2017.

You can find information on all provider-administered specialty medications requiring prior authorization on our websites.

BlueCare Tennessee
BlueCare PlusSM
Commercial
CoverKids
Medicare Advantage

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are going into effect Jan. 1, 2018 for air ambulance providers (rotary or fixed-wing):

- NPI and the appropriate taxonomy codes are required to distinguish between ground charges and air charges when filing claims.
- You must include pick-up and drop-off ZIP codes, mileage, etc.

Member cost share can be significant for this type of service, so please try to work with in-network providers.

You can find updated billing guidelines for Commercial plans in your BlueCross BlueShield of Tennessee Provider Administration Manual.

Non-Emergent Air Ambulance Transportation Requires Prior Authorization for Commercial plans*

Starting Jan. 1, 2018, prior authorization is required for non-emergent air ambulance transportation. Prior authorization won’t be required for emergency transport (e.g., from the scene of an accident when ground isn’t appropriate or would pose a threat).

To arrange non-emergent air ambulance transport for a patient with BlueCross Commercial benefits, please request prior authorization by calling BlueCross at 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. ET.

This prior authorization requirement may affect your patients if an out-of-network air ambulance is used for non-emergent transportation.
Be Prepared for the 2017–2018 Flu Season

It’s important that you help set preventive care measures to protect your patients during this time of year. Please educate all patients and parents of children older than 6 months of age on the importance of getting a yearly flu vaccine.

**Because patients 65 and older are at a greater risk for serious complications from the flu, they have the option to receive a higher-dose vaccine or the standard-dose vaccine.**

The higher-dose vaccine is 24 percent more effective for people in this age group according to The New England Journal of Medicine.

Please make every effort to schedule your high-risk patients for a flu shot as early as possible this flu season. To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations.

**The following influenza immunization and reimbursement guidelines apply for BlueCross.**

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

**BlueCare Tennessee**
- Vaccine and administration
  - Intramuscular flu vaccine is a covered benefit for those 6 months of age and older.
  - Intradermal-administered vaccine is recommended for people 18 through 64 years of age.
  - Note: Flu vaccines are available through the Tennessee Department of Health’s Vaccines for Children (VFC) Program for children 18 years of age and younger. The intradermal-administered vaccine isn’t available under VFC.

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

**Medicare Advantage**
- Intradermal vaccines
  - Covered benefit

**CoverKids**
- Vaccine and administration
  - The influenza vaccine, including intradermal is a covered benefit.

**Note:**
- Code 90756 will become effective on Jan. 1, 2018, for Flucelvax Quadrivalent — antibiotic-free vials (2017-2018 NDCs 70461-0301-10 and 70461-0301-12). Prior to the implementation/effective date, codes 90749 or Q2039 may be billed for this product.
- Code 90674 became effective on Sept. 1, 2016, for BlueCare and Jan. 1, 2017, for all other lines of business for Flucelvax Quadrivalent – preservative and antibiotic-free syringes (2017-2018 NDCs 70461-0201-01 and 70461-0201-11).

**Help Bust Flu Shot Myths**

You play an important role in making sure our members have accurate information about flu shots. Here are some common misconceptions and answers you can share with your patients:

**It might give me the flu.**

The flu shot can’t cause the flu. Randomized, double blind studies show the only difference between the flu shot and a placebo is soreness and redness at the injection point.

**It will make me sick.**

A few people may have a low-grade fever or minor achiness, but double blind studies showed no difference in symptoms between those who received the flu vaccine and those who received a placebo.

**It won’t protect me.**

The flu shot only protects against the flu. There are several illnesses, like the common cold, that cause symptoms similar to the flu. Sometimes people develop symptoms because they are exposed to the flu before their vaccine becomes fully effective, which can take a few weeks.
Social Problems from Bullying

**Bullying** is aggressive and intentional behavior that causes another person discomfort. It can take the form of physical contact, words or more subtle actions.

**Cyberbullying** includes sending hurtful or threatening messages, spreading rumors, or posting embarrassing photos of others on e-mail, instant messaging or social media.

In recent years, cyberbullying has increased dramatically among preteens and teens. A recent survey indicates fewer students feel upset or afraid when bullied online than in person. However, victims of cyberbullying are more likely to show social problems or even harass peers online, themselves.

Surprisingly, a little more than half of the youth surveyed spoke up about the harassment they were experiencing. As a health care provider, you may learn about bullying — or suspect bullying — during a routine office visit. It’s an ideal time to engage parents, discuss social concerns and ways to help their child.

- Second Youth Internet Safety Survey published by the American Academy of Pediatrics

**Non-Compliance Denials**

Please note that non-compliance denials aren’t subject to reconsideration. However, you have 60 days to submit an appeal related to a non-compliance denial. Please complete and submit the Provider Appeal Form located on our provider webpage under the forms section. If you send the Reconsideration Form, it will delay your appeal, so be sure to use the correct form. If you need help or have questions, please call the Provider Service Line.

**Claims Editing Process Update Is Now Complete and Applies to Facilities**

An important claims editing process update was completed the last week of August. This update moved our Commercial member claims process, which includes facility claims, to an automated system. There are also additional claims editing capabilities that allow us to process claims more efficiently. We already use this system to process claims for our BlueCare Tennessee and Medicare Advantage lines of business.

With this upgrade, our system can identify and apply pre-payment edits to claims that weren’t possible in the past. Because the system performs a closer review of claims, some unintended or incomplete items that have passed through for payment in the past may process differently in the future. However, this update won’t reduce contracted provider reimbursement rates, your patients’ benefits or the speed at which we pay your claims.

The editing system meets industry rules and federal regulations for health care claims including modifier usage, diagnosis coding and MUEs for facilities. Additional information can be found in the NCCI Manual, BlueCross Provider Administration Manual, the Code Editing page on our website and previous editions of the BlueAlert newsletter.
Cologuard®: In-Home Colon Cancer Screening Test for Commercial Plans

Colon cancer is the second leading cause for cancer deaths in America. It is also one of the most preventable. If you have a patient (50 years or older) who declines colonoscopy, you can now offer Cologuard, annual fecal immunochemical testing (FIT), as an in-home colon cancer screening test. Cologuard, a DNA fecal test administered by Exact Sciences Laboratory, is part of the preventive services and considered an eligible service. However at this time, Exact Sciences does not participate in the BlueCross BlueShield of Tennessee provider networks. We are currently talking with Exact Sciences and hope to bring them into our networks in the near future. In the meantime, a claim from Exact Sciences Laboratory will process as an out-of-network provider and the member will be responsible for any disallowed amounts that are over the maximum allowable.

Availity Coming Soon

We’re excited to announce that we’ve partnered with Availity to provide a free advanced account management system scheduled to replace BlueAccessSM. Initially, Availity will be used to review remittance advices, claims status, eligibility and benefits—though more features will be added throughout the transition. For example, these BlueCross-specific features will be available at or shortly after launch:

- **Unified Member Search** – This custom member search will closely match our capabilities in BlueAccess and will include search options by SSN, name and DOB.
- **BlueCard®** – Searches for your out-of-state patients will be available in the same interface, which means you’ll no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- **Claims Management Tool** – This upgraded tool features a customized search function, so you can find rejected and adjudicated claims. You’ll also be able to see your full claim lifecycle in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications and updates.

As we get closer to transitioning our online provider tools to the Availity web portal, we’ll send you complete information. In the meantime, you may want to begin sharing information with the person who will create and manage accounts for other users.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.

New Member ID cards, ID numbers, and Prefixes for NECA and IBEW Anthem Plan Members Effective in January

As of Jan. 1, 2018, member ID cards will be reissued for NECA and IBEW Anthem plan members. These ID cards will have new Member ID numbers and prefixes. Below is a quick reference guide with prefixes that are terminating on Dec. 31, 2017, and the new prefixes replacing them as of Jan. 1, 2018.

Please be sure to use the updated information on the new member ID card for these groups when filing claims for services beginning Jan. 1. Direct any questions to the appropriate Provider Inquiry Customer Service phone number listed below.

<table>
<thead>
<tr>
<th>Current Prefix</th>
<th>New Prefix as of Jan. 1, 2018</th>
<th>State</th>
<th>Plan Name</th>
<th>Provider Inquiry – Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>FJJ Group# 004009986 (Members) – KFM</td>
<td>all, except GA</td>
<td>BlueCard</td>
<td>1-844-594-0393</td>
<td></td>
</tr>
<tr>
<td>FFX Group# 004009986 (Members) – QFM (GA AltNet)</td>
<td>GA</td>
<td>GA Alt Net</td>
<td>1-844-594-0393</td>
<td></td>
</tr>
<tr>
<td>FJJ Group # 004009987 (Employees) – VFE</td>
<td>all, except GA</td>
<td>BlueCard</td>
<td>1-844-594-0393</td>
<td></td>
</tr>
<tr>
<td>FFX Group # 004009987 (Employees) – ZFE (GA AltNet)</td>
<td>GA</td>
<td>GA Alt Net</td>
<td>1-844-594-0393</td>
<td></td>
</tr>
</tbody>
</table>
BlueCare Tennessee

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

New Reporting Form for HCBS CHOICES Critical Incidents

The new HCBS CHOICES Critical Incident Reporting Form is now available online. The new form is now consistent among all TennCareSM managed care organizations (MCOs), including BlueCare Tennessee, to help make critical incident reporting easier for providers. Here are a few of the changes you’ll notice on the form:

- Checkboxes for providers to indicate the correct MCO for the member.
- Free-form fields – replacing drop down boxes – for easier documentation.
- Reorganized sections to help streamline the reporting process.
- New headings to help gather information for the investigation.

Please use the new form to report all HCBS CHOICES critical incidents. If you have any questions about critical incident reporting, please email us at CHOICESQuality@bcbst.com.

TennCare Issues Budget Memo for 2018 Fiscal Year

Each year, TennCare updates its fiscal year budget to provide guidance based on the current budget appropriations for the State of Tennessee fiscal year. You can view the TennCare Budget Memo at the BlueCare Tennessee website.

In addition to the budget reductions and/or buyback as described in the memo, all other previous reductions and limits remain in effect.

BlueCare Tennessee Members Exceeding Monthly Benefit Limit for Antidepressants

If you have BlueCare Tennessee members in your care that have been prescribed five or more antidepressants in a month, you may be able to help them get additional medications with an attestation request. While this exceeds our monthly prescription benefit limit, we understand you may have patients who could suffer adverse health consequences without these medications. This includes members who could be hospitalized, institutionalized or at risk of death within 90 days.

Here are the steps:

1) **Determine if the medicine is on the TennCare Attestation List.** If so, we may be able to approve the medicine for high-risk members who are at their monthly prescription benefit limit (more than five prescriptions or two brand medications). For the complete list, visit https://tenncare.magellanhealth.com.

2) **Call Magellan Health Services** at 1-866-434-5524 to make an attestation request.

3) **Fax a completed Attestation Fax Form** to Magellan Health Services at 1-866-434-5523. You can find the form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_RxLimit_Override_Attestation_Fax_Form.pdf.

If you have questions or need to request prior authorization for BlueCareSM or TennCareSelect members for any of these medications, please contact Magellan Health Services at 1-866-434-5524 or fax your request to 1-866-434-5523.
Free Transportation for Your TennCare Kids Patients

If you have TennCare Kids patients who can’t get to their appointments for services because they don’t have a ride, let them know they have an option. Southeastrans will get them to and from their visit with you at no charge. To schedule a ride, please have them call one of the following numbers:

- BlueCare East Region – 1-866-473-7563
- BlueCare West Region – 1-866-473-7564
- TennCareSelect – 1-866-473-7565

TennCare Implements 200 Morphine Milligram Equivalent Daily Limit

TennCare began a new policy for prescription narcotics on Sept. 5, 2017. Patient claims for any short-acting or long-acting narcotic or combination of the two that exceed 200 Morphine Milligram Equivalent (MME) per day will be denied. Prior authorization is required for patient prescriptions that exceed the daily MME limit.

In addition, the following products (brand and generic) have new daily quantity limits:

- Hydrocodone/APAP: 6/day
- Hydrocodone/ibuprofen: 6/day
- Oxycodone IR 5, 7.5,10 mg: 8/day
- Oxycodone IR 15, 20, 30 mg: 4/day
- Oxycodone/APAP: 6/day
- Oxycodone/ibuprofen: 6/day
- Oxymorphone: 4/day

Click here to view a summary of the PDL changes.

BlueCare Tennessee Changing to 30-Day Readmission Review Period in November

BlueCare Tennessee will begin using a 30-day readmission look-back period for members 21 or older starting Nov. 1, 2017. A re-admission is a preventable, unplanned admission of a patient to the same facility for a condition or complication related to the original hospital stay.

This policy applies to all readmissions except those in the BlueCare Tennessee Provider Administration Manual specifically listed as readmissions that MAY be approved for authorization and payment. Claims for patients re-admitted under these circumstances aren’t eligible for multiple payments at facilities that are paid on a DRG or per diem basis and are subject to retrospective claims review and recovery.

Review of 2016 ASH Claims Begins in October

During the fourth quarter of 2017, we will begin a review of all BlueCare, TennCareSelect and CoverKids claims submitted in 2016 that include an absolute or possible abortion, sterilization or hysterectomy (ASH).

If your practice submitted an ASH claim for a procedure conducted last year, we may contact you to request records if they weren’t submitted with the claim.

Billing Limit for Private Duty and Home Health Agencies

When providing care for BlueCare Tennessee members who are 21 or older, please note that the State’s level 1 and level 2 daily allowable benefit limits for home health aide and home health nursing is eight hours per day. Claims submitted outside the benefit limits will be denied.
Medicare Advantage

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

Prior Authorization Required for Medicare Advantage and BlueCare Plus

Beginning Oct. 1, 2017, the provider-administered specialty medications listed below will require prior authorization for Medicare Advantage and BlueCare Plus plans.

<table>
<thead>
<tr>
<th>Adagen</th>
<th>Krystexxa</th>
<th>Supprelin LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldurazyme</td>
<td>Lumizyme</td>
<td>Sylvant</td>
</tr>
<tr>
<td>Arranon</td>
<td>Portrazza</td>
<td>Temodar (IV)</td>
</tr>
<tr>
<td>Folotyn</td>
<td>Remodulin</td>
<td>VPRIV</td>
</tr>
<tr>
<td>Kanuma</td>
<td>Ruconest</td>
<td>Yondelis</td>
</tr>
</tbody>
</table>

You can find information on all provider-administered specialty medications requiring prior authorization for each line of business on our website.

2013 Jimmo v. Sebelius Settlement Clarifies Skilled Nursing and Therapy Benefits

CMS wants you to know about two changes to therapy guidelines that resulted from the settlement. The Jimmo Settlement Agreement (January 2013) explained that Medicare covers skilled nursing care and skilled therapy services under its skilled nursing facility, home health and outpatient therapy benefits when a beneficiary needs skilled care to maintain function, prevent or slow decline/deterioration (provided all other coverage criteria are met). Because of the settlement, program manual revisions were made to restate a “maintenance coverage standard” for both skilled nursing and therapy services under these benefits:

- Skilled nursing services are covered when these services are necessary to maintain the patient’s current condition, prevent or slow down further deterioration, as long as the beneficiary requires skilled care for the services to be safely and effectively provided.
- Skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates the specialized judgment, knowledge and skills of a qualified therapist (“skilled care”) are necessary to perform a safe and effective maintenance program. The program to maintain the patient’s current condition or to prevent or slow further deterioration is covered as long as the beneficiary requires skilled care for the safe and effective performance of the program.
Administrative Approval Updates for Home Health Skilled Nursing Visits*

Effective Oct. 1, 2017, Medicare Advantage is reducing the number of days it takes to get administrative approval on initial Home Health Skilled Nursing Visit requests. To better facilitate extension requests, the number of days will go from 30 to 14 days.

Initial requests for these visits will be approved for up to seven visits over a timeframe of up to 14 days. This should be sufficient to cover an initial evaluation and up to three visits per week for two weeks. No clinical information is necessary other than a diagnosis for these administrative approvals. If you make an additional request after the initial visit approval or 14-day timeframe, it will be considered an extension request, which will require supporting clinical documentation for a medical necessity review.

If you need to request more than seven visits within or beyond the 14-day timeframe on your initial request, please submit all supporting documentation for medical necessity review with this request.

Administrative approvals don’t apply to home health related rehabilitation services visits (speech, physical and occupational therapies), which will be reviewed and approved based on medical necessity.

Billing for Home Health Care Supplies

Supplies on the BlueCross Home Health Agency Non-Routine Supply List should be billed using the appropriate revenue and HCPCS codes effective for the date of service. Supplies will be denied if they’re not billed this way.

Reimbursement for supplies not included on the list used in conjunction with the above skilled nursing services is included in the maximum allowable for the home health service. The supplies won’t be reimbursed or authorized separately even if requested by another provider in lieu of the home health agency. Supplies not used in conjunction with a home health visit aren’t billable by the home health agency provider.

The only supplies you may bill in addition to the above home health skilled nursing services are those indicated on the BlueCross Home Health Agency Non-Routine Supply List (found in the billing section of the provider administration manual) along with the appropriate revenue code.

Notice of Medicare Non-Coverage

According to CMS regulations, home health agencies, skilled nursing facilities and comprehensive outpatient rehabilitation facilities are responsible for delivering Notice of Medicare Non-Coverage to the member or the authorized member representative.

CMS requires the notice be delivered at least two days before the member’s authorized services end. Days won’t be extended because of untimely delivery of the notice by the facility. If the member’s services last less than two days, the home health agency, skilled nursing facility or comprehensive outpatient rehabilitation facility must provide the notice to the member at the time of admission to the home health agency or facility.

Please fax the Notice of Medicare Non-Coverage to BlueAdvantage by noon the day after you receive it:

Attn: BlueCross BlueShield of Tennessee Care Management 1-888-535-5243 or 1-423-535-5243.

You can find the Notice of Medicare Non-Coverage form on our website at http://www.bcbst.com/providers/medicare-advantage/forms.shtml.

Revenue Code 510 (Hospital-Based Clinic Services)*

Effective Dec. 1, 2017, we’re changing the payment structure for hospital-based clinic services for Medicare Advantage plan members. When a member receives Evaluation & Management (E&M) professional services with a procedural service on the same day by the same provider:

- Payment for provider-based clinic professional services includes any technical or facility fees.

- Any additional technical or facility fee billed with Revenue Code 510 won’t be paid and will be identified on provider remittances as provider responsibility.

Providers and facilities may not bill Medicare Advantage members for the facility fees associated with provider-based clinic visits.

Note: “Same Provider” means any physician, other health care practitioner, or the provider or facility that owns or operates the provider-based clinic on or off campus.
# Quality Care Partnerships

*This information applies to all lines of business unless stated otherwise.*

## 2018 Medicare Advantage Quality Care Partnerships Performance Measures

Our Medicare Advantage (MA) plans will be sending quality amendments for 2018. Below is the list of planned measures. Please speak with your Quality Incentive Consultant if you have any questions.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>2018 Star Ratings Projected Cut Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment (ABA)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;43%</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;45%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;60%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;48%</td>
</tr>
<tr>
<td>Medication Reconciliation Post-Discharge (MRP)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;20%</td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture (OMW)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;23%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) - HbA1c Control (&lt;9.0%)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>1 Star: &lt;51%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>1 Star: &lt;40%</td>
</tr>
<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>1 Star: &lt;67%</td>
</tr>
<tr>
<td>Medication Adherence for Hypertension (RASA)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>1 Star: &lt;73%</td>
</tr>
<tr>
<td>Medication Adherence for Oral Diabetes Medications (OAD)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>1 Star: &lt;72%</td>
</tr>
<tr>
<td>Plan All-Cause Readmissions (PCR)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>1 Star: &lt;13%</td>
</tr>
</tbody>
</table>

### Additional Measures Applicable only to Quality Amendments

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>2018 Star Ratings Projected Cut Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;94%</td>
</tr>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>1 Star: &lt;55%</td>
</tr>
</tbody>
</table>

Note: Measures and cut points for the MA Star Ratings Program are determined by CMS and are based on prior year performance of all MA plans. To adjust for industry improvement in the upcoming year, BlueCross retains the right to adjust the cut points based on statistical analysis of industry trends from prior years’ performance.
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 TennCare.Select. For TTY help call 771 and ask for 888-418-0008.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member’s ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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

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1 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 and follow the prompts to reach Network Contracts or Credentialing to update your information; and

- Update your provider profile on the CAQH ProView™ website.

<table>
<thead>
<tr>
<th>Commercial Service Lines</th>
<th>1-800-924-7141</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<th>Commercial UM</th>
<th>1-800-924-7141</th>
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<tr>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)</td>
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<tr>
<th>Federal Employee Program</th>
<th>1-800-572-1003</th>
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<tr>
<th>BlueCare</th>
<th>1-800-468-9736</th>
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<tr>
<th>TennCareSelect</th>
<th>1-800-276-1978</th>
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<th>CoverKids</th>
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<tr>
<th>CHOICES</th>
<th>1-888-747-8955</th>
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<tr>
<th>ECF CHOICES</th>
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<tr>
<th>BlueCare PlusSM</th>
<th>1-800-299-1407</th>
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<th>BlueChoiceSM</th>
<th>1-866-781-3489</th>
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<tr>
<th>SelectCommunity</th>
<th>1-800-292-8196</th>
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<td>Available Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<th>BlueCard</th>
<th>Benefits &amp; Eligibility</th>
<th>1-800-676-2583</th>
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<tr>
<td>All other inquiries</td>
<td>1-800-705-0391</td>
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<tr>
<th>BlueAdvantage</th>
<th>1-800-841-7434</th>
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<tr>
<th>BlueAdvantage Group</th>
<th>1-800-818-0962</th>
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<tr>
<th>eBusiness Technical Support</th>
<th>Phone: Select Option 2 at (423) 535-5717</th>
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<tr>
<td>Email: <a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
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<tr>
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