

BlueAlertSM

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 policy listed below can be found at bcbst.com/providers/medical-policy-manual/index.page under the "Upcoming Medical Policies" link.

Effective Aug. 1, 2017

- Corneal Collagen Cross-Linking (Revision)
- Genetic (Human Leukocyte Antigen) Testing for Celiac Disease (Revision)
- Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy (Revision)

Effective Aug. 23, 2017

- Autologous Chondrocyte Implantation (Revision)

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

Utilization Management (UM) Guideline Updates/Changes

The BlueCross website has been updated to reflect upcoming changes to select UM Guidelines. [Click here](#) to review the pending modifications.

Effective Aug. 23, 2017

The following Utilization Management Guideline related to Home Care will be updated:

- Hyperemesis Gravidarum

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

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Coming Soon: Availity

BlueCross has partnered with Availity to help ensure your online experience is equal to or better than your experience with BlueAccessSM. Initially, Availity will be used to review remittance advices, claims status, eligibility and benefits with more features added throughout the year. For example, these BlueCross-specific features will be available at or shortly after the upcoming 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 will 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** – BlueCross will be among the first payers to implement Availity's upgraded Claim Management Tool for managing claim follow-up tasks. A customized search for BlueCross will include rejected claims, as well as adjudicated claims, allowing you to retrieve a full picture of your claim lifecycle all 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, you will receive more information about the next steps you'll need to take. To prepare for the transition, identify the person in your office who would 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.

Online Claims Submission Exception

BlueCross requires providers to submit claims online, but we know that sometimes things happen that are out of your control. If you have a technical and/or temporary issue or extenuating circumstances that prevent you from submitting claims online, please call our eBusiness Department at (423) 535-5717 (select option 2) or email us at eBusiness_TechSupport@bcbst.com.

For complete information and requirements to submit paper claims when there are extenuating circumstances that prevent electronic filing, please see the Billing and Reimbursement section of our [BlueCross BlueShield of Tennessee Provider Administration Manual](#).

Post-Hospitalization Mental Illness Follow-up

Appropriate follow-up care after discharge from an acute inpatient stay due to a mental health disorder is an essential component in helping ensure high quality health care for your patients. Completing a follow-up appointment within seven days of discharge decreases the possibility of medication interruption, offers support at a vulnerable time and decreases the likelihood of readmission by almost 50 percent.

Sample diagnoses for follow-up visits include:

- Dementia
- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Other mental illnesses

What can you do to help increase patient follow-up visits after discharge?

1. Schedule follow-up visits with patients within seven days.
2. Share information about established patients with hospital staff to make sure their discharge needs are met.
3. Make sure your patient understands the discharge plan and importance of keeping follow-up appointments.
4. Advise office staff/schedulers about the importance of follow-up visits within seven days.
5. Follow up with a patient who misses an appointment and attempt to reschedule.



FREE Quality Training for Network Providers

BlueCross is offering a two-day class Aug. 23 to 24, 2017, to promote health care quality. The training class will be held in the BlueCross BlueShield of Tennessee Community Room, 1 Cameron Hill Circle in Chattanooga. The class is designed to help those planning to take the Certified Professional in Healthcare Quality® (CPHQ) examination and offers intermediate quality improvement content that can benefit anyone working in the health care quality field. [Get more information on our website.](#)

Although the training costs \$399, BlueCross is offering the class to our network providers at no charge. Space is limited, so please contact us soon to register. To qualify for the training you must meet the following criteria:

- Currently employed in a role related to quality improvement or management
- Currently employed by a BlueCross network provider

Registration for network providers is limited to two participants per group/facility for the 2017 class. To register, email tawanda_malone@bcbst.com.

Prior Authorization Required for Imfinzi

Periodically, new Specialty Pharmacy drugs are added to our Provider-Administered Specialty Drug List requiring prior authorization. Imfinzi was added to the Provider-Administered Specialty Drug Lists requiring prior authorization for all lines of business effective June 1, 2017.

You can find information on all provider-administered specialty medications requiring prior authorization on our website(s).

Reminder: Prior Authorization Submissions for Provider-Administered Specialty Medications

Please note we are not able to accept prior authorization requests for specialty medications by fax. Because more detailed information is requested through the prior authorization process, and because we want to help ensure you get faster responses from us, we require online or phone prior authorization submissions. These direct interactions with clinical pharmacists and board-certified physicians will help ensure we get all the information required to make informed and timely decisions. For help submitting your authorizations online using BlueAccess, please contact your eBusiness Marketing Consultant.

Reminder: NDC Required for All Provider-Administered Medications

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. The NDC has been required on all CMS-1500 claims for provider-administered medications for all lines of business since Jan. 1, 2014.

The qualifier code N4 (NDC) or ZZ (narrative description of unspecified code) and a description of supplemental information must be entered in the shaded lines of Block 24 in the CMS-1500 claim form. To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- ME Milligram
- ML Milliliter
- GR Gram
- UN Unit

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS PORTER	F. \$ CHARGES	G. DAYS OR UNITS	H. UNITS PER DAY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPHCPCS	MODIFIER								
N4	50	24	20	06	01	ME1.25	ZZ	Avastin		13	500.00	20	N	1B	12345678901	
10	01	05	10	01	05		J1563								0123456789	

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

Paper claims will only be accepted when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call [eBusiness Technical Support](#) to discuss any barriers that may prevent you from filing electronic claims.

Reminder: New Claims Editing System to Take Effect Later this Year

BlueCross will implement a more robust editing system for Commercial professional and facility claims in the latter part of 2017. The editing system adheres to industry rules and standards, as well as federal regulations and policies governing health care claims.

You may see some slight differences in how claims are processed as a result of this change. Look for more information in upcoming issues of BlueAlert.

Reminder: New Requirements for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect Jan. 1, 2017.

BlueCross had previously indicated that claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants would be considered out of network and would be denied beginning May 1, 2017. To allow more time to comply with this requirement, BlueCross will not process these claims as out of network at this time. A revised date will be published in an upcoming BlueAlert.

You can begin the credentialing, enrollment and contracting process by completing the online [Provider Enrollment Form](#). Please contact your local Provider Network Manager if you have any questions. If you don't know who your Network Manager is, please visit our website to locate [your BlueCross contact](#).



Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise

Post-Operation Billing for Unrelated Procedures

We want to make sure your claims process efficiently and without any issues. So when the same issues trigger denials on a regular basis, we want you to know.

More claims are being denied when incorrect modifiers are used during a global billing period.

Modifiers 24 (unrelated post-op evaluation and management) and 79 (unrelated post-op procedure) are available to help simplify the post-op billing process, but the use of these modifiers is very strict. These two modifiers are only for care that has no relation to the surgery. Please include documents that substantiate any care unrelated to the surgery to help speed the payment of your claims.

For more information, refer to the "Medicare Claims Processing Manual," Chapter 12, Section 40.2, on the [CMS website](#).

Radiopharmaceutical Allowance Updated for Code A9500

Starting Aug. 1, 2017, we will no longer require supplemental information when filing claims with HCPCS Code A9500. This change is the result of our in-depth analysis of code A9500 (Technetium Tc-99m sestamibi, diagnostic, per study dose) to address provider concerns about the reimbursement process. In this analysis, data from paid claims were reviewed along with invoice documents supplied by providers to establish a reasonable allowable.

Reminder: Prior Authorization Required for CPT® Code 81545

Effective July 8, 2017, prior authorization is required for CPT® Code 81545 (Molecular Markers in Fine Needle Aspirates of the Thyroid) for Commercial lines of business. For a list of services that require prior authorization, see the [BlueCross website](#).

Reminder: Billing Guidelines for Non-Eye Care Professionals Conducting In-Office Retinal Eye Screenings for Medicare Advantage Members

If you perform in-office digital retinal eye screenings and send the results to eye care professionals to review and interpret, please verify your claims have the appropriate CPT® II, procedure and diagnosis codes.

Without the correct CPT® II code (e.g., 2026F or 3072F), a gap in care for the Comprehensive Diabetes Care Eye measure cannot be closed per NCQA requirements in the 2017 HEDIS® technical specifications for this measure.

- Code 2026F documents that you reviewed the results and confirm the patient had retinal imaging.
- Code 3072F documents that you reviewed evidence the patient had a negative retinal eye exam during the prior year and therefore did not need a retinal eye exam during the current measurement year.

Please use the date of retinal imaging as the date of service.

If you have any questions about in-office retinal eye exams, please contact your BlueCross Quality Outreach Consultant.

BlueCare Tennessee

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

Latest Changes to TennCare PDL Become Effective July 1

The latest release of the TennCare Preferred Drug List (PDL) includes changes that may affect some of the medicines your patients take. Some of the most notable changes are anti-infectives, gastrointestinal agents, endocrine and metabolic agents, as well as vitamins and electrolytes.

[Click here to view the notice of PDL changes effective July 1, 2017.](#)

Provider Satisfaction Survey Coming Soon

Your satisfaction is important to BlueCare Tennessee. Your responses to our annual BlueCare, BlueCare Plus, TennCareSelect and CoverKids Provider Satisfaction Surveys will help us continue to improve the services and support you need. The surveys are conducted by random sampling. If selected, you will receive the survey at the email address we have on file for you between July 5 and Sept. 29, 2017.

Durable Medical Equipment Review Process Update

As of Aug. 1, 2017, BlueCare Tennessee will begin using MCG Care Guidelines for durable medical equipment reviews. When MCG Care Guidelines are not available, Medicare Local Coverage Determination (LCD)/National Coverage Determination (NCD) Coding Guidelines will continue to be used.

Providers Cannot Accept Cash Payments from TennCare Enrollees that Exceed Copayments

The Bureau of TennCare has identified a large number of prescriptions written for members with TennCare coverage that don't correspond with a provider claim. If your office sees patients with BlueCare Tennessee benefits, you cannot accept cash payments that exceed the amount of their authorized copayments. Providers who violate this part of their contract can be removed from participating in TennCare provider networks.



Reminder: Tips to Help More Children Get TennCare Kids Screening

Thousands of kids (ages 20 and younger) from low-income homes in Tennessee miss their annual well-care checkups and that number increases every year. Statewide, about three of every 10 kids enrolled in BlueCare Tennessee do not get the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings they need. We're working to reverse that trend and are asking for your help.

Combining a Well-Care Visit with Other Types of Visits

Any time a child is in your office is a great time to make sure their checkups are up to date. While the visit might be for an illness, shots, sports physical or a prescription refill, statistics show it could be years before you get another chance to conduct a checkup – especially if the patient is a teenager. TennCare Kids Screening Guidelines allow reimbursement for both a "sick" and "well" visit on the same day, so you don't have to schedule another appointment for a checkup.

Reminder: Document Any Refusal to Vaccinate

Each parent/guardian or patient has the right to refuse recommended vaccines. If the parent/guardian or patient decides not to get recommended immunizations, their decision must be documented in the patient's medical record. Resources for documenting the refusal are available on the [American Academy of Pediatrics website](#). Additionally, the [CDC website](#) has conversation tools to help talk with parents/guardians and patients about the importance of immunizations and the importance of preventive care.

Medicare Advantage

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

Medicare Advantage End Stage Renal Disease (ESRD) Prescription Drugs Part D Versus Part B

The CMS final rule (79 FR 66149) identified four ESRD drug categories included in the ESRD base reimbursement rate, which are not separately payable:

Access Management	Drugs that remove clots from grafts to ensure access will reverse anticoagulation if too much medication is given.
Anemia Management	Drugs used to stimulate red blood cell production and/or treat or prevent anemia. This category includes Erythropoietin Stimulating Agents (ESAs) as well as iron.
Bone and Mineral Metabolism	Drugs used to prevent/treat bone disease secondary to dialysis. This category includes phosphate binders and calcimimetics.
Cellular Management	Drugs used for deficiencies of naturally occurring substances needed for cellular management. This category includes levocarnitine.

BlueCross reviews prescription drug claims for ESRD patients processed through their Medicare Part D benefit. If we find BlueCross paid for a prescription for renal dialysis-related drug that was under the ESRD Prospective Payment System, we will recoup that amount from the Part B renal facility claim on file.

Reminder: BlueCross Medicare Advantage Case Management Program

BlueCross' Medicare Advantage Case Management program helps our most complex or sickest patients, and those suffering from chronic conditions, effectively manage their illnesses to help ensure they live the highest quality of life possible.

Our programs are designed to assist members who have catastrophic health care needs and limited knowledge or understanding of chronic conditions. Services include nutritional counseling and general assistance with medications, transportation and other barriers to care.

Our members are eligible for case management at no additional cost, and our programs support your plan of care. It is an opt-out program, meaning your patient can choose to leave at any time. However, we encourage our members to participate to help them get the support they need to live happy and healthy lives. You can help your patients by also encouraging them to participate.

Refer your patients to case management by calling 1-800-611-3489 or faxing 1-800-727-0841.

Reminder: Behavioral Health Launches Partnership with AbleTo for Medicare Advantage Members

Beginning Aug. 1, 2017, BlueCross will partner with AbleTo to provide a telephonic counseling and outreach program to a small group of Medicare Advantage members with adjustment and mood disorders. AbleTo will provide 16 telephonic sessions with a licensed therapist and a behavioral health coach over the course of eight weeks. Once enrolled in the program, members can access these services 24 hours a day, seven days a week at no additional cost.

Initially, this service will be limited to 250 Medicare Advantage members with adjustment and mood disorders and other chronic health conditions. BlueCross will be sending letters to identified members that would be eligible for and benefit from the AbleTo program or you can refer a BlueCross Medicare Advantage patient by calling 1-866-287-1802. This program does not limit any other behavioral health services patients have through their Medicare Advantage plan.

Reminder: In-Home Test Kits Available for Homebound Medicare Advantage Members

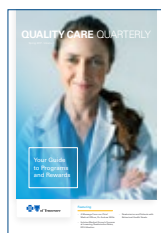
We know that getting to the doctor's office can sometimes be a challenge for some of your patients. That's why we offer in-home test kits for three of the most common annual screenings Medicare Advantage members should receive.

With a simple phone call, our partner Home Access, can mail your patient an in-home test kit for a:

- Fecal immunochemical (iFOBT of FIT) blood screening for colorectal cancer
- Kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

The member then follows the instructions to mail the kit back to the vendor for lab testing and the written results are sent to you and your patient. The screenings are at no cost to the patient and count toward your practice's quality rewards incentive for attributed members.

For more information on how to order an in home test kit for your patients, contact your BlueCross Quality Outreach Consultant.



Quality Care Rewards

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

New Quality Newsletter Available Online

BlueCross has developed a quarterly newsletter devoted to information on our quality programs. The spring 2017 Quality Care Quarterly provides insights on our quality initiative, and includes informative articles on quality measures, helpful tips and success stories from your peers.

Each edition of the newsletter will be sent to you by your BlueCross contact and will be posted online. If you didn't receive the link to the spring 2017 Quality Care Quarterly, you can view it [here](#).

REMINDER: Updated THCI Preview and Performance Reports Now Available

The Tennessee Health Care Innovation Initiative (THCI) preview and performance reports are now available on Blue Access for your review. You can use them to identify specific opportunities to further improve quality and reduce the cost of care.

- View your reports by logging in to [BlueAccess](#).
- Scroll to Tennessee Healthcare Innovation Initiative to locate your reports.

Note: Reporting is segmented by Tax ID.

For more information, or if you need help understanding your Episode of Care reports, see our webpages:

- [BlueCare Tennessee Episode of Care Program](#)
- [Commercial Episode of Care Program](#)

Reminder: Preventing Falls

One of every five falls causes a serious injury like a broken bone or blow to the head. The risk of falling is higher for someone who is weak or confused because of a previous injury, surgery, medical condition or medicine. Falls become even more dangerous if the person is taking certain medicines (like blood thinners).

Here are some tips you can share with your at-risk patients that may help reduce the risk of falls in their homes:

- Remove clutter and items that could cause a trip like small furniture, rugs and electrical cords.
- Make sure railings are installed on both sides of stairs.
- Use non-skid adhesive strips on stairs.
- Install grab bars in showers, bathtubs and near toilets.
- Place non-skid mats in the bath and shower.
- Make sure any dark areas are well lit and add nightlights in areas such as the kitchen, bathrooms and hallways.
- Use walkers or canes.
- Wear proper shoes

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not 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.

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

CPT® is a registered trademark of the American Medical Association

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Be sure your **CAQH ProView™** profile is kept up to date at all times. We depend on this vital information.

† 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.

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	1-800-572-1003
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 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-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
Email:	eBusiness_service@bcbst.com
Monday-Thursday, 8 a.m. to 6 p.m. (ET)	
Friday, 9 a.m. to 6 p.m. (ET)	