

BlueAlertSM

BlueCross BlueShield of Tennessee, Inc.

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

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 Oct. 1, 2017

- Analysis of MGMT (O6-methylguanine-DNA methyltransferase) Promoter Methylation in Malignant Gliomas (Revision)
- Daily Hemodialysis in the Home (Revision)
- Circulating Tumor DNA (Liquid Biopsy) and Circulating Tumor Cells (Revision)
- Genetic Testing for Mitochondrial Disorders (Revision)

The following medical policies will be archived and no longer active 30 days after this notification:

- Suprachoroidal Delivery of Pharmacologic Agents
- Chromoendoscopy as an Adjunct to Colonoscopy
- Cervical Cancer Screening Technologies

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

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

We've updated our BlueCross BlueShield of Tennessee Health Care Practice Recommendations for July 2017 to include the American Academy of Pediatrics (AAP) re-publication of their Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain. Additionally, the AAP has new content and a new web address for Bright Futures. These and other updates can be viewed online at <http://www.bcbst.com/providers/hcpr>. You can also request paper copies of any clinical practice guideline by calling (423) 535-6705.

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Current Data Verification Forms Necessary to Improve Provider Directory Quality

BlueCross members often use our Find a Doctor Tool on our websites to find in-network doctors by name, location, specialty or medical procedure. We make every effort to make sure the provider information in our provider directory is current and accurate, but we need your help.

When you receive a Data Verification Form, please:

1. Verify your demographic information is up-to-date for each provider at the group/location.
 - Confirm network participation.
 - Indicate if they are accepting new patients.
 - Verify location/facility hours.
 - Specify provider's status at each location, e.g., sees patients or doesn't see patients.

Note: We only list provider locations where members can call and make an appointment.

2. If changes are needed, please mark through the incorrect information and print the correct details in the space beside that field.
3. Please sign and return all of the forms for each provider, even if the information is correct.
4. Send completed forms by fax to (423) 535-3066 or email to PNS_GM@bcbst.com.

It's also very important that your office staff members who make appointments for our members, are aware of the specific demographic information for each location.

If you have any questions or need help with the Data Verification Form, please call the Provider Service Line at 1-800-924-7141. To help make sure your call is routed to the appropriate area, select the option "Provider Network Services" when prompted.

Prior Authorization Required for Brineura, Radicava and Renflexis

New specialty pharmacy drugs are periodically added to the Provider-Administered Specialty Drug Lists. The following specialty drugs have been added and require prior authorization:

Specialty Drug	Effective Date	Line of Business
Brineura	July 28, 2017	Commercial and BlueCare SM
Radicava	July 28, 2017	All
Renflexis	July 29, 2017	All

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

Non-Compliance Denial Reminder

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](#).

UPDATE: Technical Component for Professional Services Performed in a Facility*

Commercial and BlueCare Tennessee DRG and outpatient case rates paid to a facility include any technical component for professional services provided for facility patients. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist or other provider. Payment is not made under the physician fee schedule for technical component services provided for facility patients. The member cannot be held liable in these cases, as reimbursement for technical component services is part of the all-inclusive global payment made to facilities. Should a facility choose to partner with a provider for the technical component associated with the facility services, the facility will be responsible for payment of the provider.

These guidelines do not apply to Medicare Advantage plans. Medicare Advantage claims should continue to be billed consistent with CMS billing guidelines.

Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

Primary care providers are often the first point of care for alcohol and drug dependence treatment. Thank you for helping our members get the care and resources they need to adhere to treatment, improve their health and achieve a sense of well-being.

We're here to support you as you help our members:

- Stay engaged in their behavioral health treatment plans.
- Transition successfully across treatment settings.
- Understand why, when and how to take their medications.
- Receive other care coordination and case management services that promote resilience and recovery.

To learn more how you can help patients manage their dependence on alcohol and other drugs, click this [Treatment Training](#) link. You'll be connected to a WebEx on the Initiation and Engagement for Alcohol and other Drug Dependence Treatment (IET).

Reminder: Further Updates to Claims Editing Process Aim to Increase Payment Accuracy

Earlier this year, BlueCross began updating the claims payment process for all lines of business, including BlueCare Tennessee and Medicare Advantage. The latest updates will include a more careful analysis during the pre-payment phase of claims editing. The goal is delivering payments to providers with more accuracy and reducing the need to recover payments that exceed claims liability.

Because of this 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 provider reimbursement rates, your patients' benefits or the speed at which we pay your claims.

While these updates won't completely eliminate overpayments or the need for recovery, our efforts will help ensure a more accurate and efficient payment process.

Reminder: 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 on Jan. 1, 2017.

Providers can begin the credentialing, enrollment and contracting process by completing the online [Provider Enrollment Form](#). Please contact your local provider network manager with any questions. Or visit our website to find your [BlueCross contact](#).



Reminder: Availity Coming Soon

We're excited to announce that we have 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 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 – 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 complete information once we're ready to launch. 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.

Tips for Coding Professionals

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

Key Points to Remember for Diagnosis Coding

We want to help make sure your claims process efficiently and without any issues that will delay your reimbursement. Below are coding items that are triggering denials and appearing on a regular basis.

- When diagnosis codes include an age range, make sure the patient's age matches with the diagnosis code.
- The sequence of how encounter codes are listed is important. This situation happens often with chemotherapy treatments. If a patient admission/ encounter is only for administering chemotherapy, immunotherapy or radiation therapy, please assign the appropriate encounter code as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.
- Please follow the ICD-10 guidelines for the sequence of external codes not used for a primary diagnosis.



Reminder: Appropriate Billing of CPT® Code 95165

BlueCross professional reimbursement is based on CMS - RBRVS methodology, as defined in our provider administration manuals. CMS publishes fees that are used as the basis for BlueCross contracting and referenced in the provider contract. In order to facilitate correct payment, providers should bill non-venom antigens as outlined by CMS in their [Claims Processing Manual](#).

This isn't a policy change, only a reminder due to findings that some providers are billing this code with an inappropriate number of units resulting in incorrect reimbursement. Please refer to your contract for correct reimbursement procedures.

BlueCare Tennessee

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

Let Us Help Coordinate Care for Your Patients with Chronic or Complicated Health Conditions

Our Population Health Management programs for BlueCare, TennCare^{Select}, BlueCare Plus and CoverKids members can help coordinate care for your patients with complicated care needs, chronic illnesses, and catastrophic illnesses or injuries. Our clinical teams can help educate your patients about their conditions, as well as provide tools and resources that will assist them and their families when making health care decisions. These include behavioral and physical health activities, as well as CHOICES care coordination processes when appropriate. (CHOICES services aren't available to CoverKids members.)

We identify members for specific programs using claims data, health risk assessments and provider referrals. If you have patients with conditions who could benefit from our Population Health Management programs, please call 1-888-416-3025.

Billing Changes for Long-Acting Contraceptives*

Beginning Oct. 1, 2017, BlueCare Tennessee and CoverKids will begin reimbursing providers for long-acting reversible contraceptives (LARC) as separate items. Charges for LARC devices implanted during the labor and delivery inpatient stay must be billed as part of the inpatient claim. The following is a list of current HCPCS codes that will be affected:

J7297	J7300	J7307
J7298	J7301	Q9984

This change doesn't affect claims billed by physicians who perform implants in the hospital. These services can still be billed using the CPT[®] code associated with the procedure.

Member Complaints Process Changing Name to Grievance Rights*

BlueCare Tennessee is building a new process to address member complaints and it will include a name change. Based on a contract amendment with the Division of TennCare, Complaint Rights will now be called Grievance Rights

Provider Satisfaction Survey Responses Are Due September 29

BlueCare Tennessee recently sent out satisfaction surveys to a number of BlueCare, BlueCare Plus, TennCare^{Select} and CoverKids providers. If you've received a survey, please be sure to return it as soon as possible. We won't be able to review your responses after September 29.

Your opinions are important to us, because they help us determine how we can improve service to our providers. Thank you for your participation.

TennCare Eliminates Pre-Pay Submission of IEP for School Therapy

Effective immediately, TennCare has ended the requirement for schools to submit an Individual Education Plan (IEP) prior to receiving payment for covered, medically-necessary services delivered in a school setting.

Please note, the following BlueCare Tennessee guidelines still apply:

- Services billed must meet IEP therapy standards.
- Services must be performed by a participating provider.
- BlueCare will conduct post payment audits on a sample of IEPs for members who receive school-based therapy.
- If requested, the school must send a copy of the IEP and the parental consent in support of the services.

Review of 2016 ASH Claims Begins in October

During the fourth quarter of 2017, we will begin a review of all BlueCare, TennCare^{Select} 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.



Online-Only Provider Enrollment Process Starting Oct. 1

Earlier this year, we launched a new online [Provider Enrollment Form](#) to simplify the enrollment process. This step has greatly improved efficiency by reducing omissions, the need for follow-up phone calls and duplicate applications. Due to the success of this online process, we have decided to accept online-only submissions starting Oct. 1, 2017. We'll accept paper copies of the provider enrollment form (PDF version) by email, fax or mail up to that point, ending Sept. 30, 2017.

Reminder: Scheduling Non-Emergency Transportation

Transportation is a vital element of patient care. BlueCare Tennessee is reminding network facilities about the guidelines for any non-emergency trip requested by a hospital, facility or other provider.

The mode of non-emergency transportation is a decision the facility will make based on the patient's condition and care needs. When you have BlueCare or TennCare*Select* members who need non-emergency transportation, please contact Southeastrans♦.

If the patient must travel on a stretcher, but doesn't need medical care during the trip, Southeastrans will provide a stretcher van, along with a driver and attendant to transport the patient. To ensure Southeastrans provides the proper service and vehicle, please have the following information available when scheduling non-emergency transportation:

- Patient's name and BlueCare Tennessee member ID number
- Addresses for patient's pick-up and destination (including room numbers if necessary)

- Date of transportation and appointment time (if applicable)
- Special medical needs of the patient
- Any escorts that will travel with the patient

To schedule non-emergency transportation, please call Southeastrans in your area of the state:

- BlueCare East – 1-866-473-7563
- BlueCare Middle – 1-866-570-9445
- BlueCare West – 1-866-473-7564
- TennCare*Select* – 1-866-473-7565

If you have questions about non-emergency transportation, please call 1-800-468-9698 for BlueCare members or 1-800-263-5479 for TennCare*Select* members.

♦ Southeastrans isn't equipped to provide emergency transportation.

Converting a Sports Physical to TennCare Kids Checkup

Across the state, only about 70 percent of kids enrolled in BlueCare Tennessee get their annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) checkups. There are many ways you can help us push that rate above 80 percent. One effective way is to convert a sports physical to a well-care visit.

As a reminder, stand-alone sports physicals and their corresponding codes aren't covered services. However, by converting that appointment into a complete well-care visit, you can meet all requirements of the sports physical and receive reimbursement for a covered service.

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

Beginning Oct. 1, 2017, the specialty medications listed below will require prior authorization for Medicare Advantage.

Specialty Medications Requiring Prior Authorization (effective Oct. 1, 2017)		
Abraxane	Firmagon	Ozurdex
Acthar HP	Fusilev	Perjeta
Adcetris	Gazyva	Proleukin
Aloxi	Glassia	Provenge
Aralast/Prolastin/Prolastin C/Zemaira	Halaven	Retisert
Arzerra	Ilaris	Signifor_LAR
Beleodaq	Iluvien	Soliris
Benlysta	inflectra	SOMATULINE DEPOT
Berinert	Istodax	Synribo
Cerezyme	Jetrea	Thyrogen
Cimzia	Jevtana	Trelstar Depot
Cinryze	Kadcyla	Tyvaso
Cyramza	Kalbitor	Vantas
Elelyso	Kyprolis	Vimizim
Eligard/Lupron Depot	Lupron Depot	Xiaflex
Empliciti	Marqibo	Zaltrap
Epoprostenol (Flolan/Veltri)	NAGLAZYME	Zoladex
Fabrazyme	Onivyde	

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

Reminder: Home Health Administrative Approvals Updates

Effective Oct. 1, 2017, Medicare Advantage will update the number of days spanned for administrative approval on initial home health skilled nursing care requests from 30 days to 14 days.

Initial requests for home health skilled nursing authorization will receive administrative approval of up to seven visits over a timeframe of up to 14 days. The number of visits and timeframe given is sufficient to cover an initial evaluation and up to three visits per week for two weeks. No clinical information is necessary for administrative approvals other than a diagnosis. Any additional requests for services beyond the initial timeframe will require supporting clinical documentation for a medical necessity review.

Reminder: Hospice Prescription Drugs Review

Members who are in hospice care generally experience common symptoms, including pain, nausea, constipation and anxiety during end-of-life care. CMS identified four common prescription categories typically used to treat these symptoms: Analgesics, anti-nauseants, laxatives and anti-anxiety drugs.

CMS requires Medicare Advantage plans to review claims paid within the hospice election period for prescription drugs in these four categories. It also plans to conduct outreach to the hospice provider or prescriber.

Hospice facilities may receive written requests from the Medicare Advantage plan to retrospectively determine payment responsibility for the four categories of drugs used in the hospice setting. You can find more information on the [CMS website](#).

Reminder: Don't Forget to Submit Your Provider Assessment Forms (PAF)

In 2017, you're eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service as E/M Code 96160, with an allowable charge through the end of the year as follows:

- \$175 for dates of service between July 1 and Sept. 30, 2017
- \$150 for dates of service between Oct. 1 and Dec. 31, 2017

You can receive your reimbursement by completing and submitting the [Provider Assessment Form](#) electronically via [BlueAccess](#). You may also complete the fillable form and fax it to 1-877-922-2963. The form should be included in your patient's chart as part of their permanent record.

Note: It's not necessary to wait 365 days between PAF submissions. For additional information about the PAF, please see the [Quality Care Rewards](#) section of our website.

Reminder: 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 levocamitine.

BlueCross reviews prescription drug claims for ESRD patients processed through their Medicare Part D benefit. If we find BlueCross paid for a prescription for a 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.



Quality Care Rewards

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

THCII Episodes of Care Reports Now Available

Episodes of Care Final Performance, Interim Performance and Preview Reports for Commercial and Medicaid lines of business are available. If you have episodes in Waves 1 or 2, you have a Final Performance Report available for the Medicaid lines of business. Both Interim Performance Reports and Preview Reports are available based on respective Waves for all lines of business. Gain- or risk-share payments will be initiated in November of this year.

Please login to [BlueAccess](#) to view your reports. Reports are aggregated to the Contract ID + Tax ID level. You can find more information related to Episodes of Care on our [BlueCare Tennessee](#) and [Commercial](#) websites, or visit the [state's website](#) for additional program detail.

If you believe you should have reports, but cannot access them, please call [eBusiness](#) at (423) 535-5717.

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

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† 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)	



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