of Tennessee

APRIL 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective May 13, 2017

- Breast Cancer Gene Expression Assays (Revision)
- Small Bowel/Small Bowel-Liver/Multivisceral Intestinal Transplantation (Revision)
- Spinal Cord Stimulation/Peripheral Subcutaneous Field Stimulation for the Treatment of Pain (Revision)

Effective June 21, 2017

- Osteochondral Allografting (Revision)

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

Intracavitary Balloon Catheter Brachytherapy for Malignant Gliomas or Metastases to the Brain – This medical policy is no longer used by BlueCross Utilization Management. It will be archived and no longer active 30 days after this notification.

You're Invited! Annual All Blue Workshops

Please join us at one of our free annual All Blue provider workshops. Our knowledgeable representatives and subject matter experts will be available to answer questions and address your concerns. Register online today!

- Chattanooga – April 5, 2017
- Johnson City – April 18, 2017
- Knoxville – April 19, 2017
- Nashville – May 4, 2017
- Memphis – June 6, 2017
- Jackson – June 7, 2017

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Prior Authorization Required for Lartruvo

Lartruvo will be added to the Provider-Administered Specialty Drug Lists requiring prior authorization, for all lines of business, effective April 1, 2017. Periodically, new specialty drugs are added to the lists which vary by lines of business. You can find information on all provider-administered specialty medications requiring prior authorization on the web pages below.

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

See the CDC's Recommended Immunization Schedules for 2017

The Centers for Disease Control and Prevention (CDC) has released its 2017 immunization schedules. As is the case each year, there are a number of changes to the vaccine recommendations. Among them were three vaccines that showed low member compliance in 2016: Human papillomavirus (HPV), influenza and meningococcal.

For the new recommendations regarding HPV, flu and meningococcal, as well as the complete 2017 schedule of immunizations for kids 18 years and younger, see the CDC website.

Claim and Remittance Explanation Codes Updated Online; Remapped Quarterly

The Centers for Medicare & Medicaid Services (CMS) maintains and publishes codes used by providers when filing claims and by payers when issuing payments. These codes are updated frequently and can be found on the BlueCross website.

Several times a year, BlueCross reviews and updates code mapping in order to remain compliant with CAQH CORE EFT & ERA Operating Rules. These updates may impact your internal processes. Please remember to check our website regularly to remain informed of these code changes. The changes will be highlighted and can be found here.

Code changes are also published by the Washington Publishing Company. See Claim Adjustment Reason Codes (CARC) and Remittance Advice Remarks Codes (RARC) on the Washington Publishing company website.

Dental Credentialing/ Recredentialing Is Required

As of March 1, 2017, BlueCross requires all dental providers to be credentialed. This will apply to dental providers who have not been credentialed and/or recredentialed in the past three years. You should receive a letter soon providing additional information about the credentialing process.

Reminder: New Process Aims to Increase Payment Accuracy, Reduce Administrative Burden on Providers

Beginning in April BlueCross has a new process that will help reduce the administrative burden put on providers when we recover overpayments on your patients' claims. Our claims payment process for all lines of business, including BlueCare Tennessee and BlueAdvantage (PPO)SM, will more carefully analyze claims with the goal of delivering payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability.

This process will not reduce provider reimbursement rates, your patients' benefits or the speed at which we pay your claims. In fact, this addition to our system will increase efficiency and compliance with standards set by CMS and other governing organizations.

While this system will not completely eliminate overpayments or the need for recovery, our efforts in 2017 help ensure a more accurate and efficient payment process to our providers.

Reminder: All Provider-Administered Medications Require NDC Codes

Medical claims for all provider-administered drugs must include the National Drug Code (NDC) of the drug(s) administered, along with the quantity and unit.

Providers are encouraged to share NDC billing requirement guidelines with their electronic software vendor to assist in the submission of electronic claims and to help ensure accurate placement of data. http://www.bcbst.com/docs/providers/Supplemental-EDI-Information.pdf

Please note: Claims submitted for provider-administered drugs without the appropriate NDC may be rejected.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims. Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Changes to Moderate Conscious Sedation Codes

In keeping with current coding standards, BlueCross made changes to payment rates for codes related to Moderate Conscious Sedation. Please review this important information for each line of business.

BlueCross' changes are in response to CMS modification of procedure codes and corresponding payment rates for the Medicare Physician Fee Schedule, based on the AMA's CPT® coding changes for Moderate Conscious Sedation services.

- The AMA deleted procedure codes 99143-99145 and 99148-99150 effective Dec. 31, 2016, and adopted seven new Moderate Conscious Sedation procedure codes effective Jan. 1, 2017.
- CMS reduced the Relative Value Units (RVUs) for procedure codes listed in the Appendix G Summary of CPT® Codes that include Moderate Conscious Sedation last published in the 2016 AMA CPT® Manual.
- CMS changed the RVUs for certain codes included in Appendix G that now correspond with the seven new Moderate Conscious Sedation procedure codes, for which payment may be made.

For more information, see our website at http://www.bcbst.com/sedationcode.

Reminder: CT and MRI Associated With Joint Arthrogram

CT and MRI testing for Commercial members associated with joint arthrogram procedure codes 23350, 27093, 27095, 27370, G0259, and G0260 can be authorized through the Musculoskeletal Program administered by OrthoNet.

Prior authorization requests can be submitted via BlueAccess℠ at www.bcbst.com/blueaccess, by phone at 1-866-747-0586 or by fax to 1-866-747-0587. (When submitted online, the musculoskeletal code must be the primary code.)

Reminder: New Requirements in Effect 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 requirement went into effect Jan. 1, 2017, and applies even if nurse practitioners and physician assistants are employed by a physician or group already contracted with BlueCross.

Important Notes:

- Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form.
- Once this process is complete, nurse practitioners and physician assistants must submit bills under those/their specific specialties.

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- Nurse practitioners and physician assistants are not permitted to bill as a delegated service and claims will be denied beginning May 1, 2017.
- Claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants will be considered out of network beginning May 1, 2017.

Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, visit http://www.bcbst.com/providers/mycontact/ to locate your BlueCross contact.

BlueCare Tennessee

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

Copays are the Only Acceptable Payment Allowed from TennCare Patients

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

Bright Futures Online Resource for Kids' Well-Care Schedule

The American Academy of Pediatrics (AAP) recommends a schedule of comprehensive, age-specific, preventive health care screenings, assessments, physical examinations and procedures used as the standard of care for your young patients. These recommendations have recently been updated in the Bright Futures/AAP Periodicity Schedule.

In addition to covering scheduled periodic checkups, BlueCare Tennessee also covers other inter-periodic screens for kids. Children should have 12 TennCare Kids checkups between birth and age 30 months and a checkup every year from age 3 to age 20.

Helping You Coordinate Care for Your BlueCare Tennessee Patients

Ideally, BlueCare Tennessee members who are assigned to you as their primary care provider (PCP) would visit you for all of their care. Seeing you for check-ups, as well as when they're sick, would allow you to best coordinate their care. Since that doesn't always happen, our claims data is a great resource when you need to know more about your patients' complete health histories.

BlueCare Member Information Available to Assigned PCPs is available to you and includes:

- Patient demographics
- Well-care visits including Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Sick visits
- Hospitalization
- Medication history
- Age specific screenings
- Immunizations
- Lab results
- Allergies

To request the health history of a BlueCare Tennessee member, please call Provider Service.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978

If you need to request information regarding a SelectKids member, please e-mail your request including the member name, member ID number and date of birth to SelectKids_GM@bcbst.com.

Due to privacy concerns, any claims related to Behavioral Health Services will not be released.

Abortion, Sterilization and Hysterectomy (ASH) Form Reminder

Please ensure each field in the TennCare published ASH forms are completed accurately. The Hysterectomy form has been revised for clarity to help ensure providers complete only one section of the form. All ASH forms, along with instructions for completion, are accessible online in the ASH section of the BlueCare Tennessee Provider Administration Manual.

Note: This information is applicable to your patients with BlueCare Tennessee and CoverKids health plans.

Reminder: TennCare Behavioral Health Guidelines Update

As a part of the Tennessee Health Care Innovation Initiative, Level 2 Mental Health Case Management is no longer a reimbursable service. Instead, members can be referred for Care Coordination Services that are delivered by Bureau-approved Tennessee Health Link providers. For more information, please visit https://www.tn.gov/hcfa/article/tennessee-health-link.

Medicare Advantage

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

Behavioral Health Launches Partnership with AbleTo for Medicare Advantage Members

Approximately one in five seniors is likely to struggle with behavioral health issues, and this can worsen other chronic health problems. Additionally, the senior population typically manages multiple medical conditions on a daily basis, which puts them at greater risk for behavioral health issues such as depression and anxiety. This can negatively impact medication compliance and other efforts to follow your prescribed treatment plan.

Starting June 1, 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. Members may be asked to participate via letter, 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 through the patient's Medicare Advantage plan.

Integrated Denial Notice Revised by CMS

CMS revised the Notice of Denial of Medical Coverage (Integrated Denial Notice [IDN]) template that all Medicare Advantage plans must use by April 10, 2017. CMS issues the IDN to inform enrollees of their appeal rights as applicable for payment or service denials and for discontinuation or reduction of a previously authorized course of treatment.

Please note the following changes to the IDN:

- A suggestion for the enrollee to share a copy of the decision with his or her doctor so it can be discussed. The notice also explains that a copy of the decision was sent to the doctor if the he or she made the request on the enrollee's behalf.
- Information on how enrollees can request the notice in an alternative format
- Language related to the doctor's supporting statement for an appeal
- A new statement: "We recommend keeping a copy of everything you send us for your records."
- The Standard Appeal formatted documentation for mailing address, phone and fax number, in-person delivery address, and TTY user call number
- The Fast Appeal formatted documentation was updated to include a TTY user call number.

New Home Health Billing Guidelines for Medicare Advantage*

Beginning June 1, 2017, Medicare Advantage will require HCPCS codes for all outpatient physical, occupational and speech therapy services. Skilled nursing, medical social services and home health aide services also require the appropriate HCPCS codes that correspond with the Revenue Code being billed.

Please be sure the billing units for home health services are filed as 1 unit for each 15-minute increment. Refer to the BlueCross BlueShield of Tennessee Provider Administration Manual for additional home health billing information

Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Physical Therapy	421	G0151	1 unit per 15 minutes
		G0157	
		G0159	
Home Health Occupational Therapy	431	G0152	
		G0158	
		G0160	
Home Health Speech Therapy	441	G0153	
		G0161	
Home Health Agency Skilled Nursing (RN or LPN)	551	G0493	
		G0494	
		G0495	
		G0496	
Home Health Agency Medical Social Services	561	G0155	
Home Health Agency Home Health Aide	571	G0156	

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member's condition. The MA plan follows Medicare policy. According to 42 U.S.C. § 1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

According to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.24(e) and (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

As with Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. Reimbursement will not be considered for dialysis clinic claims in a given calendar year if a completed CMS-2728-U03 form is not on file with BlueCross. The initial and subsequent claims will be denied requesting you to submit the completed form.

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

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Reminder: No Prior Authorization Required for Home-Based Polysomnography Sleep Studies

Home-based polysomnography sleep studies do not require a prior authorization. Facility-based sleep studies (polysomnogram or PSG), CPAP titration and split-night sleep studies all require prior authorization.

Reminder: Medicare Risk Adjustment Medical Records

CMS requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross has partnered with ArroHealth to obtain medical records on our behalf to meet this requirement.

ArroHealth will formally request medical records beginning in late April and early May. You will soon receive a letter along with a list of requested member records and instructions on how to send medical records. Please follow the instructions provided with your letter how to return the requested medical records to ArroHealth.

You have three convenient ways to submit medical records to ArroHealth:

- Fax:1-866-790-4192
  1-646-883-9921
- Mail: (please mark envelope as "Confidential")
  ArroHealth
  Attn: MRR3 Unit – BlueCross BlueShield of Tennessee
  49 Wireless Blvd Suite 140
  Hauppauge, NY 11788
- Secure Email: auditing@arrohealth.com

You also may request on-site assistance by calling ArroHealth at 1-855-651-1885, or by contacting your Provider Relations Consultant.

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.

*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 http://www.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
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
BlueChoice℠	1-866-781-3489
***Select*Community**	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)	