of Tennessee

MAY 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 policy listed below can be found at bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective June 10, 2017

Homocysteine Testing in the Screening, Diagnosis, and Management of Dyslipidemia and Cardiovascular Disease and Venous Thromboembolic Disease (Revision)

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

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee Health Care Practice Recommendations have been revised to include the **2017 Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease (GOLD Report) and American Diabetes Association: Standards of Medical Care in Diabetes**. These and other updates can be viewed in their entirety online at bcbst.com/providers/hcpr. Paper copies of the guidelines are available upon request by calling 1-800-924-7141, ext. 6705.

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Coming Soon: New Provider Portal Offers Enhanced Online Tools

BlueCross is making enhancements to our online tools to keep pace with advancements in technology and to provide you with the resources you need. We have partnered with Availity, a leading provider of electronic health care transactions, to offer you a wider range of web-based products and services. Availity offers a multi-payer portal solution allowing you to use a single sign-on to work with BlueCross and other participating health care plans online.

Initially, the new portal will be used for reviewing remittance advices, claims status, eligibility and benefits with more features phased in throughout the year. As changes emerge, you will see eBusiness and other BlueCross resources leading efforts on education, provider engagement and training. We will continue to keep you updated about our transition to Availity through BlueAlert, online messages and updates through BlueAccess℠. Availity will eventually replace BlueAccess for providers.

New Claims Editing System to Be in Effect Later this Year

BlueCross plans to 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.

New and Improved Online Provider Enrollment Form

The Provider Enrollment Form has recently been updated and can now be completed and submitted online. The new online form will help reduce processing time and prevent some of the return phone calls to providers to verify or obtain required information for processing the form.

When the new Provider Enrollment Form is submitted online, you will receive a reference number (DCN) that you will need to use when contacting (by phone or email) Provider Network Services for status.

We will continue to accept paper copies of the old Provider Enrollment Forms (PDF version) by email, fax or mail until June 30, 2017. Beginning July 1, 2017, we will no longer accept printed versions the Provider Enrollment Form. The Provider Enrollment Form must be completed and submitted online.

Prior Authorization Required for CPT® Code 81545

Effective July 8, 2017, a 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.

Prior Authorization Required for Spinraza and Sustol

Effective March 30, 2017, Spinraza and Sustol requires prior authorization for all lines of business. These drugs have been added to the Provider-administered Specialty Drug Lists.

The Provider-administered Specialty Drug Lists vary by lines of business. For the most current provider-administered specialty medications requiring prior authorization, visit our website(s).

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

Alternative Provider-administered Specialty Medications Not Requiring Prior Authorization (PA)

Many provider-administered specialty medications require prior authorization, often due to safety, handling and/or storage concerns. However, there are some provider-administered specialty medications that do not require prior authorization, and if appropriate for the patient, could possibly save office staff time and patient out-of-pocket expense.

The following are some examples of alternative provider-administered specialty medications that do not require prior authorization:

Provider-Administered Specialty Medications REQUIRING Prior Authorization	Provider-Administered Alternative Specialty Medications NOT Requiring Prior Authorization
Lucentis, Macugen, Eylea	Compounded Avastin for ophthalmic use
Neulasta	Granix, Neupogen, or TPO-filgrastim
Fusilev	Leucovorin
Aloxi	Ondansetron
Abraxane	Taxol

Patient Safety: Medication Errors

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm. Medication errors occur in all settings and may or may not cause an adverse drug event.

Here are some ways to help prevent medication errors:

- Workers who are not certified or licensed should never administer medication to patients in the home.
- Encourage patients to keep their medications in a lock box.
- Educate your patients on the following:
  - What is the medicine used for?
  - How long is the medicine to be taken?
  - How is the medicine administered?
  - What should they do if they experience side effects?
  - Is the medicine safe to take with other medications or with certain foods?
  - Can the patient continue normal activities while taking the medication?

Following these steps can help keep patients safe.

Long-acting Opioid Prior Authorization Requirements

(Applies to your patients with BlueCross Commercial, BlueAdvantage (PPO)℠, BlueChoice (HMO)℠ and BlueCare Plus (HMO SNP)℠ plans)

Earlier this year, BlueCross announced a policy change requiring your patients who take long-acting opioid pain medication therapy covered by BlueCross Commercial and Medicare plans to have a prior authorization for these medications effective Jan. 1, 2017. Following is the documentation required to process prior authorization for a long-acting opioid:

- Documentation containing the patient's diagnosis, evaluation and medical assessment for the requested medication which clearly indicates ALL of the following:
  - Nature and intensity of pain
  - Past and current treatments of pain (e.g., receiving opioids previously in treatment of acute pain)
  - Underlying or concomitant disorders and conditions
  - Effect of the pain on physical and psychological functioning
  - Review of history, physical examination and laboratory findings
- Pain management agreement signed by the patient and the provider in the past six months
- Aberrant behavior risk assessment tool
  - SOAPP (Screener and Opioid Assessment for Patients with Pain) for a new opioid user
  - COMM (Current Opioid Misuse Measure) for a current opioid user
  - ORT (Opioid Risk Tool)

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- Documentation confirming the state controlled substance database has been reviewed in the past 90 days
- Treatment plan signed by patient and provider that includes goals, monitoring and periodic drug testing agreement
- Documentation with patient's results from a chronic opioid therapy assessment, using either the 5A's assessment or a pain assessment tool, e.g., Pain, Enjoyment and General Activity (PEG) scale

Note – Opioid treatment for patients in hospice care or undergoing cancer treatment will receive approval but still requires a prior authorization request.

Please note that there may be other components required for completion of the prior authorization. To view the entire policy on the Use of Opioids in Control of Chronic Pain, visit our website at bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm and select Administrative Services.

The 2017 Long Acting Opioids Criteria for the Commercial/Essential plans is available in the Pharmacy section of our website.

How to Obtain Prior Authorization for Your Patients

- For your patients with **BlueCross Commercial** plans, please call 1-877-916-2271 or fax your request to 1-800-837-0959.
- For your patients who are covered by **BlueAdvantage**℠, **BlueChoice**℠ or **BlueCare Plus**℠ plans, please call 1-844-648-9628 or fax your request to 1-877-328-9799.

BlueCross Morphine Equivalent Dose (MEqD) Criteria Effective 1/1/2017

(Applies to your patients with BlueCross Commercial, BlueAdvantage, BlueChoice and BlueCare Plus plans)

A component of the opioid policy change that was effective Jan. 1, 2017, was setting MEqD criteria. The policy change set a MEqD limit of 200mg per day across all opioids, both short-acting and long-acting, covered by BlueCross Commercial, BlueAdvantage, BlueChoice and BlueCare Plus plans.

Currently, approval of requests over the 200mg MEqD are limited to a maximum MEqD of 600mg with a six- month approval timeframe. If your patient is still receiving a cumulative MEqD greater than 200mg at the end of the six-month approval, a renewal request will need to be submitted. Following are helpful hints to aid in the MEqD prior authorization renewal process.

In order to process your patient's prior authorization for a MEqD renewal, we require the following information:

- Patient's cumulative MEqD for their opioid regimen at the time of the initial request
- Patient's current cumulative MEqD for their opioid regimen at the time of the renewal request
- Documentation of a taper plan to less than 200mg MEqD in the next six months

MEqD Resources:

agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Note – Opioid treatment for members with a terminal illness or undergoing cancer treatment will receive approval in six month increments and will not be limited to a MEqD of 600mg. However, these requests will still require prior authorization.

How to Obtain Prior Authorization for Your Patients

- For your patients with BlueCross Commercial plans, please call 1-877-916-2271 or fax your request to 1-800-837-0959.
- For your patients who are covered by BlueAdvantage, BlueChoice or BlueCare Plus plans, please call 1-844-648-9628 or fax your request to 1-877-328-9799.

Recommended Blood Glucose Testing for Overweight, Obese Patients

The US Preventive Services Task Force (USPSTF) has endorsed blood glucose testing as part of cardiovascular risk assessment in adults, 40 to 70, who are overweight or obese. Patients with abnormal blood glucose results should be referred for behavioral counseling to promote a healthy diet and physical activity. These interventions can help lower blood pressure, glucose and lipid levels and weight, all of which can reduce a patient's risk for type II diabetes.

The Centers for Disease Control and Prevention's (CDC's) National Diabetes Prevention Program website lists nationally recognized programs that have agreed to use a CDC-approved curriculum that meets established duration, intensity and reporting requirements.

Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

Providers are often the first point of care for alcohol and drug dependence treatment. Incorporate these suggestions to improve the chances that an individual will engage in and successfully complete treatment:

- Use screening tools to identify alcohol and other drug dependencies (AOD).
- Educate the patient on the new alcohol and other drug dependence diagnosis.
- Ensure the initial treatment is scheduled within 14 days of the diagnosis.
- Schedule two additional follow-up appointments within 29 days of starting treatment.
- Educate the patient's support system on the patient's diagnosis after obtaining an appropriate release of information to involve the patient's support system.
- For help finding a behavioral health provider to refer your patients, call the number listed on the back of their Member ID card.

Correction: Billing Assistant-at-Surgery Services for Commercial Plans

The March BlueAlert incorrectly stated that nurse practitioners (NPs) are eligible for reimbursement when providing assistant-at-surgery services. Assistant-at-surgery services provided by an NP or clinical nurse specialist (CNS) is considered ancillary support, is included in reimbursement to the licensed supervising physician or to the facility and should be compensated directly to the NP or CNS by the supervising physician or facility. The maximum allowable for reimbursement of assistant-at-surgery services provided by an NP or CNS is $0.00.

We apologize for any inconvenience this error may have caused.

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 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.

BlueCross had previously indicated that claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants would deny beginning May 1, 2017; however, to allow more time to comply with this requirement, BlueCross will not begin denying claims on May 1. A revised date will be published in an upcoming BlueAlert.

Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, please visit bcbst.com/providers/mycontact to locate your BlueCross contact.

Reminder: Credentialing Requirements

Professional providers are reminded to update and maintain current information with CAQH®. With the following required information completed and kept up to date, the credentialing process should be seamless:

- Attest to the accuracy of your information with CAQH every 120 days.
- Current Certificate of Insurance (BlueCross cannot accept a Declarations Page)
- BlueCross requires call coverage – please complete this section on CAQH.
- If the practitioner does not admit to a hospital, BlueCross requires the name of the person authorized to admit for the practitioner.
- Complete work history with any gaps in work history explained
- Nurse Practitioners/Physician Assistants: Please upload professional certifications to CAQH.

Reminder: Durable Medical Equipment (DME) and Prosthetics and Orthotics Requirements

Providers billing for DME should have a Home Medical Equipment license. The only exceptions are providers billing for non-motorized equipment (e.g. walkers, canes, crutches). DME and medical supplies should only be billed by a DME provider when the services are purchased in a DME retail store or delivered to the member at their private residence. DME or medical supplies provided in a facility setting or during ambulance transport should not be billed by the DME provider. DME and supply services in these settings are incidental to the services provided by the facility or ambulance provider. Services billed improperly by DME or medical supply providers for items provided during a facility stay or ambulance transport are subject to recovery.

Providers billing for prosthetics or orthotics should have proper certification or accreditation. The provider is responsible for ensuring all codes billed are valid for the date of service. Information about certification and licensing requirements, as well as billing guidelines, is available in the provider administration manuals located on the company website at bcbst.com/providers/manuals.page.

Reminder: Requesting an MRI with Arthrogram for Commercial Members

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.

- Member benefits should always be verified prior to submitting.
- If the member has musculoskeletal benefits and the procedure is on the Musculoskeletal Code List, the requested arthrogram should be submitted to OrthoNet including the MRI. You can request an authorization from OrthoNet through BlueAccess or by fax to 1-866-747-0587.
- If the member does NOT have musculoskeletal benefits but has high-tech imaging benefits, the MRI authorization request can be submitted to eviCore through BlueAccess as well. You may also call eviCore at 1-888-693-3211 or fax the request to 1-888-693-3210.
- In cases where the member has musculoskeletal benefits, when requesting authorization through BlueAccess, be sure the initial code listed is for the injection (for example 23350) then list the MRI code. This will help ensure the entire case is routed appropriately to OrthoNet.

Reminder: Electronic Claims Submission Required

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.

BlueCare Tennessee

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

Tennessee Health Link, Patient-Centered Medical Home Preview Reports

Preview reports for Tennessee Health Link (THL) and Patient-Centered Medical Home (PCMH) – two newer programs of the Tennessee Health Care Innovation Initiative (THCII) – will be posted during the month of May.

To review your reports, login to BlueAccess at bcbst.com. If you need help accessing the reports, contact our eBusiness team at (423) 535-5717, Option 2 or at ebusiness_service@bcbst.com.

Children with Special Needs Require Annual TennCare Kids Checkups Too

Children with special needs often receive extra care and visits to specialists or Primary Care Providers for specific reasons. While the reasons for the visits may not be for a checkup, children with special needs should also have TennCare Kids well-child checkups every year. You can find Recommendations for Preventive Pediatric Health Care at the American Academy of Pediatrics website.

If you have questions about coding or billing, please see Preventive Services Billed with Evaluation & Management Codes in the **TennCare Kids** section of the BlueCare Tennessee Provider Administration Manual.

TennCare Registration Required for Secondary Providers on Certain Claims

Beginning with claims on or after June 1, 2017, the following secondary providers submitting professional and/or institutional claims for BlueCare Tennessee and CoverKids members must be registered with the Bureau of TennCare as well as with BlueCare Tennessee for all dates of service on the claim.

Institutional Claims

- Attending Provider
- Operating Provider
- Other Operating Provider
- Rendering Provider
- Service Facility Location

Professional Claims

- Service Facility Location
- Purchased Service Provider

Claims submitted on or after June 1, 2017, with an unregistered secondary provider will be returned to the provider unprocessed.

To learn more about registering with TennCare please visit the TennCare website.

To register with BlueCare Tennessee, please call the Provider Service lines.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CoverKids 1-800-924-7141

CDC Revises Vaccine Program for Dually Enrolled Children*

The CDC has updated guidance issued in 2017 for the Vaccines for Children (VFC) Program regarding children dually enrolled in Medicaid and private insurance. **Until further notice, BlueCare Tennessee will follow the guidelines in the 2016 VFC Operations Guide**.

Insured and Medicaid as Secondary Insurance:

Situations occur where children may have private health insurance and Medicaid as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid. The parent is not required to participate in the VFC program. The following are options for the parent and provider:

- **Option 1:** A provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee.
- **Option 2:** A provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee.

If you have questions, please contact Provider Service.

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

First Step for VFC Immunization Reimbursement is to Register with TennIIS

Your practice can receive payments for the administration of vaccines under the federal VFC program by registering with the Tennessee Immunization Information System (TennIIS). TennIIS is a statewide system managed by the Tennessee Department of Health to help ensure Tennesseans of all ages are properly immunized. The program allows health care providers, pharmacists, schools and childcare organizations to access and update vaccination records.

To learn more about TennIIS and VFC programs, please visit the TennIIS website.

If you are interested in enrolling in the VFC Program for the first time or would like to request a Starter Kit, please contact the VFC Enrollment team directly at VFC.Enrollment@tn.gov.

New Athletic Training Evaluation Codes Not Covered by BlueCare Tennessee and CoverKids

BlueCare Tennessee and CoverKids cover a complete, preventive checkup each year, so when your office is seeing patients for the purpose of a sports physical, these visits will serve as a great opportunity to perform a well-care visit.

Also, because these annual physicals meet or exceed the criteria required of a physical evaluation for playing sports, BlueCare Tennessee and CoverKids will not cover the four new athletic training evaluations codes released by the Centers for Medicare & Medicaid Services (CMS) (97169, 97170, 97171 and 97172) at the start of 2017.

BlueCare Plus Reimbursements for Patient Readmissions

In conjunction with the CMS Hospital Readmissions Reduction Program, BlueCare Plus will reimburse for readmissions to acute care hospitals that occur within 31 days from the index admission discharge as follows:

Facilities are not eligible for two DRG inpatient payments if a same or similar diagnosis readmission occurs within three to 31 days from a complication of the original hospital stay or admission – and it's due to a modifiable cause related to the facility's discharge diagnosis. This applies to readmission to the same facility or any other facility that is operating under the same contract.

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The facility will be reimbursed for a single inpatient DRG (the higher weighted of the two admissions) only. All other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for medical necessity.

A same or similar diagnosis readmission that occurs within 48 hours of an acute care hospital discharge from the same or similar facility, or facility operating under the same contract, will not be reimbursed regardless of the length of stay. CMS considers a short term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the member not being clinically stable at the time of the original discharge.

BlueCare Plus readmission guidelines are less stringent than the Readmission Reduction Program guidelines for original Medicare by not penalizing a facility for all diagnoses that could lead to a readmission or adjusting all Medicare payments. BlueCare Plus applies the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the individual member that is readmitted.

The goal of this program is to engage providers and facilities in addressing transition of care options. CMS considers 31 day readmissions to be an indicator of quality of care.

Notes:

- Members cannot be held liable for denied charges associated with a readmission within 31 days of a previous admission as indicated above.
- Standard facility appeal remedies are applicable.

NCCI Guidelines for 2017 Codes Available on CMS Website

No one is more aware of how complicated the coding process is for medical claims than providers and their support staff. The CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding methods nationwide.

The **NCCI Coding Policy Manual for Medicare Services** is updated each year and includes explanations for NCCI edits. The 2017 version is available at the CMS website and serves as a great reference tool for proper claims billing and the correct use of modifiers when billing specific services.

Implementing Patient Goals for Home Health

Home health care is often seen as a long-term or even perpetual service for patients. However, its intended role is to stabilize patients in a home environment to the point where they no longer need medical care. The demand for home health care is on the rise and stretching beyond capacity. To help ensure your patients continue to get the care they need, BlueCare Tennessee will implement new guidelines to help track progress as the health of patients improves. Specifically this will require providers who order private duty nursing (billed under code T1000) to set long-term and short-term goals, as well as evaluate their patients' progress toward those goals. Further details will be available in future editions of BlueAlert.

Guidelines for Expedited Medical Service Appeal

If you have a patient who is at risk of serious health problems or might die if he or she does not get health care, you can file an expedited appeal on their behalf. Expedited appeals for medical service must be approved or denied within three business days by the Bureau of TennCare.

To request an expedited appeal from the Bureau of TennCare, you may submit the Treating Provider's Certificate: Expedited TennCare Appeal Form located on TennCare website. See the TennCare website for details on how to file a medical appeal.

If you need to verify your patient's TennCare Eligibility, please visit TennCare's Verify Eligibility page.

Reminder: Coordinating Therapy for Your School-Age Patients

If you have a patient who is 20 or younger and needs physical, occupational and/or speech therapy while at school, BlueCare Tennessee can coordinate those services for our members. Before your patient begins therapy, in order to receive payment, the school must submit the patient's Individual Education Plan (IEP) to BlueCare Tennessee, along with a consent form signed by the patient's parent.

Please note that BlueCare Tennessee only pays for covered, medically necessary services performed by a licensed therapist.

For more information about the requirements for therapy, please see the BlueCare Tennessee Provider Administration Manual.

Medicare Advantage

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

Provider Star Ratings Now Available in BlueAccess

The Medicare Advantage Quality Care Rewards Program offers providers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2016 measurement period of Jan. 1 – Dec 31, 2016. Providers may now visit BlueAccess to view their current Star rating based on the clinical data received from their practice for the previous measurement year.

After logging in to BlueAccess through bcbst.com/providers and accessing the Quality Rewards tool, providers may click on their Medicare Advantage scorecard and view their star rating at the top of the scorecard.

Star ratings, as calculated by the previous year's performance, may have impacted each provider's current reimbursement rates, effective April 1, 2017.

Providers should refer to their contract amendments for information about their base rate, the quality escalator and total earning potential. A complete listing of all providers who achieved 4-Star or above performance is available on our website.

BlueCross Medicare Advantage Members Have Free Gym Membership

Physical activity is an important part of living a healthy and fulfilling life as a person ages. SilverSneakers® is a value-added benefit that allows all BlueCross Medicare Advantage members access to hundreds of fitness facilities and classes throughout Tennessee. To find out more about this benefit and what it can do for your patients' activity levels, sign up for a free 30-minute webinar.

You'll learn that 86 percent of active SilverSneakers participants answer "yes" to the important quality survey question "Have you discussed physical activity with your provider?" and 62 percent of SilverSneakers participants report their health as either "very good" or "excellent."

Sign up to find out how SilverSneakers can help your patients.

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.

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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 patients have through their Medicare Advantage plan.

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: 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
  (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.

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: Medicare Advantage Home Health Billing Guidelines

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 G0157 G0159	1 unit per 15 minutes
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	

Note: These coding changes will not affect current reimbursement.

Quality Care Rewards

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

THCII Episodes of Care Annual Feedback Session is May 16

The Tennessee Division of Healthcare and Finance will hold its annual feedback session on May 16, 2017. This is an opportunity for the public to comment on what is working well with each episode's clinical design and offer suggestions on changes for next year.

Twenty episodes of care (waves 1 – 4) will be open for discussion. Sessions will be offered simultaneously by video conference in six locations across the state. Episodes are grouped in four broader categories:

- Gastrointestinal Episodes, 8 – 9:30 a.m., CT
- Orthopedic and Cardiac Episodes, 9:45 – 11:15 a.m., CT
- Respiratory and Primary Care Episodes, 12:15 – 1:45 p.m., CT
- Behavioral Health Episodes, 2 – 3:30 p.m., CT

Click here to register for a session and select your meeting location.

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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.

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- 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.

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