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 revised policies. To read the complete information, click Upcoming Medical Policies.

Effective May 1, 2018

- Cryosurgical Ablation of Miscellaneous Solid Tumors other than Renal and Prostate (Revision)
- Diagnosis and Treatment of Sacroiliac Joint Pain (Revision)
- Prostatic Urethral Lift (Revision)
- Serum Tumor Markers for Breast Malignancies (Revision)

Is Your Tax ID Number Updated for Availity® Usage?
Thank you for helping us transition to Availity. Please remember that each provider’s NPI must be linked to the Tax ID Number (TIN) we have on file for your organization(s). To make sure each provider’s NPI is correct and linked to the correct Tax ID Number:

- Go to the “BCBS TN” section at Availity.com.
- Go to My Providers > Express Entry to confirm your NPI.
- Go to My Account Dashboard > Maintain My Organization to confirm your TIN. (Availity sends these numbers to us so they can be matched to the TIN we have on file.)

If your TIN has changed since enrollment, or you need additional help, please contact your eBusiness Regional Consultant at (423) 535-5717, option 2 or eBusiness_service@bcbs.com.
Need help with Availity?

Now that the Availity Provider Portal has replaced BlueAccess℠ for providers, we want to make sure you have the support you need for important business transactions.

If you need help or have questions about your Availity account, please:

- Call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday from 8 a.m. to 7:30 p.m. ET (excluding holidays).
- Call BlueCross eBusiness Technical support at (423) 535-5717, option 2. Representatives are available Monday through Thursday from 8 a.m. to 6 p.m. and on Fridays from 9 a.m. to 6 p.m. ET. You can also email ebusiness_techsupport@bcbst.com.
- Contact your eBusiness Regional Marketing Consultant. Your consultant will be happy to answer your questions and help you transition to the Availity portal.

If you need training on the Availity tool:

1. Click Help & Training, and then click Get Trained.
2. In the Search field at the top of the page, type BCBS of Tennessee.
3. Then select Availity Portal Administration for BCBS of Tennessee Providers – On-Demand.
4. Or contact your eBusiness Regional Marketing Consultant.

Thank you for your patience through our transition to Availity.

Prepare for New Behavioral Health Treatment Record Audits with Online Training

The processes for behavioral health treatment record audits are changing during the second quarter of 2018. These changes will apply to all lines of business and we want to help you get ready for them. We’ve created a WebEx training presentation with details and directions about the new processes. If you have any questions, please contact your Behavioral Health Network Manager at 1-800-924-7141.

New Behavioral Health Forms

We’re pleased to announce new tools that should simplify the process of obtaining prior authorizations for your patients. Please use these new forms when requesting prior authorizations for your patients covered by BlueCare℠, TennCare Select, CoverKids℠, BlueCare Plus (HMO)℠ and BlueAdvantage lines of business.

The new forms are as follows:

- Mental Health Inpatient Request Form
- Mental Health Outpatient Request Form
- Provider Discharge Form
- Behavioral Health Out of Network Request Form
- Psychiatric Residential Treatment Request Form
- Psychological Testing Form

These forms are located on the forms page. Please discontinue use of the previous forms that were used for these services and use the new forms for your patients covered by these lines of business.

New Prior Authorization Requirements for Specialty Medications

Bortezomib (J9999), a new generic drug to market, was added to the provider-administered specialty medications that require prior authorization for all lines of business effective March 2, 2018.

You can find information on all provider-administered specialty medications that require prior authorization on our website.
**New Outpatient Drug Testing Policy**

Please note our timeline has changed. Beginning June 1, 2018 urine/serum drug testing will be limited to 20 episodes per annual individual benefit period. An episode is defined as either a presumptive or confirmatory test (or both for the same date of service per provider billed on the same claim). A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen.

A confirmatory test is a definitive or combined qualitative/quantitative test. This policy does not apply to BlueCare Tennessee, CoverKids, FEP or our Medicare Advantage members.

**Temporary Suspension of Payment Policy for Anatomic Pathology Services Provided at Facilities for Commercial Plans**

We understand some providers have been confused about billing and payment practices when anatomic pathology services are provided at facilities. Even though this has been a long-standing payment practice, we’ve elected to temporarily suspend this policy for 2018 services.

You should have received a letter in late March announcing this decision. In the letter, we stated we’ll accept and pay claims for the technical component of anatomic pathology services submitted:

- By physicians and other providers;
- For patients receiving these services in a facility setting between Jan. 1 and Dec. 31, 2018.

We will resume our regular payment policy again for services that occur on and after Jan. 1, 2019.

Under this policy, we pay facilities an all-inclusive rate for inpatient and outpatient services. This includes payment for all services and supplies associated with the inpatient and outpatient services (unless there’s a contractual exception).

- This facility payment includes the technical component for professional services provided while a patient is in a facility setting.
- This policy applies regardless of where the technical component is performed – or what relationship exists between the facility and the professional performing the service.

If you have any further questions, please contact your BlueCross Network Manager.

**Reporting Management of Testosterone**

When assessing how your testosterone replacement therapy patients respond or react to treatment, BlueCross recommends conducting in-office evaluations at three and six months after starting therapy, then annually after your patient is stabilized.

There are always exceptions to this guidance because your patients may need evaluation services at more frequent intervals due to treatment complications or other reasons. If this happens, please clearly document why you needed to provide evaluation and management services more often, as well as report those services appropriately with modifier 25 when billed with other services that bundle for the same date of service.

Modifier 25 is used to report a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service (and not to bypass the bundling edit by indicating that only lab results were discussed). Those types of services are considered integral to the administration of testosterone replacement therapy and not a separately identifiable evaluation and management service.

**Prior Authorization Requirement for Genetic Testing**

Please note our timelines have changed. Beginning June 1, 2018, you’ll need to request prior authorization from eviCore for molecular and genomic testing for our Commercial fully-insured and individual members. You may log in or call us at 1-888-693-3211 to obtain authorization.

You can also learn more about this important change by registering for online orientation designed to help you and your staff with the new molecular and genomic testing program.

During these sessions, you’ll learn more about prior authorization requirements as well as how to navigate eviCore’s website, where you’ll find Clinical Guidelines and request forms. Get the orientation schedule and other program resources, including step-by-step instructions on how to register for training, by clicking here.

Please call eviCore’s Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.
Coordinating Patient Care is Key
The coordination of a patient’s care is essential for healthy outcomes. If you’re a primary care physician (PCP), please remember to ask your patients if they’ve seen other providers since you last saw them. These can include visits to:
- Specialists
- Urgent care
- An emergency room
Also be sure to ask your patients if they’ve received durable medical equipment, physical therapy or other services from other providers. It’s always a good idea to encourage the discussion of treatment plans they’ve received elsewhere, so you can request information from the other provider(s).
If you are not the patient’s PCP, obtain the name of the patient’s primary physician and share medical assessments, prescriptions or treatment provided.
Note: This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus plans.

Annual CAHPS Survey Includes Questions About Member Experiences With Physicians
Every year, CMS conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We’re sharing this information with you, because we think it’s important for you to know the survey includes questions about the care you’re providing.
Here are a few examples of the questions your patients will see:
- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed it?
- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often was it easy to get an appointment with a specialist?
Note: This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus plans.
Visit Bright Futures for Kids’ Well-Care Schedules

The American Academy of Pediatrics (AAP) recommends a schedule of comprehensive age-specific, preventive health care screenings, which we use as the standard of care for your young BlueCare and TennCareSelect patients. These recommendations are known as the Periodicity Schedule, and you can find them on the AAP website.

In addition to covering scheduled periodic checkups, BlueCare and TennCareSelect also cover other inter-periodic screens for kids. Children should have 12 TennCare Kids check-ups before their third birthday. After they turn three, they should have a check-up every year up to age 21.

Medicare Advantage

This information applies to BlueAdvantage (PPO)™. BlueCare Plus (HMO SNP)™ is excluded unless stated otherwise.

New Medicare Advantage ID Cards

In an effort to protect seniors from fraudulent use of Social Security numbers, combat identity theft and safeguard taxpayer dollars, CMS will launch an initiative that includes removing SSN numbers from member ID cards. Some members may begin receiving new cards as early as April 1, depending on the schedule outlined by CMS.

CMS will provide more information about the changes on a dedicated website, as well as via mail campaigns and webinars, among other activities. We’ll share more information in upcoming issues of the BlueAlert newsletter.

Provider Stars Ratings Now Available in Availity

BlueCross’ Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2017 calendar year. You may now visit Availity to view your 2017 Stars rating.

After logging in to Availity through Availity.com and accessing the Quality Rewards tool, click on your Medicare Advantage scorecard and view your Stars rating at the top of the scorecard.

Effective April 1, 2018, Stars ratings, which are calculated by the previous year’s performance, impact your reimbursement rates. Please refer to the rate attachment in your rebasing rate notification letters mailed at the end of March.

You can reference your contract amendments for information about the Medicare Advantage base rate, quality adjustment and total earning potential.
Medicare Advantage Home Health Billing Guidelines Reminder
Medicare Advantage requires a HCPCS code to be submitted for all outpatient physical, occupational, and speech therapy services. Skilled nursing, medical social services, and home health aide services should also be submitted with the appropriate HCPCS code. These codes should correspond with the Revenue Code being billed.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Physical Therapy</td>
<td>421</td>
<td>G0151</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0157</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0159</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td>Home Health Occupational Therapy</td>
<td>431</td>
<td>G0152</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0158</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0160</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Skilled Nursing (RN or LPN)</td>
<td>441</td>
<td>G0153</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0161</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Medical Social Services</td>
<td>551</td>
<td>G0493</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0494</td>
<td>1 unit per 15 minutes</td>
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<td></td>
<td></td>
<td></td>
<td>G0495</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G0496</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Home Health Aide</td>
<td>561</td>
<td>G0155</td>
<td>1 unit per 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>571</td>
<td>G0156</td>
<td>1 unit per 15 minutes</td>
</tr>
</tbody>
</table>

Also, please make sure billing units for home health services are filed as 1 unit for each 15-minute increment. Please refer to the Medicare Advantage section of the BlueCross BlueShield of Tennessee Provider Administration Manual for additional home health billing information.

New Benefit for Pre-Diabetic Medicare Advantage Members
On April 1, 2018, we rolled out a new CMS benefit for our pre-diabetic Medicare Advantage members through our partnership with Solera Health. Our Medicare Diabetes Prevention Program is available for members at risk of developing diabetes and free for those who qualify.

The National Institutes of Health and the CDC proved the program decreased the risk of developing Type 2 diabetes by 58 percent for those who lose 5 to 7 percent of their body weight through diet and exercise changes.

The program includes:
- Sixteen weekly lessons followed by monthly sessions for the rest of the year
- A lifestyle health coach to help set goals and keep participants on track
- A small group setting for support and encouragement
- A focus on healthier food choices and increased activity levels

BlueCross Medicare Advantage members are eligible for the program if they have a BMI >25 (>23 for Asian descent), and at least one of the following blood tests:
- Fasting plasma glucose of 110-125 mg/dL
- Two-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- Hemoglobin or A1C test with a value between 5.7-6.4 within the previous 12 months. Patients with previous history of diabetes (excluding gestational) or end stage renal disease aren’t eligible for the program, as outlined by CMS.

You’ll also be able to refer your patients to the program through BlueCross’ Population Health Program at 1-800-611-3489 or fax 1-800-727-0841. If you have any questions about this benefit, please call our Provider Service Line.
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 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.

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^{1} Provider Service Lines

**Featuring “Touchtone” or “Voice Activated” Responses**

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the “touchtone” option or press 1. Then, press 1 again and follow the prompts to reach Network Contracts or Credentialing to update your information; and
- Update your provider profile on the CAQH ProView™ website.

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

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