Upcoming Changes to Utilization Management Guidelines

Effective Feb. 21, 2018, the following Utilization Management Guidelines related to inpatient and surgical care will be updated:

- Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy and Salpingectomy
- Laparotomy for Gynecologic Surgery, Including Myomectomy, Oophorectomy and Salpingectomy

Click here to view all guidelines modified by BlueCross.

Changes to Specialty Pharmacy Network

Specialty Pharmacies participating in the BlueCross BlueShield Specialty Pharmacy Network in 2018 are listed on the Details on Specialty Pharmacy Program page on our website.

The following are changes to our Specialty Pharmacy Network effective Jan. 1, 2018:

- Added as a participating provider:
  - Caremax Pharmacy of Loudon, dba Paragon Infusion
- No longer participating:
  - FFP Holdco, LLC Factor Support Network Pharmacy
  - FFP Holdco, LLC, dba Medex BioCare
  - Kroger Specialty Pharmacy, Inc.

How can you help?

Advise your BlueCross Commercial patients to:

- Check the list of specialty pharmacies in their network by visiting the Details on Specialty Pharmacy Program page on our website.
- Switch to a specialty pharmacy in their network to pay less for specialty prescriptions. If they don’t choose a specialty pharmacy on the list, they’ll pay more.
- Contact a consumer advisor if they need help. Our consumer advisors are available Monday through Friday from 8 a.m. to 6 p.m. (ET).
Prior Authorization Required for Mylotarg and Kymriah

As of Dec. 7, 2017, Mylotarg and Kymriah were added to the Provider-Administered Specialty Drug Lists and will require a prior authorization for all lines of business.

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

BlueCare Plus™ CoverKids
BlueCare Tennessee Medicare Advantage
Commercial

Change in Authorization for Some Skilled Nursing Care Supplies

Starting Jan. 1, 2018, prior authorization is required for non-routine wound care supplies used for skilled nursing care provided in a patient’s home or a facility. Both the supplies and associated service will require authorization.

You can find the Home Health Agency Non-Routine Supply List in the billing section of your BlueCross BlueShield of Tennessee Provider Administration Manual. You won’t be reimbursed for charges related to non-routine supplies if they aren’t included and reviewed during the authorization. Also, please bill supplies using the appropriate revenue and HCPCS codes when filing claims.

Under Medicare guidelines, routine supplies are included in the per diem reimbursement. They aren’t separately reimbursed, even if requested by another provider for the same dates of service.

Have You Registered for Availity®?

The Availity Provider Portal is now open for BlueCross providers to access information and interact with BlueCross and other health plans through a single system to review remittance advices, claims status, eligibility and benefits.

Availity also features a BlueCross-specific payer space, which lets you see updates from BlueCross and use our custom applications. For example, to visit our Quality Care Rewards tool, you’ll go to Payer Spaces in the Availity Provider Portal, and then select BlueCross BlueShield of Tennessee.

Exclusive features for BlueCross providers include:

• Unified Member Search – This custom member search within the Eligibility and Benefits Inquiry tool closely match our capabilities in BlueAccess™, and includes search options utilizing patient ID, Social Security number, member name, and date of birth.

• BlueCard® – Searches for your out-of-state members are available in the same interface through Eligibility and Benefits Inquiry and Claim Status (New), which means you’ll no longer have to use a separate application to view your out-of-state members (a valid member ID and prefix are required).

• Claim Status (New) – 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.

If you haven’t registered for Availity, it’s time to get started at Availity.com. If you’re already an Availity user, you can set up your BlueCross account from the dropdown menu on your Availity dashboard. Also, you should notify any third-party vendors who are using BlueAccess on your behalf.

What you need to do to get started:

• Select someone in your organization who will create and manage accounts. The Availity organization administrator will be responsible for setup, which includes registering the organization, setting up and assigning access to users, as well as other applicable registration and setup activities.

• To register, go to Availity.com and click REGISTER in the upper right corner of the home page, select Let’s get started! and follow the instructions in the Availity registration wizard.

To aid in your transition, BlueAccess for providers will continue running through March 2, 2018, but won’t be available after that time. Please contact your eBusiness Regional Marketing Consultant if you have additional questions or need help transitioning to the Availity portal.
Continuing to Improve the Provider Enrollment Process

We continue to explore ways to make the provider enrollment process easier for you. Our online enrollment application has helped make the process more efficient for provider offices and we’re working on ways to continue that trend. For example, the application will soon include an update that displays what specific documents are needed based on the provider type along with the capability to upload the information when submitting the online application.

A requirement of the application is to have a valid CAQH ID and permission for us to review that data. Our system will soon verify the information in real time and notify you if there are any issues to resolve. Look for these and other changes in the coming months.

Proper Copays for Nurse Practitioners in a Specialist’s Office

If you have a nurse practitioner working in a specialist setting, you may not be collecting the correct copays. When a nurse practitioner is registered with BlueCross as a specialist provider, you must collect the specialist copay, not the copay for a primary care provider (PCP).

Please refer to this table for collection guidelines for nurse practitioner services:

<table>
<thead>
<tr>
<th>Provider/Clinical Setting</th>
<th>Copay</th>
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<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>PCP</td>
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<tr>
<td>Nurse Practitioner, Acute Care</td>
<td>Spec</td>
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<tr>
<td>Nurse Practitioner, Adult Health</td>
<td>PCP</td>
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<tr>
<td>Nurse Practitioner, Family Practice</td>
<td>PCP</td>
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<tr>
<td>Nurse Practitioner, Gerontology &amp; Adult Health</td>
<td>Spec</td>
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<tr>
<td>Nurse Practitioner, Neonatal</td>
<td>Spec</td>
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<tr>
<td>Nurse Practitioner, Oncology</td>
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<tr>
<td>Nurse Practitioner, Pediatrics</td>
<td>PCP</td>
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<tr>
<td>Nurse Practitioner, School</td>
<td>Spec</td>
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<tr>
<td>Nurse Practitioner, Women’s Health (OB/GYN)</td>
<td>PCP/Spec</td>
</tr>
</tbody>
</table>
Preparing for the 2017-2018 Flu Season

It’s important that you help set preventive care measures to protect your patients during this time of year. Please educate all patients and parents who have children older than 6 months of age on the importance of getting a yearly flu vaccine.

Please make every effort to schedule your high-risk patients for a flu shot. To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations.

The following influenza immunization and reimbursement guidelines apply for BlueCross.

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are now in effect for air ambulance providers (rotary or fixed-wing):

- NPI and the appropriate taxonomy codes are required to distinguish between ground charges and air charges when filing claims.
- You must include pick-up and drop-off ZIP codes, mileage, etc.

Member cost share can be significant for this type of service, so please try to work with in-network providers.

You can find updated billing guidelines for Commercial plans in your BlueCross BlueShield of Tennessee Provider Administration Manual.

Non-Emergent Air Ambulance Transportation Requires Prior Authorization for Commercial plans

Prior authorization is now required for non-emergent air ambulance transportation. Prior authorization won’t be required for emergency transport (e.g., from the scene of an accident when ground isn’t appropriate or would pose a threat).

To arrange non-emergent air ambulance transport for a patient with BlueCross Commercial benefits, please request prior authorization by calling BlueCross at 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. ET.

This prior authorization requirement may affect your patients if an out-of-network air ambulance is used for non-emergent transportation.

Commercial

- **Vaccine and administration**
  The influenza vaccine, including intradermal, is a covered benefit if offered under the member’s health care plan. Please verify coverage by calling our Provider Service Line.

BlueCare Tennessee

- **Vaccine and administration**
  Intramuscular flu vaccine is a covered benefit for those 6 months of age and older. Intradermal-administered vaccine is recommended for people 18 through 64 years of age.

  **Note:** Flu vaccines are available through the Tennessee Department of Health’s Vaccines for Children (VFC) Program for children 18 years of age and younger. The intradermal-administered vaccine isn’t available under VFC. For more information, please call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

Medicare Advantage

- **Intradermal vaccine**
  This is a covered benefit.

CoverKids

- **Vaccine and administration**
  This is a covered benefit.

  **Note:** Code 90756 became effective on Jan. 1, 2018, for Flucelvax Quadrivalent – antibiotic-free vials (2017-2018 NDCs 70461-0301-10 and 70461-0301-12). Prior to the implementation effective date, codes 90749 or Q2039 submitted with NDC may be billed for this product.

Code 90674 became effective Sept. 1, 2016, for BlueCare, and Jan. 1, 2017, for all other lines of business for Flucelvax Quadrivalent – preservative and antibiotic-free syringes (2017-2018 NDCs 70461-0201-01 and 70461-0201-11).

  **Reminder:**
  FDA labeling, including “approved for use” information, should be consulted when selecting the appropriate agent for specific beneficiaries.
Be Aware of Member Rights and Responsibilities

As a BlueCross BlueShield of Tennessee network provider, you should know what our members expect from you and what you should expect from our members. To comply with regulatory and accrediting requirements, we periodically remind members of their rights and responsibilities. These reminders are intended to make it easier for them to access quality medical care and additional services.

For your convenience, we publish our current member rights and responsibilities online in our provider administration manuals. To review this information, you can link to these manuals from the Quick Links section of our website.

BlueCare Tennessee

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

TennCare Benefit Limits for Opioids Begin Jan. 16, 2018

TennCare is changing the benefit limits for opioids to help to address the increasing negative health outcomes associated with the opioid epidemic in Tennessee.

TennCare, through its pharmacy benefits manager Magellan Health, will strengthen existing opioid coverage limits for first-time and non-chronic opioid users.

Effective January 16, 2018, TennCare will limit acute opioid therapy coverage for ALL new and non-chronic opioid users as follows:

- A member can receive opioid prescription coverage for up to 15 days in a 180-day period at a maximum dosage of 40 morphine milligram equivalents (MME) per day.
  - All first-fill scripts within a 180-day period will be limited to a five-day supply of a short-acting opioid at a maximum dose of 40 MME per day without the need for prior authorization.
  - After the first-fill prescription, a member can receive up to an additional 10 days of opioid treatment at a maximum dose of 40 MME per day in each 180-day period, with pre-authorization.
- Any long-acting opioid agent will require prior authorization.

For more information, please see the following notices that were mailed to providers in December.

- TennCare Opioid Provider Letter
- BlueCare Tennessee/TennCare Opioid Provider Memo

TennCare Member Benefit Renewal Flier for Your Office

TennCare routinely sends redetermination packets to members every month to assess their eligibility status for another year. TennCare created a benefit renewal flier for provider offices to remind members about how important it is for members to open these packets and take action. Please help remind your patients by printing the flier and posting in your office.

Documenting Your Patients’ Well-Child Visits

When your patients covered by BlueCare Tennessee or CoverKids receive their well-child visit, make sure all seven required components of the exam are recorded.

Your patients’ medical records should document the following during the exam:

- Complete health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Shots (as necessary)
- Health education

The medical record should also indicate:

- Assessments of your patients’ nutrition and physical activity
- If the child is uncooperative or the exam was refused

Helpful services are available from the Tennessee Chapter of the American Academy of Pediatrics website for the required components of the TennCare Kids exam as well as required medical record documentation criteria.
**Taxonomy Code Reminder**

As a reminder, professional claims need a taxonomy code to be submitted for the billing and rendering NPIs. It’s extremely important that both the billing and rendering provider taxonomy codes match the taxonomy codes on file for BlueCross. If you don’t submit the appropriate taxonomy codes for BlueCare Tennessee, CoverKids, and BlueCare Plus, your claims may be denied or the reimbursement reduced.

**Medicare Advantage**

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

**Lung Cancer Screening With Low Dose Computed Tomography (LDCT)**

To ensure proper claim payment for requests for lung cancer screening with Low Dose Computed Tomography (LDCT), HCPCS codes G0296 and G0297, the claim must be billed with ICD-10 diagnosis code Z87.891. These codes are limited to reimbursement once per calendar year.

Additional Medicare eligibility criteria includes:

- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 30 pack-years
- Current smoker or one who has quit within the last 15 years
- A written order for an LDCT
- Counseling on risk factors and screening

**Annual Wellness Exams and 2018 Member Incentives**

An annual wellness exam is an important first step to a healthy 2018. Patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. They may also be eligible to earn a reward for completing the exam. You can help your BlueAdvantage and BlueCare Plus patients earn additional rewards for their healthy living by scheduling a check-up early.

In 2018, members will need to take two steps to be eligible for rewards:

- BlueCross Medicare Advantage members will need to “opt in” to the rewards program with OnLife Health, our rewards partner. Each member will receive a welcome kit in January detailing opt-in instructions, which can be online or by phone.
- An annual wellness claim must be on file for members to receive additional rewards in 2018 for other needed screenings. Annual wellness exams should be filed with 99387, 99397, 99385, 99395, 99386, 99396, 96160, G0402, G0438, G0439, plus appropriate E/M codes.

Note: The Annual Wellness Exam is a calendar year benefit, which means each member is entitled to one wellness exam annually, regardless of the number of days between each exam. **It’s not necessary to wait 365 days between exams.**

**Flu Vaccines Keep Your Patients Healthy**

With flu season in full swing, remind your patients to get their annual flu shot. It’s quick, easy and included in the benefits for BlueAdvantage and BlueCare Plus members. Most important, it can help keep them healthy.

Patients 65 and older are at greater risk for serious complications from flu. Because our immune system weakens as we age, almost 90 percent of flu-related deaths happen in patients older than 65, along with nearly 60 percent of hospitalizations for this same age group. The flu shot is a calendar-year benefit, so it’s covered once a year regardless of the number of days between vaccinations.

Your senior patients may receive the regular or newer higher dose vaccine. The higher dose vaccine is 24 percent more effective in those who are 65 and older according to The New England Journal of Medicine.

This time of year is also a good time to review your patient’s pneumococcal vaccine status.
Provider Assessment Form Reimbursement for 2018

In 2018, you’ll again be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueChoice℠ patients.

Please use CPT® code 96160 to file a PAF. BlueAdvantage will continue to reimburse the service as E/M Code 96160, with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2018
- $200 for dates of service between April 1 and June 30, 2018
- $175 for dates of service between July 1 and Sept. 30, 2018
- $150 for dates of service between Oct. 1 and Dec. 31, 2018

To receive reimbursement, you must submit the completed form through Availity and BlueAccess or fax a completed writable form to 1-877-922-2963. The form should also be included in your patient’s chart as part of their permanent record.

You don’t need to wait 365 days between PAF submissions. For additional information about the Provider Assessment Form, please visit bcbst.com/providers/quality-initiatives.page.
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.

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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BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee are Independent Licensees of the BlueCross BlueShield Association

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>Commercial Service Lines</th>
<th>1-800-924-7141</th>
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<tr>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<th>Commercial UM</th>
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<tr>
<th>Federal Employee Program</th>
<th>1-800-572-1003</th>
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<tr>
<th>TennCare Select</th>
<th>1-800-276-1978</th>
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<tr>
<th>CoverKids</th>
<th>1-800-924-7141</th>
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<tr>
<th>CHOICES</th>
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<th>ECF CHOICES</th>
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<th>BlueChoice℠</th>
<th>1-866-781-3489</th>
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<tr>
<th>SelectCommunity</th>
<th>1-800-292-8196</th>
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<th>BlueCard</th>
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<th>Benefits &amp; Eligibility</th>
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<tr>
<th>All other inquiries</th>
<th>1-800-705-0391</th>
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<tr>
<th>BlueAdvantage</th>
<th>1-800-841-7434</th>
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<th>BlueAdvantage Group</th>
<th>1-800-818-0962</th>
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| Monday-Friday, 8 a.m. to 6 p.m. (ET) |

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<tr>
<th>eBusiness Technical Support</th>
<th>(423) 535-5717</th>
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<tr>
<th>Phone: Select Option 2 at</th>
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| 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.