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. The following policy will be archived and no longer active 30 days after this BlueAlert notification. It has been determined that this procedure is now generally considered standard/conventional practice and is supported by the American Academy of Orthopaedic Surgeons.

- Unicompartmental Knee Replacement

Availity® Replaces BlueAccess™ for Providers*

Availity is now your single system to transact with BlueCross and other health plans. If you’re not registered for the Availity Provider Portal, please register now to avoid disruption of important business processes. For FAQs and more information about registering with Availity, visit Availity.com/bcbst.

If you need additional help registering or have questions about your Availity account, you can:

- Call Availity Client Services at 1-800-AVAILITY (282-4548). Support is available Monday through Friday from 8 a.m. to 7 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 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.

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A New Look for Online Authorizations Through Availity

We’ve recently updated our online authorization tools to help make this process even more convenient. You can find the tools by clicking the “Authorization Submission/ Inquiry” tile from Availity’s BlueCross Payer Space. We hope you find these tools useful and that they offer a more streamlined experience.

Please note that BlueCross BlueShield of Tennessee will remain your primary source for authorizations for our members through the Availity Payer Spaces. Authorizations for BlueCard members can be obtained through Availity’s Multi-Payer Authorizations and Referrals tool.

If you have questions or need help transitioning to the Availity portal, please contact your eBusiness Regional Marketing Consultant.

THCII Episodes of Care: Quarterly Reports

The Episodes of Care Quarterly Reports are now available for review.

Please login to Availity to view your reports. If you believe you should have reports, but can’t access them, please call eBusiness at (423) 535-5717 and select option 2.

For more information related to Episodes of Care, please visit our BlueCare Tennessee and Commercial websites.

New Outpatient Drug Testing Policy

Urine/serum drug testing will be limited to 20 episodes per annual individual benefit period, effective May 1, 2018. 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.

Changes to Morphine Milligram Equivalent Calculations

(Appplies to BlueCross Commercial, BlueAdvantage (PPO)™ and BlueCare Plus (HMO SNP)™ plans)

On Jan. 1, 2017, BlueCross adopted a safety edit regarding a member’s Morphine Milligram Equivalent (MME) daily dose. This safety edit requires any member exceeding 200 mg MME per day to have a prior authorization. At the same time, CMS announced an update regarding a graduated conversion factor for methadone.

Effective Jan. 1, 2018, we adopted the graduated conversion factor for methadone based on the updated CDC calculations and CMS regulations. The new conversion factor logic is listed below, along with a link to the CDC’s website for guidance in calculating total daily MME.

<table>
<thead>
<tr>
<th>Daily Methadone Dose (Methadose)</th>
<th>Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 20 mg per day</td>
<td>4</td>
</tr>
<tr>
<td>21 – 40 mg per day</td>
<td>8</td>
</tr>
<tr>
<td>41 – 60 mg per day</td>
<td>10</td>
</tr>
<tr>
<td>&gt; 60 mg per day</td>
<td>12</td>
</tr>
</tbody>
</table>


Prior Authorization Requirement for Genetic Testing

Beginning May 1, 2018, BlueCross will require prior authorization for genetic testing for some Commercial members. Please check for additional information in upcoming issues of the BlueAlert newsletter.

New Prior Authorization Requirements for Specialty Medications

Visco-3 was added to the provider-administered specialty medications requiring a prior authorization for all lines of business effective Jan. 1, 2018.

The following provider-administered specialty medications require a prior authorization for all lines of business effective Jan. 26, 2018:

- Luxturna
- Durolane
- TriVisc

You can find information on all provider-administered specialty medications requiring prior authorization on our website.
New Skilled Nursing Facility Benefit for FEP Members

Federal Employee Program (FEP) members with Standard Option coverage have a new skilled nursing facility (SNF) benefit with an annual maximum of 30 days. The Basic Option will continue to use flexible benefits when approved by Case Management for SNF coverage. This criteria checklist can help you determine if a patient is eligible for the benefit:

- Will the patient benefit from short-term SNF services with a goal of returning home?
- Is the patient enrolled in case management before admission to the SNF? The case manager must have a signed member consent form before SNF admission can be approved.

Before admission, you must perform a functional status and preliminary development assessment including:

- Neurological and cognitive
- Musculoskeletal status and functional mobility
- Integumentary
- Medications and therapies – medication reconciliation must occur between the transferring facility, receiving SNF and plan case manager before SNF admission
- Renal
- Cardiopulmonary
- Mental health
- Nutritional and gastrointestinal, including the ability to swallow and digest, and the need for special diets
- Psychosocial assessment
- Educational needs

You’ll also need prior authorization (handled by the applicable case manager) – and an approved treatment plan, including proposed therapies and a stated need for daily SNF care.

If your facility provides skilled nursing services, you should have received a detailed letter and sample consent form in January. If you have questions, please call the FEP Provider Service Line.

Use Correct Forms to Ease Enrollment Process

In order to provide a smooth enrollment process, we’d like to share some important reminders:

- We’ve replaced our paper Provider Enrollment Forms (PEFs) with convenient, online forms for all individual practitioners.
- Practitioners should use the online PEF when submitting an initial enrollment or additional network request. Look for the orange “Apply Now” button on bcbst.com/providers/
- For all other requests (TIN change, address change, name change, etc.), please use the Commercial Practitioner Change Form.

If you need additional information, please contact our Provider Service Line.

Tips for Coding Professionals

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

Announcing Two New CMS Modifiers

CMS has established guidelines for using new modifiers, FY and JG, when billing charges for the following:

- X-Ray Taken Using Computed Radiology – requires Modifier FY
- 340B Acquired Drug – requires Modifier JG

As of Jan. 1, 2018, providers are required to use these modifiers when billing these charges for our Medicare Advantage members, which will result in an applicable payment reduction.

Beginning March 1, 2018, claims for all other lines of business will require these modifiers for informational purposes only. If BlueCross decides at a later date to use these as pricing modifiers, we’ll notify you in advance.
BlueCare Tennessee

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

Abortion, Sterilization and Hysterectomy Code Notice

Beginning April 1, 2018, all claims filed with an ICD-10 and CPT® code that clearly, or even possibly, indicate an abortion, sterilization or hysterectomy (ASH) was performed for the purpose of rendering someone incapable of reproduction, must include:

- Completed certification/consent forms (if applicable), and
- Supporting medical documents (detailed history and physical and/or office notes, operative report, pathology report, ultrasound report of fetal demise, if applicable).

Model of Care Training

BlueCare Plus offers Model of Care (MOC) training for all primary care providers. CMS requires all primary care providers to participate in annual training, which describes the framework for our dual eligible special needs plan BlueCare Plus. Providers who complete MOC training between Jan. 1 and March 31, 2018, will receive a 1 percent bonus to your base rate of reimbursement. You can find registration link on our website.

Tips for Coding EPSDT and Well-Child Visits

The Tennessee Chapter of the American Academy of Pediatrics offers free training and resources to help providers properly code preventive care services for TennCare Kids members. When you use the right coding for preventive care, you help speed the claims process and are more likely to receive correct payment for the care you provide.

When you keep up-to-date records, external reviews and medical audits are much easier and more effective, too.

For more information, tips and guidelines on coding, please visit the Tennessee Chapter of the American Academy of Pediatrics website.

Coding Change for Long-Acting Contraceptive Kyleena

Beginning Nov. 1, 2017, BlueCare Tennessee and CoverKids began reimbursing providers for voluntary reversible long-acting contraceptives (VRLAC) billed as separate items, including Kyleena. Kyleena remains on the VRLAC list, however as of Jan. 1, 2018, coding for this drug changed from Q9984 to J7296. Code Q9984 is no longer eligible for reimbursement. Please use the updated code when billing for this drug in the future.

New Guidelines for Requesting Home Health Services Begin May 1

All TennCareSM managed care organizations, including BlueCare Tennessee, will soon require providers to submit a patient plan of care for their BlueCare and TennCareSelect patients with requests for home health services. Beginning May 1, 2018, initial requests for nursing care or home health aides under codes S9122, S9123, S9124 and T1000 must include the following home health agency forms:

- Plan of Care Agreement – This form outlines the expectations of services to the patient and will require signatures from the patient, patient’s representative and home health agency.
- Plan of Care Form – The agreement between the home health agency and your patient with specific details about care the patient will receive, times they will receive it and who’ll provide the care.
- Caregiver Training Checklist – This form will serve as confirmation that all training elements were addressed with the caregiver and the person was properly trained.

Large Orders of Incontinence Products Require Medical Necessity Review

When ordering incontinent products for your BlueCare and TennCareSelect patients through Medline, remember that quantities >200 per month require medical necessity review for diapers, underpads and pull-up’s.

Submit prior authorization requests for these supplies by phone, fax or email.

- Phone: 1-877-853-7558
- Fax: 1-866-557-2737
- Email: BlueCareTennessee@medline.com
CoverKids and BlueCare Tennessee Benefits Not Identical

While the programs are similar, the benefits for CoverKids are not the same as BlueCare and TennCare Select. The major difference in the programs is funding. CoverKids is part of Tennessee’s Children’s Health Insurance Program (CHIP), while BlueCare Tennessee covers your patients in the Medicaid program. For more information see the BlueCare Tennessee Provider Administration Manual.

You can find a list of covered services in the BlueCare, TennCare Select or CoverKids Member Handbooks.

Provider Subcontracting Rules

Providers who participate in the BlueCare Tennessee Network are not allowed to subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior agreement, claims for services provided by the subcontractor could be denied and previous payments could be subject to recoup.

An example of unapproved subcontracting is in the area of antigen therapy. Network providers can’t subcontract with a vendor to prepare antigen therapy and submit claims indicating the antigen therapies were prepared by the provider.

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

Medicare Advantage

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

Changes to Our Medicare Advantage Quality+ Partnerships Incentive Program

If you participate in the Medicare Advantage Quality Incentive Program, you should receive a letter in early March announcing changes that will impact reimbursement rates. If you haven’t received your letter or need more information about these changes, please call your Medicare Quality Outreach contact.

Diabetic Statin Use Added to Stars Program

CMS has introduced a new 2018 Stars program measure focused on diabetic statin use, and it will also be part of the Medicare Advantage quality program for 2019.

This measure is based on the number of diabetic patients aged 40-75 who start using a statin or statin combination medication. It overlaps with medication adherence measures for statins and diabetes medications that encourage patients to continue with prescribed therapy. According to the American Diabetes Association data, diabetic patients have better outcomes when they also control their cardiovascular risk factors.
2018 Inpatient Only List Updates

CMS has released its updated 2018 Inpatient Only list. Under payment rules, services on the list can only be paid if they’re billed as an inpatient service. The table below lists added and removed, but you can view the entire 2018 Inpatient Only List on our website.

<table>
<thead>
<tr>
<th>Codes Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0051T Implant total heart system</td>
</tr>
<tr>
<td>0052T Replace thrc unit hrt syst</td>
</tr>
<tr>
<td>0053T Replace implantable hrt syst</td>
</tr>
<tr>
<td>0255T Evasc rpr iliac art bifr s&amp;i</td>
</tr>
<tr>
<td>0293T Ins lt atrl press monitor</td>
</tr>
<tr>
<td>0294T Ins lt atrl mont pres lead</td>
</tr>
<tr>
<td>0309T Prescrl fuse w/instr 14/15</td>
</tr>
<tr>
<td>27447 Total Knee arthroplasty</td>
</tr>
<tr>
<td>34800 Endovas aaa repr w/sm tube</td>
</tr>
<tr>
<td>34802 Endovas aaa repr w/2-p part</td>
</tr>
<tr>
<td>34803 Endovas aaa repr w/3-p part</td>
</tr>
<tr>
<td>34804 Endovas aaa repr w/1 –p part</td>
</tr>
<tr>
<td>34805 Endovas aaa repr w/long tube</td>
</tr>
<tr>
<td>34806 Aneurysm press sensor add-on</td>
</tr>
<tr>
<td>34825 Endovasc extend prosth init</td>
</tr>
<tr>
<td>34826 Endovasc exsten prosth addl</td>
</tr>
<tr>
<td>34900 Endovasc iliac repr w/graft</td>
</tr>
<tr>
<td>43282 Lap paraesoph her rpr w/mesh</td>
</tr>
<tr>
<td>43772 Lap rmvl gastr adj device</td>
</tr>
<tr>
<td>43773 Lap replace gastr adj device</td>
</tr>
<tr>
<td>43774 Lap rmvl gastr adj all parts</td>
</tr>
<tr>
<td>55866 Laparo radical prostatectomy</td>
</tr>
<tr>
<td>75952 Endovasc repair abdom aorta</td>
</tr>
<tr>
<td>75953 Abdom aneurysm endovas rpr</td>
</tr>
<tr>
<td>75954 Iliac aneurysm endovasc rpr</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Codes Added</th>
</tr>
</thead>
<tbody>
<tr>
<td>0483T Tmvi percutaneous approach</td>
</tr>
<tr>
<td>0484T Tmvi transthoracic exposure</td>
</tr>
<tr>
<td>0494T Prep &amp; cannulj cdvr don lung</td>
</tr>
<tr>
<td>0495T Mntr cdvr don lng 1st 2 hrs</td>
</tr>
<tr>
<td>0496T Mntr cdvr don lng ea addl hr</td>
</tr>
<tr>
<td>31241 Nsl.sins ndsc w/artery lig</td>
</tr>
<tr>
<td>33927 Impltj tot rplcmnt hrt sys</td>
</tr>
<tr>
<td>33928 Rmvl &amp; rplcmnt tot hrt sys</td>
</tr>
<tr>
<td>33929 Rmvl rplcmnt hrt sys f/transpl</td>
</tr>
<tr>
<td>43286 Esoph tot w/laps moblj</td>
</tr>
<tr>
<td>43287 Esphg dstl 2/3 w/laps moblj</td>
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<tr>
<td>43288 Esphg tot thrc moblj</td>
</tr>
<tr>
<td>58575 Laps tot hyst resj mal</td>
</tr>
<tr>
<td>92941 Prq card revasc mi 1 vsl</td>
</tr>
</tbody>
</table>

Medicare Advantage Readmissions Program Clarification

Starting May, 1, 2018, if an inpatient services claim is fully denied for a Medicare Advantage hospital readmission within 48 hours of an acute hospital discharge or other fully-denied readmission claim, the associated professional provider claims will also be denied.

New Oxygen Approval Timeframe

In February, BlueAdvantage (PPO)SM changed the oxygen authorization approval timeframe to a 12-month rolling period from the date of request. This change will result in fewer total authorizations, because approvals only need to happen on a true 12-month basis — not a calendar year. This is different from the prior process that approved up to 12 months of oxygen within the current calendar year.

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 as recommended by their provider. They may also be eligible to earn a reward for completing this exam.

In 2018, BlueCross Medicare Advantage members need to “opt in” to the rewards program with Onlife® Health, our rewards partner. Each member received a letter in March detailing opt-in instructions. We encourage members to opt in online, although they also may complete the process by phone or mail.

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.
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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# 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 PlusSM 1-800-299-1407

## BlueChoiceSM 1-866-781-3489

## SelectCommunity 1-800-292-8196

Available Monday-Friday, 8 a.m. to 6 p.m. (ET)

## BlueCard

<table>
<thead>
<tr>
<th>Benefits &amp; Eligibility</th>
<th>1-800-676-2583</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other inquiries</td>
<td>1-800-705-0391</td>
</tr>
<tr>
<td><strong>Monday–Friday, 8 a.m. to 6 p.m. (ET)</strong></td>
<td></td>
</tr>
</tbody>
</table>

## BlueAdvantage 1-800-841-7434

## BlueAdvantage Group 1-800-818-0962

**Monday-Friday, 8 a.m. to 6 p.m. (ET)**

## eBusiness Technical Support

<table>
<thead>
<tr>
<th>Phone: Select Option 2 at</th>
<th>(423) 535-5717</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
</tr>
<tr>
<td><strong>Monday-Thursday, 8 a.m. to 6 p.m. (ET)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Friday, 9 a.m. to 6 p.m. (ET)</strong></td>
<td></td>
</tr>
</tbody>
</table>

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