of Tennessee

JULY 2018

BlueAlert℠

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

Effective Aug. 1, 2018

- Accelerated Breast Irradiation and Brachytherapy Boost after Breast-Conserving Surgery for Early-Stage Breast Cancer (Revision)
- Measurement of Serum Antibodies to Infliximab, Adalimumab, and Vedolizumab (Revision)
- Noninvasive Prenatal Testing Using Cell-Free Fetal DNA (cffDNA) (Revision)

Utilization Management Guideline Updates/Changes

We've updated our website to include upcoming changes to select Utilization Management Guidelines. You can find all Utilization Management Guideline updates on the Utilization Management webpage.

Effective Aug. 1, 2018

The following Utilization Management Guideline related to Home Care will be updated:

- Hyperemesis Gravidarum

New Prior Authorization Requirement for Provider-Administered Specialty Medication

Akynzeo (J3490), a new-to-market provider-administered specialty medication, requires prior authorization for all lines of business effective June 8, 2018. Find out more about all provider-administered specialty medications that need prior authorization on our website.

INSIDE THIS ISSUE

Prior Authorization Requirement for Genetic Testing*

Prior authorization for molecular and genomic testing for our Commercial fully-insured, individual and select self-funded members is now required from eviCore. You may log in or call 1-888-693-3211 to obtain authorization. You can learn more about prior authorization requirements on eviCore's website, where you'll find clinical guidelines and request forms. Please call eviCore's Client Provider Operations at 1-800-646-0184 if you have any questions or need more information.

Note: You may submit authorization requests to eviCore through BlueCross' payer space within the Availity provider portal, where you can also verify benefits, or by calling 1-888-693-3211.

New Outpatient Drug Testing Policy for Commercial Plans

As of June 1, 2018, urine/serum drug testing is 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 for each provider billed on the same claim). Billing for both tests for the same member on the same day is considered one episode.

A presumptive test is also known as a qualitative point-of-care test (POCT) or a drug screen. A confirmatory test identifies the drugs in a patient's system as well as the exact amount present at the time the sample was taken.

BlueAlert℠ Switches to Downloadable PDF Format Only

We understand that your time is valuable, so we want to make sure you get the BlueCross updates you need quickly and conveniently. Starting July 1, 2018, our BlueAlert Provider Communications newsletter will be available as a downloadable PDF only. With just one click, you can download, save and share.

Go to Availity® for Benefits and Eligibility Information

In the near future, all providers except Dental will have to go to Availity.com to determine benefits and eligibility status – not our Provider Service Line.• We understand you may prefer phone communication.However, that takes longer and can keep us from answering more complex calls. When we make this switch, we'll offer a quicker way to get information by phone if you can't find what you need online. If you haven't used Availity yet, we encourage you to try it now. We'll update you on further developments in the coming weeks.

•For now, Dental providers can access Benefits and Eligibility status by phone while we update Availity. We'll notify you if you're required to access this information on Availity.

Requirements of the New Provider Stability Act

On April 5, 2017, Governor Bill Haslam signed into law the Provider Stability Act (PSA) – a new Tennessee mandate intended to increase transparency and accountability between Tennessee health plans and contracted health care providers. This law, which will take **effect Jan. 1, 2019**, will require Tennessee health plans to:

- Notify health care providers of any material change made at the sole discretion of the insurance entity to a previously released provider manual or a reimbursement rule and policy at least 60 days before the effective date of the change
- Notify health care providers of any change to a provider's fee schedule and the effective date of the change at least 90 days prior to the effective date of the change
- Limit fee schedule changes to once in a 12-month period
- Send all Provider Stability Act notices and disclosures to a dedicated email address supplied by the provider

The PSA only applies to contracted Commercial providers in Tennessee.

How You Can Help

As part of the Provider Stability Act, we'll need to collect a dedicated contracting email address so we can notify you of changes to the Provider Administration Manual, reimbursement rules, fee schedules and policy changes. We'll continue to share updates about this law and how you can provide your preferred email address in future BlueAlert articles.

Telehealth Billing Changes Start Aug. 1, 2018*

Starting Aug. 1, we'll no longer require the GT modifier in claims filed for telehealth services, per the Centers for Medicare & Medicaid Services (CMS) billing guidelines. However, if this modifier is filed on a claim, we'll still use it for informational purposes.

Please continue to file all telehealth-related services with Place of Service (POS) code 02. This applies for both originating and distant-site providers, and coding it otherwise could affect your reimbursement.

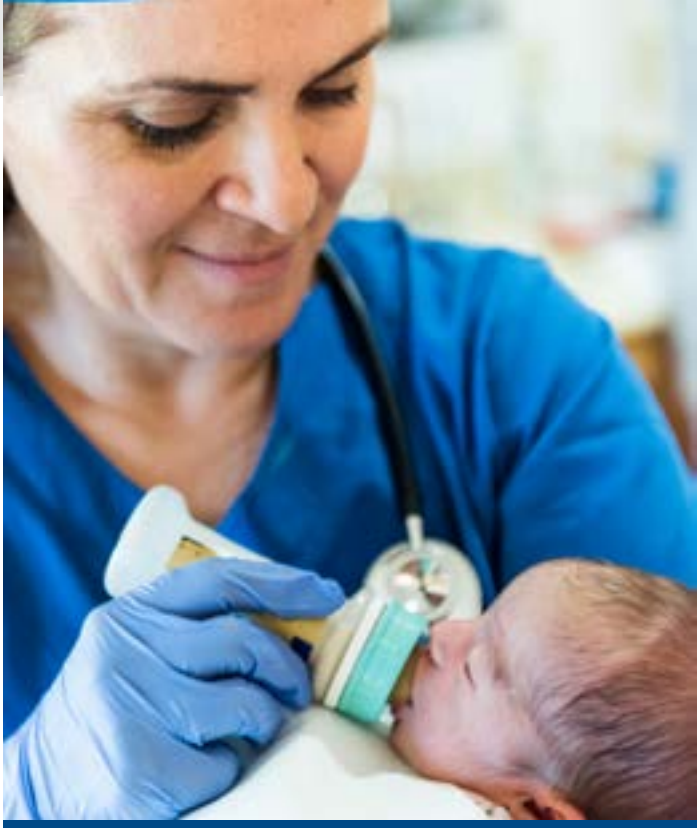
Please note we'll be auditing claims billed outside policy guidelines and/or without a corresponding claim for the same date of service but not filed with POS 02.

Updates to Hearing-Related Products and Services Billing Effective Aug. 1, 2018*

We want to make you aware of some changes going into effect Aug. 1, 2018. When billing for hearing-related services and equipment, please use the most appropriate "V" HCPCS code and number of units. Billing guideline updates include:

- Hearing exams, screenings, hearing aid fitting/orientation/checking, ear impressions, non-disposable ear molds/inserts and conformity evaluations will be reimbursed based on the lesser of line level-covered charges or the network maximum allowable fee schedule.
- Hearing aids will require an invoice showing the cost and be reimbursed based on policy Reimbursement Guidelines for Codes Classified as DME, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable.
- Hearing aid batteries and accessories assisted listening devices, disposable ear molds, dispensing fees, shipping/handling fees, and sales tax won't be separately reimbursed unless the member has specific group coverage. You may need to verify benefits before providing services.
- Not all plans cover hearing aids for all members and some plans contain dollar limits for hearing aids. Please verify benefits before providing services.
- Be sure to include the right side or left side (RT or LT) modifier with the appropriate HCPCS code for unilateral hearing aids as the first line item on the claim. This will help us process your claims more quickly. Please note that any claims for unilateral hearing aids that don't have the correct modifiers will be denied. There is no modifier required for codes identifying bilateral procedures or devices.

These guidelines apply to services billed on professional claims for our Commercial plans, with the exception of the Federal Employee Program, unless otherwise stated in their contract.



Changes to NICU Utilization Management and Care Management Services*

Starting Sept. 1, 2018, BlueCross will handle all utilization management and case management services for neonatal intensive care unit (NICU) babies covered by Commercial plans. Previously, Progeny helped us with these services.

To request authorizations, please call our Provider Service Line at 1-800-924-7141. For case management, call 1-800-818-8581, ext. 6900.

Printed Commercial Prior Authorization Letters Discontinued

Reminder - The Commercial Utilization Management area no longer mails prior authorization notification letters. You will receive notification by fax or electronically for web authorizations. This new method will speed the approval process and prevent misrouted letters. Prior authorization requests may be made by fax or phone, or you can get immediate approvals on some authorizations by logging in to the Availity Provider Portal for online authorization requests.

You may print web authorization approvals for your records. For FAQs and more information about registering, please log in to Availity.

Tips for Coding Professionals

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

Allowance Updated for Electric Breast Pumps (HCPCS Code E0603)

As of July 1, 2018, supplemental information will no longer be required for filing Commercial claims for electric breast pumps billed with HCPCS Code E0603, unless specifically requested.

Historically, electric breast pump allowances have been based on the policy for codes without established fees – those that are determined by invoice. We've conducted an in-depth analysis of code E0603 to address provider concerns regarding reimbursement. We reviewed data from paid claims as well as provider invoice documents to establish a reasonable allowable.

Supplies and accessories needed for the initial provision of the breast pump kit will not be paid in addition to the established Electric Breast Pump E0603 code reimbursement. Additional replacement supplies or accessories are not separately reimbursed.

Some members may have specific group coverage for breast pumps; therefore, providers may need to verify benefits before providing services.

BlueCare Tennessee

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

How to Streamline the Transition from Pediatric to Adult Care

When BlueCare Tennessee members turn 21, their TennCare benefits change. For example, federal law requires that children under 21 receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, some of these services aren't covered by TennCare for adults, like dental, hearing or routine vision services. As part of this transition in coverage, your patients may also encounter limits on home health visits or changes to their private duty nursing coverage eligibility.

We've created an FAQ document that answers common questions about these changes and other TennCare programs and benefits that may help fill gaps in coverage. You can find it under "General" in the provider section of bluecare.bcbst.com. If you have questions about this document or transitioning your patients, please contact your patient's BlueCare Care Coordinator or call 1-800-468-9736.

Weight Assessment and Coding for EPSDT Checkups

EPSDT/TennCare Kids exams require completion and documentation of all seven components, which includes education and guidance. A key element of the education component is counseling for nutrition and physical activity, as well as calculating body mass index (BMI) during the weight assessment. However, claims for checkups are often missing BMI codes. When you enter patient information for EPSDT checkups, please use the following diagnosis codes for children.

Pediatric – BMI Percentile	Diagnosis Code
<5th percentile for age	Z68.51
5th percentile – <85th percentile for age	Z68.52
85th percentile – <95th percentile for age	Z68.53
95th percentile or greater	Z68.54

These requirements do not apply to CoverKids members.

Medicare Advantage

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

Changes to Medicare Part D Coverage Determinations and Appeals Process*

BlueCross now manages the Medicare Part D coverage determination and appeal process for BlueAdvantage℠ and BlueCare Plus℠ members, so please submit your requests directly to us. For easy reference, here's how you can submit Medicare Part D coverage determination and appeal requests:

BlueAdvantage

Phone: 1-800-831-2583

Fax: (423) 591-9514

Mail: BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Online: bcbst.com/providers/medicare-advantage/bappo-pharmacy.page

BlueCare Plus

Phone: 1-800-299-1407

Fax: (423) 591-9514

Mail: BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Online: bluecareplus.bcbst.com/provider-resources/

You may call us during normal business hours, Monday through Friday from 8 a.m. to 9 p.m. ET, or you may leave a voicemail after hours on our secure voicemail. Please be sure to include the following information in your message:

- Member name, date of birth, full address, phone number and member ID
- Provider name, phone number, fax number and full address
- Medication name, quantity and day supply requested
- Type of request (e.g., Coverage Determination or Redetermination)
- Appropriate supporting statement for exception requests including indication for use and previous therapies tried and failed
- If your request is expedited or standard

Vision Refractions Not Covered Effective Sept. 1, 2018

Starting Sept. 1, 2018, BlueAdvantage will no longer cover vision refractions, regardless of the diagnosis or condition being treated. Please refer to the Medicare Advantage section of your BlueCross BlueShield of Tennessee Provider Administration Manual for additional billing information. Your patients can obtain a refraction as part of their supplemental vision benefits through our vision partner, Eyemed. Please note they must use Eyemed's network for these benefits.

Ophthalmology Services Updated to Specialist Copay

CPT® codes for general ophthalmology services (92002, 92004, 92012 and 92014) were updated so a specialist copay is now required instead of a BlueAdvantage covered vision exam copay. This means a Sapphire, Garnet or Ruby plan member's copay dropped from $40 to $35 for these service codes. Please note the copay for members with our Diamond plan is still $30 because the vision exam copay and specialist copay are the same. These services don't include vision refraction.

New Medicare ID Cards

CMS is launching an initiative to remove Social Security numbers (SSNs) from Medicare Health Insurance ID cards. This is to help protect Medicare enrollees from fraud and identity theft, and to safeguard taxpayer dollars.

Some of your patients may have already received new cards, depending on the schedule outlined by CMS. You can find more information about how the new Medicare number will impact you in the Providers section on the CMS website.

Quality Care Partnerships

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

FREE Quality Training for Network Providers

BlueCross is offering a two-day class Aug. 2 to 3, 2018, to promote health care quality. The training class will be held in the BlueCross Community Room, 1 Cameron Hill Circle in Chattanooga. The class is designed to help those planning to take the Certified Professional in Healthcare Quality® (CPHQ) examination and offers intermediate quality improvement content that can benefit anyone working in the health care quality field.

Although the training costs $400, BlueCross is offering the class to our network providers at no charge. Space is limited, so please contact us soon to register. To qualify for the training you must meet the following criteria:

- Currently employed in a role related to quality improvement or management
- Currently employed by a BlueCross network provider

Registration for network providers is limited to two participants per group/facility for the 2018 class. For more information see our website. To register, email tawanda_malone@bcbst.com.

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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CAQH Solutions | PROVIEW™

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

† 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
***Select*Community**	1-800-292-8196
Available Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-841-7434
BlueAdvantage Group	1-800-818-0962
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	eBusiness_service@bcbst.com
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	