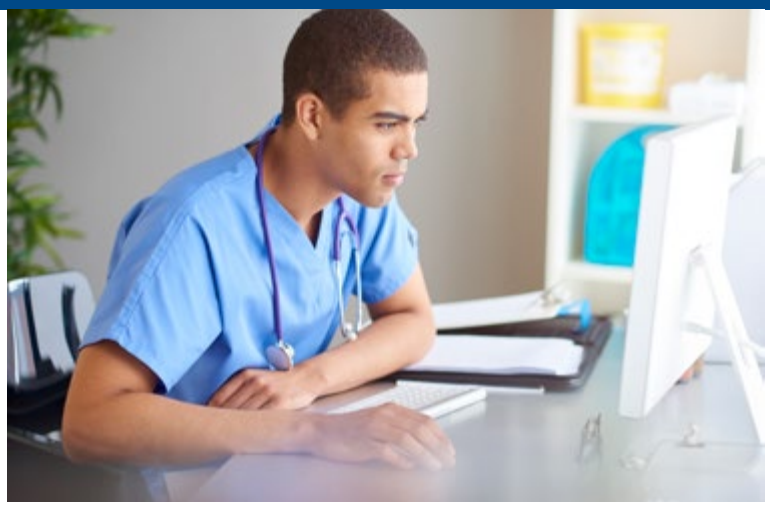
of Tennessee

SEPTEMBER 2018

BlueAlert℠



BlueCross BlueShield of Tennessee, Inc.

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

Go to Availity® for Eligibility and Benefits Information

As of Aug. 1, all providers except dental are required to go to Availity.com for eligibility and benefits status – not to our Provider Service Line. Simply log in to Availity and click **Patient Registration**, then **Eligibility and Benefits Inquiry**.

If you are not registered, go to Availity.com and click **Register** in the upper right corner of the home page, select **Providers**, click **Register** and follow the instructions in the Availity registration wizard.

If you make an inquiry in Availity and can't get the information you need, the system will provide a special code to contact Provider Service for help.

For now, dental providers can get eligibility and benefits status by phone. We'll notify you when you need to get this information through the portal.

If you have questions, please contact your eBusiness Regional Marketing Consultant. Thank you for using all of Availity's self-service features.

INSIDE THIS ISSUE

Provider Stability Act Alert

Please Provide Your Email Address through Availity

The Provider Stability Act (PSA) goes into effect Jan. 1, 2019, and requires all Commercial Tennessee health plans to communicate activities impacting reimbursement, medical policies and fee schedules by email.

It's important we have your updated information so we can effectively communicate with you.

What You Need to Do

- If you haven't yet, register with **Availity**.
- Go to **Payer Spaces** at Availity.com.
- Select the **Contact Preferences** application to verify your preferences for BlueCross contracts. A step-by-step guide is available on our landing page listed below.

To learn more, please see our step-by-step guide on the Provider Stability Act page at bcbst.com/providers/psa.

Medical Policy Updates/Changes

We're updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, click Upcoming Medical Policies.

Effective October 24, 2018

- Vulvectomy **(Revision)**
- Diagnosis and Treatment of Facet Joint Pain **(Revision)**
- Non-invasive Positive Pressure Ventilators (In-Home Use) **(Revision)**
- Home Nutritional Support (Total Parenteral/Enteral Nutrition) **(Revision)**

The following medical policies will be archived and no longer active 30 days (October 1, 2018) after this BlueAlert notification. We have determined that there is no longer a need for our Commercial and BlueCare Tennessee Utilization Management departments to maintain this policy.

- **Electrocardiographic Body Surface Mapping** – This particular product is no longer available on the market.
- **Patient-Specific Cutting Guides and Custom Knee Implants Instrumentation for Joint Arthroplasty** – We'll develop a new medical policy that only addresses three-dimensional printed orthopedic implants.
- **Percutaneous Tibial Nerve Stimulation** – We'll transition over to utilizing an MCG Care Guideline that considers this procedure to be appropriate if specific clinical indication criteria are met.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross BlueShield of Tennessee's Health Care Practice Recommendations web page has updates for Assessment of Cardiovascular Risk from the American College of Cardiology/American Heart Association and *Guidelines for Perinatal Care* from the American Academy of Pediatrics/ American College of Obstetrics and Gynecology. These and other updates are available on our website at bcbst.com/providers/hcpr/index.page.

You may obtain paper copies of any listed clinical practice guideline by calling (423) 535-6705.

Reminder: Contract Amendment Relating to Payment for Anatomic Pathology Services Provided at Facilities for Commercial Plans

In March 2018, we announced a temporary suspension of our payment policy for the technical component of some anatomic pathology services. The policy suspension relates to services furnished to Commercial members in facilities (other than freestanding ambulatory surgical centers (ASCs)) between Jan. 1 and Dec. 31, 2018.

As mentioned in the August BlueAlert, BlueCross will resume its regular payment policy for these services furnished on and after Jan. 1, 2019.

- Under this policy, BlueCross pays facilities (other than free-standing ASCs) an all-inclusive rate for inpatient and outpatient services.
- This facility payment includes payment for all services and supplies associated with the inpatient and outpatient services, unless there is a contractual exception. This includes the technical component for professional services provided while a patient is in a facility setting.
- The policy applies regardless of where the technical component is performed and regardless of the relationship between the facility and the physician performing the service.

To address some of the confusion providers have raised to our attention, we amended all physician and physician group contracts to clarify further our payment policy for these services.

These contract amendments were mailed in mid-August. If you have questions, please contact your BlueCross Network Manager or check our website.

Join Us for a Health Information Technology Program

If you have an interest in Health Information Technology (HIT), you're invited to join us for a special Health Information Technology Accelerator Program starting Sept. 10. This program is a joint effort between BlueCross, the Tennessee Chapter of the Healthcare Information and Management Systems Society (HIMSS) and the Belmont University Center for Executive Education.

HIT professionals lead the training, covering best practices, real-world challenges and the future of health care and technology. The course runs Monday nights from 6:30 to 9:30 p.m. ET, Sept. 10 to Dec. 17. It'll be available on campus at Belmont University in Nashville and simultaneously as a hosted teleconference in the Distance Learning Center at our Cameron Hill location. Space is limited, so we encourage you to reserve your spot as soon as possible. Participants can also dial into the teleconference from a home or work computer.

The course costs $2,495, and attendees will receive HIT certification upon completion. For more information, please contact Erica Eubank at Erica_Eubank@BCBST.com or (423) 535-7053. Registration is open and lasts through Sept. 10.

BlueCross Updating Opioid Prescription Policy Jan. 1

BlueCross continues to support the growing national effort toward more appropriate use of opioids. We've taken action on multiple fronts and continue to push forward, including changes to our opioid prescription policy for Commercial plans that will be effective Jan. 1, 2019. Details about the changes, including prior authorizations and quantity limits, will be available in the October 2018 BlueAlert.

Billing Avastin (Bevacizumab) for Retinal Use

Retinal providers (ophthalmology and pediatric ophthalmology) can now bill compounded Bevacizumab with either J7999 or J9035. As of June 1, 2018, neither code requires an authorization for retinal diseases such as diabetic macular edema, macular edema following retinal vein occlusion and neovascular (wet) age-related macular degeneration when administered by an ophthalmologist or a pediatric ophthalmologist. When using J7999, please refer to our provider administration manuals for additional HCPCS billing guidelines.

Billing Requirements for Faxed Paperwork (PWK) Attachments

When paper documentation is necessary to support an electronic claim, you can use the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to us separately. The actual supporting documentation is faxed with a PWK Fax Cover Sheet, which is matched to your electronic claim using the information supplied on the cover sheet.

A PWK Fax Cover Sheet must be completed for **each** electronic claim and faxed with documentation to (423) 591-9481. The **documentation and fax sheet should be sent on the same day**.

For more information see the BlueCross BlueShield Provider Administration Manual. If you have questions about this process, call eBusiness Technical Support or your eBusiness Regional Marketing Consultant.

Durable Medical Equipment (DME) Billing Guideline Changes

We've updated our billing guidelines for DME. Starting Oct. 1, 2018, DME providers will need to use "99" as the new place of service code when submitting a claim for an item purchased by and delivered to a member at a retail store.

Billing Accuracy and Cost Control

Effective Oct. 1, 2018, you'll be required to submit an itemized statement for all Commercial inpatient facility services that are reimbursed at a percent of charges. The itemized bill should be submitted through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

Billing Requirements for Therapeutic Continuous Glucose Monitoring Systems

Providers should now bill Therapeutic Continuous Glucose Monitoring systems with a durable medical equipment (DME) HCPCS Modifier K Code. Commercial DME prior authorization requirements apply based on the cost of the equipment. Most Commercial plans require prior authorization for DME over $500. Prior authorization requests can be faxed to 1-866-558-0789 or online through Availity.

Two Key Requirements for Ancillary Claims

Claims for ancillary services performed by independent clinical laboratories or specialty pharmacies have two important requirements:

1. The claim must include the name of the referring or ordering provider.
2. Our records must show that the referring/ordering provider practices in Tennessee.

Claims that don't meet both requirements will be denied.

If you have questions about a rejected claim related to this requirement, please contact eBusiness Provider Solutions at (423) 535-5717 (Option 2), Monday through Thursday, 8 a.m. to 6 p.m. (ET) and Friday, 9 a.m. to 6 p.m. (ET) or email eBusiness_Service@bcbst.com.

Update to Commercial Prior Authorization Requirements

Effective Oct. 1, 2018, please note CPT® Codes 64581 and 64590 will no longer require prior authorization for Commercial plans in an inpatient or outpatient setting. For a complete list of services that require prior authorization, see our Commercial Prior Authorization Requirements.

Changes to Commercial Prior Authorization Requirement for Musculoskeletal Procedures

Beginning Nov. 1, 2018, we're partnering with Turning Point Healthcare Solutions to administer prior authorizations for musculoskeletal (MSK) procedures and pain management for select self-funded and all fully insured Commercial groups. To request prior authorization, please visit the BlueCross payer space in the Availity provider portal, where you can also verify benefits. You can also request a prior authorization by calling 1-866-747-0586 or by faxing your request to 1-866-747-0587. Please let us know if you're interested in training and support to help streamline your prior authorization process.

Changes to NICU Utilization Management and Care Management Services

As of Sept. 1, 2018, BlueCross is handling 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.

BlueCare Tennessee

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

Billing Requirement for Facility Claims

In compliance with the ASC X12 837 Institutional Implementation Guide and the NUBC UB04 Data Specifications Manual, the attending provider listed on a facility claim is the individual who has overall responsibility for the patient's medical care and treatment reported on the claim. The NPI submitted on a facility claim as the attending provider's NPI must belong to an individual provider, not a group or facility, or the claim will be rejected.

Note: The only exception to this rule is for CHOICES claims where the billing provider is atypical. In this case, it's appropriate for the attending provider to not be an individual.

Refer Requests for Outpatient Lab Services to Quest Diagnostics

Quest Diagnostics is the exclusive provider of outpatient lab services for BlueCare, TennCare*Select* and CoverKids members. To prevent claims denials and help ensure your patients in these networks receive the benefits of using an in-network lab provider, please order all routine diagnostic tests directly through Quest Diagnostics.

For more information about ordering and billing for outpatient lab services, please refer to the BlueCare Tennessee Provider Administration Manual. Please note some lab services are excluded from the Quest Diagnostics requirement. You may view the Quest Diagnostics Exclusion List, which we update annually, at bluecare.bcbst.com.

Get a List of Your Patients Who Need Well-Care Checks

Many children from low-income homes aren't getting their Early and Periodic Screening, Diagnosis and Treatment (EPSDT) wellness exams as recommended. To find out if your patients are up to date, visit the Quality Care Rewards section of the Availity provider portal.

Select All Gaps to view a list of your patients who still need preventive care. Then, click on Non-Compliant Members to find a detailed record of patients who are past due for their EPSDT checkup. This list, which is updated monthly, includes the number of missed visits and the date of the last wellness check.

For easy reference, click the green X in the top corner of the web page and export the non-compliant member report into an Excel document. You can share this document with your team to use as a guide when scheduling EPSDT visits.

Note: This does not apply to CoverKids.

New Fax Numbers for Reporting Missed Shifts

Unfortunately, missed shifts happen, and we need to know when they do. Although submitting a missed shift form is a requirement, the importance of contacting us is about making sure members get the care they need.

Please note the fax numbers for reporting missed shifts have changed. If you need to report a missed shift, please fax the appropriate form to **(423) 535-1931** or **1-833-744-7587**.

If you're reporting a missed shift on the day it will occur, please call us at:

BlueCare	1-888-423-0131
TennCare*Select*	1-800-711-4104
CHOICES/ECF CHOICES	1-888-747-8955

To get help resolving missed shifts or to report missed shifts resulting from safety, environmental or enrollee/family barriers, please call Case Management at 1-800-225-8698.

Medicare Advantage

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

Changes to Medicare Prior Authorization Requirement for Musculoskeletal Procedures

Effective Nov. 1, 2018, BlueAdvantage will partner with Turning Point Healthcare Solutions for musculoskeletal (MSK) and pain management prior authorizations. To request a prior authorization, please visit the BlueCross payer space in the Availity provider portal, where you can also verify benefits. You can also request a prior authorization by calling 1-888-258-3864.

Prior authorization for physical therapy, occupational therapy and chiropractic services can be requested through the Availity provider portal or by calling 1-800-924-7141.

New Prior Authorization Requirement for Hemophilia-Related Drugs

Starting Oct. 1, 2018, we'll require prior authorization for hemophilia-related drugs for BlueAdvantage and BlueCare Plus members. Currently, these drugs are covered by the member's medical drug benefits and don't require prior authorization. If you don't obtain authorization for these drugs, your claim will be rejected and not paid. The following drugs now require prior authorization, but you can also find the Provider-Administered Specialty Pharmacy Products list in the **Pharmacy Resources & Forms** section of our provider website.

CPT4 Code	Generic Name	Drug Brand Name
J7192	factor viii	Advate
J7207	factor viii	Adynovate
J7210	factor viii	Afstyla
J7186	factor viii/vwf complex	Alphanate
J7193	factor ix	Alphanine SD
J7201	factor ix	Alprolix
J7194	factor ix	Bebulin
J7195	factor ix	BeneFIX
J7175	factor x	Coagadex
J7180	factor xiii	Corifact
J7205	factor viii	Eloctate
J7198	anti-inhibitor coagulant complex	Feiba NF
J7198	anti-inhibitor coagulant complex	Feiba
J7192	factor viii	Helixate FS
Q9995	emicizumab-kxwh	Hemlibra
J7190	factor viii	Hemofil M
J7187	factor viii/vwf complex	Humate-P
J7202	factor ix	Idelvion
J7195	factor ix	Ixinity
J7190	factor viii	Koate-DVI
J7192	factor viii	Kogenate FS
J7211	factor viii	Kovaltry
J7190	factor viii	Monoclate-P
J7193	factor ix	Mononine
J7182	factor viii	Novoeight
J7189	factor viia	Novoseven RT
J7209	factor viii	Nuwiq
J7188	factor viii	Obizur
J7194	factor ix	Profilnine SD
J7199	factor ix	Rebinyn
J7192	factor viii	Recombinate
J7200	factor ix	Rixubis
J7181	coagulation factor xiiia - subunit	Tretten
J7179	von willebrand factor	Vonvendi
J7183	factor viii/vwf complex	Wilate
J7185	factor viii	Xyntha

To start the authorization process, simply log in to Availity and go to the BlueCross Payer Space. Then, click on the Authorization Submission/Review application and select Specialty Pharmacy.

Retrospective Authorizations

Prior authorization must be obtained in the timeframes required. Only the following exceptions will be considered for retrospective review:

- The member did not provide Medicare Advantage insurance information at the time of service.
- The Member ID card was not issued.
- There was an issue with eligibility dates for the member.
- If you have proof that the provider tried to meet prior authorization timing requirements; you must submit a valid copy of the original fax transmittal as documentation.

A request for retrospective authorization review must be received within 180 days of the date of service or the date eligibility is confirmed by the Centers for Medicare & Medicaid Services. You must obtain prior authorization for Medicare Advantage members as episodes occur, during the established timeframes. We will complete all retrospective reviews within 30 calendar days of receiving your request for a standard organization determination.

Post-Service Audit Focuses on High-Level Emergency Department E&M Coding

Starting Nov. 1, 2018, BlueAdvantage will audit claims billed with Level 5 Emergency Department E&M codes to verify the discharge diagnosis justifies high complexity E&M coding. Claims billed with inappropriate E&M codes will be denied and you'll need to file with a lower acuity E&M or request an appeal.

The audit addresses what CMS notes as a sharp increase in Level 5 emergency department coding. It's not to evaluate whether an emergency existed under the Prudent Layperson Standard, or the requirement of a Medical Screening Exam under the Emergency Medical Treatment and Active Labor Act.

Utilization Management Dispute Resolution Process

As outlined in the BlueCross BlueShield of Tennessee Provider Administration Manual, you have 60 calendar days from the original decision to request a utilization management appeal if you disagree with our decision. If we don't receive your appeal request within the allotted timeframe, it won't be eligible for consideration.

If you're not satisfied with the appeal decision, you have the right to binding arbitration. You can find out more about arbitration, as well as our overall appeals process, in our provider administration manual.

Changes to Medicare Part D Coverage Determinations and Appeals Process Effective July 2, 2018

As of July 2, 2018, Express Scripts, Inc. (ESI) no longer reviews Medicare Part D coverage determination and appeal requests for BlueAdvantage and BlueCare Plus members. You should now send Medicare Part D coverage determination and appeal requests directly to BlueCross by using one of the submission methods below:

BlueAdvantage

Provider Service: 1-800-831-2583

Fax Number: 1-423-591-9514

Mailing Address: 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

Provider Services: 1-800-299-1407

Fax Number: (423) 591-9514

Mailing Address: 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/

Please remember, faxes pertaining to Medicare Part D Coverage Determinations and Appeals should *not* be sent to ESI. Instead, send them directly to BlueCross at:

BlueAdvantage 1-423-591-9514

BlueCare Plus 1-423-591-9514

Normal hours of operation for the Medicare Part D Coverage Determinations and Appeals Department are 8 a.m. to 9 p.m., ET, Monday through Friday. You may leave a secure voicemail outside of normal hours of operation.

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.

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)	