Contracting Email Address Required for Provider Stability Act

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

It’s important we have your updated information so we can reach you.

What You Need to Do

- Log in to Availity®.
  - If you haven’t yet, Register for Availity access.
- Go to Payer Spaces at Availity.com.
- Select Contact Preferences to verify your preferences for BlueCross contracts.
- From the Contract Details screen, you’ll need to confirm your contracting email address and Opt In for these communications.

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

We Need Your Updated Mailing Address, Too

If we can’t reach you by email, we’ll need to send communications by mail. If your mailing address isn’t correct in Availity, please:

1. Download and follow the instructions on our Provider Change Form.
2. Go to CAQH ProView® to make sure your information matches what you’ve sent to us.
Check Eligibility and Benefits Through Availity Self-Service Features
To check eligibility and benefit information, simply log in to Availity, click Patient Registration and then Eligibility and Benefits Inquiry. As a reminder, all providers except dental are required to go to Availity.com for eligibility and benefits status – not to our Provider Service Line.
If you make an inquiry and can’t get the information you need, the system will provide you with 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.
* This also applies to outsource vendors acting on the provider’s behalf.

General Inquiries Through Our Message Center
When submitting a General Inquiry to us through the Availity Message Center, please remember to select the appropriate line of business for the member you’re referencing. You can use the drop-down arrow to choose the correct line of business for your inquiry. Selecting the correct line of business will help us direct your inquiry to the proper area for a quicker response. If you have questions about Availity, please choose the Technical Support option to message our eBusiness staff.

Coming Soon – Cite Guideline Transparency
We’ll soon offer MCG Care Guidelines’ Medicare Compliance Product. It was designed to incorporate Medicare’s National Coverage Determinations (NCDs) into the MCG format, which will save time and improve documentation practices. MCG’s Medicare Compliance Product is offered within the MCG payer software and Cite AutoAuth.

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 our August and September BlueAlert newsletters, BlueCross will resume its regular payment policy for these services furnished on and after Jan. 1, 2019. For additional details, please refer to these newsletters or the Important Initiatives section of our website.
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.

2019 Formulary Changes
Each year, we review our BlueCross formularies and make changes based on a drug’s safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they may occur at any time because of market changes such as:
• Release of new drugs to the market after FDA approval
• Removal of drugs from the market by the FDA
• Release of new generic drugs to the market
Please visit the following links to view the 2019 Formulary Changes listed below:
• 2019 Preferred Formulary Changes
• 2019 CoverKids Formulary Changes
• 2019 Essential Formulary Changes
In November, we’ll begin sending letters to our members whose medications are changing to non-formulary status Jan. 1, 2019. We aren’t sending letters about every change to their formulary, so please remind your patients to check for changes at bcbs.com.
BlueCross Updating Opioid Prescription Policy Jan. 1

Tennessee faces one of the worst crises of opioid abuse in the country. The widespread, legitimate use of opioids makes controlling misuse and abuse difficult. There’s a perception that these pills are safe, because they’re not illegal street drugs.

BlueCross continues to explore ways to promote the appropriate use of opioids and keep members safe. We’ve worked closely with an independent panel of external pain management specialists, oncologists and end-of-life care specialists to inform our decision making. These efforts include changes to our formularies and opioid prescription policy.

Effective Jan. 1, 2019, we’re making the following changes for our Commercial* (BlueNetworksSM P, S and M) and CoverKids members: (This policy doesn’t apply to TennCare members.)

• Remove OxyContin from formulary and replace with abuse-deterrent drugs (i.e. Morphone/Hydrocodone)
• Place stops on dangerous drug combinations (i.e. opioids/benzodiazepines).
• Reduce the morphine milligram equivalent (MME**) allowed:
  – 120 MME cumulative total
  – Maximum allowed of 200 MME with a prior authorization
  – Note: Medicare Advantage still has maximum allowed of 200 MME
• Add controls for short-acting opioids:
  – Limit new prescriptions for short-acting opioids to seven days
  – Change look-back period for new prescriptions to 120 days
  – Require prior authorization on short-acting opioids prescribed for an extended period (more than 30-day supply in a 90-day period)

*As with previous clinical changes, requests from members with cancer or those who are receiving palliative or end-of-life treatment will be approved.

**MME represents a drug’s potency equivalent to a dose of morphine.

Flu Shots: Preparing for 2018-19 After Last Year’s Historic Surge

The last flu season was historically bad, especially for kids. The Centers for Disease Control and Prevention (CDC) recorded 172 pediatric flu-related deaths for the 2017-18 season. Approximately 80 percent of those deaths were children who did not get a flu shot.

As you schedule and prepare for patient visits in the next few months, please remind them about the importance of getting their annual flu shots. The CDC recommends the flu vaccine for everyone 6 months of age and older, with rare exceptions. The importance of a flu shot increases for adults who are considered high risk or who are in homes with infants younger than 6 months old.

Some pediatric offices were in short supply late last season. As a result, they’re ordering vaccinations now to be better prepared for their patients, including those who will reach 6 months of age during the upcoming flu season.

New Prior Authorization Requirement for Provider-Administered Specialty Medication

Retacrit (Q5105-non-ESRD/Q5106-ESRD) and Fulphila (Q5108), new-to-market provider-administered specialty medications, now require prior authorization for all lines of business. You can find more about provider-administered specialty medications and prior authorization requirements on our website.

Update to Commercial Prior Authorization Requirements

Effective Oct. 1, 2018, CPT® Codes 64581 and 64590 no longer require prior authorization for Commercial plans in inpatient and outpatient settings. For a complete listing of services that require prior authorization, please see our Commercial Prior Authorization Requirements at bcbst.com.
Change to Prior Authorization Requirement for Musculoskeletal Procedures

Beginning Nov. 1, 2018, we’re partnering with TurningPoint Healthcare Solutions, LLC, to administer prior authorizations for musculoskeletal (MSK) procedures for our Commercial, BlueCare Tennessee, TennCare Select, BlueCare Plus and BlueAdvantage members.

TurningPoint will also administer prior authorization for Commercial and BlueAdvantage members needing pain management. 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:

- Commercial* 1-866-747-0586
- BlueCare Tennessee 1-888-423-0131
- TennCare Select 1-800-711-4104
- BlueCare Plus 1-888-258-3864
- BlueAdvantage 1-888-258-3864

*select self-funded and all fully-insured Commercial groups

Please let us know if you’re interested in training and support to help streamline your prior authorization process.

Note: CoverKids does not participate in the MSK program.

Ancillary Claim Requirements

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

- Depending on the specialty, the claim must include the referring or ordering provider, and
- Our records must show that the referring/ordering provider practices in Tennessee.

Claims that don’t meet both requirements will be rejected.

If you have questions about a rejected claim related to this requirement, please contact:
eBusiness Provider Solutions at (423) 535-5717 (Option 2) or email eBusiness_Service@bcbst.com.

Billing Accuracy and Cost Control

As of Oct. 1, 2018, an itemized statement is required 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.
Correct Use of Modifiers for Procedure-to-Procedure Edits

Each National Correct Coding Initiative procedure-to-procedure (PTP) edit has a modifier indicator of 0, 1 or 9.

- **Modifier indicator 0** indicates NCCI-associated modifiers cannot be used to bypass the edit.
- **Modifier indicator 1** indicates NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.
- **Modifier indicator 9** indicates the edit has been deleted and the modifier indicator is not relevant.

When an edit may be bypassed by a modifier, and a modifier is clinically supported, the modifier should only be appended to the column two or “bundling” code. While the modifier may be accepted on the comprehensive codes in some instances, it shouldn’t be appended to both codes in the code edit pair. This can delay the processing and payment of claims.

Tips for Coding Childhood and Adolescent Vaccines

Vaccines are a key element of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) TennCare Kids exams. To make sure children and teens get the preventive care they need, you can perform a “sick” visit and a “well” check that includes any necessary vaccines on the same day.

When submitting claims for immunizations given during a well check or other type of office visit, please use the following CPT® codes:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>Immunization administration through 18, via any route, with counseling, first or only component of each vaccine</td>
</tr>
<tr>
<td>+904460</td>
<td>Each additional vaccine or component, with counseling</td>
</tr>
<tr>
<td>90460 and 90461 are reported when patient is 18 years or younger and the physician or other qualified health care professional performs face-to-face vaccine counseling</td>
<td></td>
</tr>
<tr>
<td>90471</td>
<td>Immunization administration ID, IM, subQ, one vaccine (single or combined vaccine)</td>
</tr>
<tr>
<td>+90472</td>
<td>Each additional vaccine ID, IM, subQ, one vaccine (single or combined vaccine)</td>
</tr>
<tr>
<td>90473</td>
<td>Immunization administration, oral, one vaccine (single or combined vaccine)</td>
</tr>
<tr>
<td>+90474</td>
<td>Each additional vaccine, oral (single or combined vaccine)</td>
</tr>
<tr>
<td>90471-90474 are reported when the patient is over the age of 18 or when counseling is not performed.</td>
<td></td>
</tr>
</tbody>
</table>

To review the Immunization Schedules for children and adolescents, please visit the CDC website. A comprehensive list of all codes for Commonly Administered Pediatric Vaccines is available through the Tennessee Chapter of the American Academy of Pediatrics website.

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

Starting Nov. 1, 2018, BlueAdvantage will audit claims 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 is 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.
Clinical Editing Update
As we continue to update and improve our claims payment process to lessen the need to recover payments made inappropriately, we want to offer some tips to help you when you submit claims:

Place of Service Codes
• Supplies and Equipment Provided in the Facility Setting:
  – Medical and surgical supplies and durable medical equipment shouldn’t be billed by professional or ancillary providers when the place of service is inpatient/outpatient facility or ambulatory surgery center (ASC).
• Evaluation and Management (E&M) Place of Service Restrictions:
  – Be sure to use the appropriate place of service code, which should indicate where services were rendered. Incorrectly reporting the place of service could result in a denial of the claim.

For more information on place of service code reporting, please see CMS.gov.

Diagnosis Codes
E&M services (excluding normal newborn care) billed with 99381-99429 (preventive medicine services) will be denied if the only diagnosis on the claim is an ICD-10 “Z” diagnosis code. According to the ICD Manual Guidelines, ICD-10 “Z” codes (Factors Influencing Health Status and Contact with Health Services) allow for the description of encounters for routine examinations (e.g. a general checkup, examinations for administrative purposes or pre-employment physicals). These codes shouldn’t be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases, the specific diagnosis code (from other chapters) is used. If a diagnosis or condition is discovered during a routine exam, it should be reported as an additional code.

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

Improving Health in Tennessee
Improving health in Tennessee is a team effort, and we want to help.

We invite you to take the Providers CARE Survey. This questionnaire is designed to help us get to know your patients and their needs. It also lets you share feedback about learning opportunities that may be useful for your practice team.

To fill out the survey, please visit https://www.tn.gov/tenncare/providers/literacy-communication-cultural-competency-and-disparities-in-health-care.html. Your answers will not have your name on them and will be combined with information from other providers.

It matters where your patients live, work, and play. Good health outcomes start in the communities where your patients live. By taking the survey, you’ll give us information about challenges your patients are facing in their communities. Our goal is to help you improve your patients’ health by:

C = Connecting them with community resources (like food pantries and housing help);
A = Acting for better health by teaching them about their care needs;
R = Reducing stigma by showing compassion to others and taking time to think about your actions and thoughts about yourself and others; and
E = Empowering yourself and others. Take the time to listen to your patients. Treating them with kindness and support can help them take the steps they need for better health and supporting them on their journeys to better health.

Improving health in Tennessee is a team effort. By taking the Providers CARE Survey you can help us learn more about the needs of your patients that can lead to learning opportunities to assist your practice.

Your answers will not have your name on them and will be combined with information from other providers.
Population Health Management Offers Quality and Effective Coordination of Care

Population Health Management offers high-quality and effective coordination of care for our members with complicated care needs, chronic conditions, high-risk pregnancies, and catastrophic illnesses or injuries. We use referrals, claims, health-risk assessments and other sources to identify members and connect them with specific programs. Activities include behavioral and physical health. When appropriate, they are also integrated with CHOICES and ECF CHOICES care coordination processes.

Our clinical teams help our members and their families so they can make better health care decisions. We educate them about health conditions and their options, and we provide them with the tools and resources they need to make smarter choices. (CHOICES services are not available to CoverKids members.)

To refer your patients to a Population Health Management program, please call 1-888-416-3025.

Providers and Members Eligible for Maternity Care Payments

BlueCare Tennessee obstetric providers can help their patients receive up to $100 toward the purchase of baby supplies, while also earning payments on top of their regular reimbursements for maternity care.

The program includes two visits: a prenatal visit during the first trimester of pregnancy or within 42 days of BlueCare Tennessee enrollment – billed with category II code 0500F, and a postpartum visit within 21 to 56 days of delivery – billed with category II code 0503F.

The steps for getting paid are easy. For each claim that meets the guidelines above, your office will receive $10. The eligibility of your patients to receive $50 gift cards is based on the claims you file and a BlueCare Tennessee checkup form that your patients must return to us. They should bring the form with them and ask the provider to sign it at the visit.

For more information about the Maternity Care Program, including forms, please visit our website.

Please note: CoverKids obstetric providers are eligible for the maternity care payment if they submit claims according to the guidelines above, but CoverKids members are not eligible for gift cards.
**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 for the attending provider on a facility claim must belong to an individual, 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.

**Medicare Advantage**

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

Patients 65 and older are at greater risk for serious complications from the 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. Current CDC guidelines recommend the high-dose flu vaccine for those over 65.

**New Medicare ID Card Update**

Earlier this year, CMS launched an initiative to remove Social Security numbers from Medicare Health Insurance ID cards. This is to help protect Medicare enrollees from fraud and identity theft, and 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.

**Flu Vaccines Keep Your Patients Healthy**

The flu season is upon us, so please remind your patients to get their annual flu shot. It’s quick, easy and free for BlueAdvantage and BlueCare Tennessee members. Most important, it can help keep them healthy. The flu shot is a calendar-year benefit, so it’s covered once a year regardless of the number of days between vaccinations. This is also a good time to review your patient’s pneumococcal vaccine status.

**Statin Medications for Patients with Diabetes**

The Centers for Medicare & Medicaid Services (CMS) created two Star measures related to prescribing statin medications. The measures are for patients diagnosed with diabetes and atherosclerotic cardiovascular disease (ASCVD). During the next few months, our Provider Engagement and Outreach team will share information related to each measure and tips on managing patients using statins.
Home Health and Outpatient Services Administrative Approval Updates

BlueAdvantage has updated its administrative approval process for initial requests for home care and outpatient speech therapy:

- **Home health skilled nursing visits**: up to 13 visits over a 30-day timeframe
- **Speech therapy** (home/outpatient): up to seven visits over a 30-day timeframe

The total number of visits and timeframe given should include the initial evaluation and treatment.

We don’t need clinical information for these administrative approvals other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are an extension request, so we’ll need clinical documentation for a medical necessity review. If you need more than the number of allowed visits within or beyond a 30-day timeframe on your initial request, please send us supporting documents for a medical necessity review.

Qualified Medicare Beneficiary Program

As a reminder, all Medicare-eligible providers and suppliers, including pharmacies, may not bill Medicare Advantage members enrolled in the **Qualified Medicare Beneficiary (QMB)** program for Medicare cost-sharing. Members enrolled in the QMB program have no legal obligation to pay copays or coinsurance for any Medicare-covered items and services. Please bill these costs to state Medicaid programs.

If you’re not sure of a member’s QMB status and exemption from cost-sharing before billing, please use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS).

Changes to Physical and Occupational Therapy Prior Authorizations

Beginning Nov. 1, BlueAdvantage will provide prior authorization for physical therapy (PT), occupational therapy (OT), and chiropractic services. You may request prior authorization by logging in to the BlueCross payer space in the Availity provider portal or by calling 1-800-924-7141.

To make it easier for you, we’ll administratively approve the initial request for the following services with notification and diagnosis only:

- PT and OT (home health or outpatient): up to 13 visits over a 30-day timeframe
- Chiropractic request for Spine only (cannot be for maintenance therapy per Medicare guidelines): up to nine visits over a 30-day timeframe

The total number of visits and timeframe given should include the initial evaluation visit and treatment visits.

We don’t need clinical information for these administrative approvals other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are an extension request, so we’ll need clinical documentation for a medical necessity review. If you need more than the number of allowed visits within or beyond a 30-day timeframe on your initial request, please send us supporting documents for a medical necessity review.

If you need to request more than the number of allowed visits noted within or beyond a 30-day timeframe on your initial request, please submit all supporting documentation for medical necessity review.
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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† 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

TennCareSelect 1-800-276-1978

CoverKids 1-800-924-7141

CHOICES 1-888-747-8955

ECF CHOICES 1-888-747-8955

BlueCare Plus® 1-800-299-1407

BlueChoice℠ 1-866-781-3489

SelectCommunity 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)

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