Use Availity® to Get the Answers You Need

Through Availity, you can get the answers you need 24 hours a day, seven days a week. Not only can you transact with us online, you have access to other payers, too – all through one convenient portal.

Log in today to:
- Check claim status
- See remittance advice
- Check benefits and eligibility status
- Access our other applications and updates on the BlueCross-specific Payer Space

New Enhancements Added to Eligibility and Benefits

We’ve added new enhancements to the Eligibility and Benefits Inquiry. You’ll now have these options:
- New Benefit/Service types:
  - Allergy and Allergy Testing
- Benefit reset date (calendar year vs. plan year) will now be populated

Check Status of Medicare Crossover Claims

If you need to check claim status or search for out-of-state Medicare crossover claims, you can:
- Select Claims Status and enter information in the search field.
  - If the claim is not found, click “Are you looking for a Medicare Primary Claim?”
- Enter required fields and submit.
- Claim list results will display.
For questions about Availity, please call Availity at 1-800-AVAILITY (1-800-282-4548) or our eBusiness technical support team at (423) 535-5717, option 2. You can also send them an email at ebusiness_techsupport@bcbs.com.

For any other questions, please contact your Provider Network Manager. You can use our Find Your BlueCross Contact tool on our website to get contact information for your Provider Network Manager.

If you need help getting your office started with Availity, you can contact your eBusiness Regional Marketing Consultant for training and education or visit Availity.com/bcbs.

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

Our Health Care Practice Recommendations web page has two new behavioral health additions for 2019:

- The American Academy of Family Physicians (AAFP) Diagnosis and Management of ADHD in Children
- The American Academy of Child & Adolescent Psychiatry (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders

You can find both documents on our website. If you’d like to request a paper copy of our clinical practice guidelines, please call us at (423) 535-6705.

Updates to the Provider Dispute Resolution Procedure Now on Hold

Last month we ran a BlueAlert article about upcoming updates to the Provider Dispute Resolution Procedure. The updates included revising the process so you have the choice to skip the reconsideration step.

However, this update is now on hold until further notice for all lines of business. We apologize for any inconvenience this may have caused. Please stay tuned to BlueAlert for future updates to the Provider Dispute Resolution Procedure.

ALL Blue2019

Last Chance to Register for the 2019 All Blue Workshops in Kingsport and Knoxville

Don’t miss your chance to attend our annual All Blue Workshops in Kingsport and Knoxville. Space is limited, so click on the links below to register.

April 16, 2019 – Kingsport
MeadowView Marriott
1901 Meadowview Parkway
Kingsport, TN 37660

April 17, 2019 – Knoxville
Knoxville Convention Center
701 Henley Street
Knoxville, TN 37902
Allergy Immunotherapy Reimbursement Update*

Effective April 1, 2019, we’ve updated our Commercial health plan reimbursement policy for allergy immunotherapy. This long-term treatment decreases allergen sensitivity and relieves symptoms, and is a clinical approach that consists of allergy immunotherapy subcutaneous injections.

Prior to April 1, the Commercial benefit defined a dose of allergen immunology as 1cc of extract. It also limited reimbursement to not more than 30 doses per day. Our Commercial health plan reimbursement policy for allergy immunotherapy now reimburses an annual limit of up to 160 doses per patient, per year.

To make sure your claims are reimbursed appropriately, please see the specific billing requirements and additional details in our updated Provider Administration Manual.

If you still have questions or need more information, please contact your Provider Network Manager.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

The following new-to-market provider-administered specialty medications will be added to the Provider-Administered Specialty Pharmacy Lists April 2, 2019, and require prior authorization for all lines of business:

- Udenyca
- Khapzory

You can find information on all provider-administered specialty medications that require prior authorization on our website.

New Prior Authorization Requirements for Oncology/Radiation Therapy

Prior authorization for certain oncology/radiation therapy procedures are now required for some Commercial members. You can check member benefits through Availity Self-Service by logging in to Availity, clicking on Patient Registration and then Eligibility and Benefits Inquiry. If you follow these steps, but can’t get the information you need, the system will provide you with a Fast Path ID to contact Provider Service for help. A valid Fast Path ID is required for each patient inquiry.

Billing Accuracy and Cost Control

Please note that an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges. Please remember to submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don’t receive the required documents, or the itemized bill doesn’t match the total claim, your claims may be denied or returned. If they’re returned, you’ll need to resubmit them along with the itemized bill.

Special Message from BlueCross BlueShield of Florida for Commercial Providers Who Serve Publix Employees Living in Tennessee and Bordering Counties

Applied Behavioral Analysis (ABA) therapy benefits are now available for Publix employees and their children who have autism spectrum diagnosis (ASD). ABA therapy benefits are managed by a dedicated coordinator through the Publix plan’s case management program, which is administered by Florida Blue’s vendor Companion Benefit Alternatives (CBA).

ABA therapy covers specific services for members with ASD. A treatment team made up of a certified technician and a qualified health professional (typically a board-certified behavioral analyst or a board-certified assistant behavioral analyst) provide behavioral therapy. And although therapy doesn’t include speech, physical or occupational therapy, these benefits are still covered under the Publix medical plan.

Please note that Florida Blue won’t cover ABA therapy services unless members receive prior authorization by CBA. An initial request for ABA therapy requires a treatment plan, signed and submitted by a licensed physician.

For more information about Florida Blue’s ABA therapy benefits or how to obtain prior authorization, please call 1-800-868-1032, ext. 25634 or email autismsupport@companiogroup.com.
Updates to Front-End Claims Edits for All Institutional Claims

Starting May 1, 2019, we’re updating our front-end claims edits for all institutional claims to comply with National Uniform Billing Committee (NUBC) guidelines and ASC X12 standards. These changes relate to the Statement Covers Period and how it differs from the Admission Date.

Here’s some information to help you file claims correctly:

1. **The Statement Covers Period** (see Form Locator 6) identifies the span of service dates included in a particular bill.
   - The “From” date is the earliest date of service on the bill.
   - If you provide all of your services on the same day, the “From” and “Through” dates should be the same.

2. **The Admission Date** (see Form Locator 12) is the date the patient was admitted as an inpatient to the facility (or the start-of-care date for home health and hospice).
   - In some cases, your Admission Date may be the same as your Statement Covers dates.
   - The Admission Date may fall outside the “From” and “Through” dates in the Statement Covers Period.
   - It must be reported on all inpatient claims whether it’s an initial, interim or final bill.

**Examples of Correct Usage:**

1. When patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement.

Therefore, the Admission Date and the “From” date will differ. On an initial bill, the “From” date would be prior to the Admission Date.

2. A patient treated in the Emergency Department is subsequently admitted after midnight (the next day). The “From” date and the ED Procedure Date would be the same, but the Admission Date would be the following day.

3. In a longer term stay, you need to issue an initial bill, one or more interim bills, and a final bill. The Admission Date is reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

Please note, the same methodology applies to the 837 Institutional Claim, which has distinct data segments and qualifiers to distinguish Admission Date and Statement Covers Period dates.

For more information on code editing best practices, please see the NUBC UB-04 manual.

**Billing Guidelines for Vaginal and Cesarean Section Delivery**

Effective May 1, 2019, obstetric providers for BlueCare, TennCareSelect and CoverKids should only use ICD-10 Procedure Coding System (ICD-10-PCS) code 10E0XZZ “Delivery Products of Conception, External Approach” when billing for a vaginal or cesarean section delivery. Claims containing this code should include the delivery date.

If you file a claim with ICD-10-PCS code 10E0XZZ without a delivery date or for services outside of a vaginal or C-section delivery, the claim will be denied.
BlueCare Tennessee

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

Authorization Process Updates for Home Health Services

To help home health agencies reduce administrative time and better serve our members, we’re expanding the authorization date span for home health services and private duty nursing (PDN). Effective May 1, 2019, the authorization date span for S (hourly) and T (PDN) codes (S9122/S9123/S9124 and T1000) will increase from 16 weeks to 180 days or six months. Benefit limits and medical necessity determination still apply.

These changes will only apply to initial and ongoing authorization requests submitted on or after May 1, and all requests must follow current rules for submitting provider orders and clinical documents. Additionally, your agency must monitor billed units versus authorized units during the authorized date span and submit a corrected bill if a claim was submitted for a visit that was missed.

Coming Soon: New Forms for PDN and Home Health Services

We’re in the process of updating the following forms for private duty nursing (PDN) and home health services based on guidance from the Division of TennCare:

- Home Health Agency Plan of Care Agreement
- Home Health Agency Plan of Care Form
- Home Health Agency Caregiver Training Checklist

These forms will be online soon, and you’ll be able to find them on the Provider Forms page of bluecare.bcbst.com under the Patient Authorizations header. At the same location, you’ll also have access to a new Division of TennCare form: Agency Caregiver Reauthorization Training Checklist. Moving forward, your agency will need to complete this form with each new authorization to continue or increase PDN and home health services.

If you have questions, please call us at 1-888-423-0131.

Note: These forms don’t apply to CoverKids.

Boost Well-Care Compliance with Alternate and Extended Office Hours

Many times, parents and others caring for children covered by BlueCare Tennessee have jobs that don’t allow them to bring their kids in for visits during normal office hours. If you have patients who can’t visit your office during the day because of their parents’ or caregivers’ work schedule, here’s something to consider. Some practices have found that offering appointments later in the evening or on weekends helps more kids and teens get preventive care.

If you’re interested in providing alternate or extended hours, consider asking your patients which ones are most convenient for them.
Screening and Diagnostic Colonoscopy Services

When your patient needs a colonoscopy, the reason for the procedure determines whether it should be a screening or diagnostic service. You’re paid regardless of the service, but your patient’s cost share changes under Affordable Care Act (ACA) rules. This is why it’s important to know which service it falls under when you file your claims.

Here’s an example: Your patient comes in for a regular screening colonoscopy (i.e., they don’t have any symptoms or complaints, and only have a history of benign polyps removed). During the procedure you find and remove polyps. This procedure is considered a screening, so a member copay won’t apply. You’ll be paid for removing the polyps, as well as for the screening colonoscopy. The diagnosis and procedure codes filed on the claim determine if the procedure is processed as screening or diagnostic.

If your patient has abdominal pain, weight loss or signs of rectal bleeding, the procedure is considered diagnostic and we’ll apply member benefits accordingly. Also, if your patient undergoes Cologuard® testing with a positive result, the follow-up colonoscopy is considered diagnostic because you’ll be evaluating the positive test result.

Coding Notes: The following codes are considered screening/preventive regardless of the diagnosis on the claim:

- G0105 colorectal cancer screening; colonoscopy on individual at high risk (which includes a history of benign polyps)
- G0121 colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

The following codes will be treated as preventive if filed with the preventive diagnosis codes (Z0000, Z0001, Z1210, Z1211, Z1212, Z800 and Z8371). However, only 45378 is considered diagnostic by description:

- 45378 colonoscopy, flexible; diagnostic, including collection of specimen by brushing or washing, when performed
- 45380 colonoscopy, flexible; with biopsy, single or multiple
- 45381 colonoscopy, flexible; with directed submucosal injection, any substance
- 45384 colonoscopy, flexible; with removal of tumor, polyp, or other lesion by hot biopsy forceps
- 45385 colonoscopy, flexible; with removal of tumor, polyp, or other lesion by snare technique

Musculoskeletal Web Submissions

All requests for outpatient musculoskeletal procedures and procedures that aren’t on the CMS Inpatient Only (IPO) list should be submitted online using the “Outpatient Surgical Procedure” form.

Please use the “Inpatient Confinement” form when submitting requests for procedures that are on the CMS IPO list or for an actual inpatient admission.

Please note that in January 2018, CMS removed total knee arthroplasties from the Medicare IPO list. To request an inpatient diagnosis-related group pre-operatively for knee replacements, you need to provide a compelling medical reason for services that can only be done in an acute inpatient setting. It’s also important to note these requests are reviewed by our Plan Medical Director.

Home Health Skilled Nurse Care Administrative Approval Update

If you have a patient who needs to start receiving home health skilled nursing care, authorization approvals will be up to 13 visits during a 30-day timeframe. This helps us make sure claims are paid correctly, based on the initial evaluation and treatment visit.

When you request a start day for service, it should indicate the actual or anticipated evaluation date.

Please note we may initially deny claims for service dates in 2019 if you didn’t have authorization for an initial evaluation before March 1, 2019, when our approval process changed. However, we will pay these claims without asking you to request authorization updates.
Quality Care Partnerships

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

Provider Stars Ratings Now Available in Availity
BlueCross’ Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement for 4-Star and above Star Quality ratings and coding accuracy completed during the 2018 calendar year. You may now visit Availity to view your final 2018 Stars rating.

After logging in to Availity and accessing the Quality Rewards tool, click on your Medicare Advantage scorecard and view your Star Quality rating at the top of the scorecard.

On April 1, 2019, and after, Star Quality ratings, which are calculated by the previous year’s performance, will impact your reimbursement rates. Please refer to the rate attachment in your rebasing rate notification letters mailed at the end of March.

You can reference your contract amendments for information about the Medicare Advantage base rate, quality adjustment and total earning potential or ask your Quality Outreach Consultant for additional information.

Quality Care Rewards Changes

The Provider Assessment Form (PAF/PACF) within the Quality Care Rewards tool has been updated to offer easier navigation and a more streamlined assessment.

Attestations in the Quality Care Rewards tool that have been in a pended state for 90 days will be cleared from the queue and must be resubmitted. This change to the QCR tool will go into effect at the end of May. Please check to see if you have attestations in this pending queue.
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

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<thead>
<tr>
<th>Service Line</th>
<th>Phone</th>
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<tbody>
<tr>
<td><strong>Commercial Service Lines</strong></td>
<td>1-800-924-7141</td>
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<tr>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td><strong>Commercial UM</strong></td>
<td>1-800-924-7141</td>
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<tr>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)</td>
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<tr>
<td><strong>Federal Employee Program</strong></td>
<td>1-800-572-1003</td>
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<tr>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td><strong>BlueCare</strong></td>
<td>1-800-468-9736</td>
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<tr>
<td><strong>TennCare Select</strong></td>
<td>1-800-276-1978</td>
</tr>
<tr>
<td><strong>CoverKids</strong></td>
<td>1-800-924-7141</td>
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<tr>
<td><strong>CHOICES</strong></td>
<td>1-888-747-8955</td>
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<tr>
<td><strong>ECF CHOICES</strong></td>
<td>1-888-747-8955</td>
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<tr>
<td><strong>BlueCare Plus℠</strong></td>
<td>1-800-299-1407</td>
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<tr>
<td><strong>BlueChoice℠</strong></td>
<td>1-866-781-3489</td>
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<tr>
<td><strong>SelectCommunity</strong></td>
<td>1-800-292-8196</td>
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<tr>
<td>Available Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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**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
- Monday-Friday, 8 a.m. to 6 p.m. (ET)

**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)

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**Important Note:**

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Email a completed Provider Change Form and any attachments to us at PNS_GM@bcbst.com. Update your provider profile on the CAQH Proview® website.

Questions? Call 1-800-924-7141.