BlueAlert

BlueCross BlueShield of Tennessee, Inc.

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

New Enhancements in Availity®

As a reminder, providers are required to verify benefits through Availity. With Availity, you can securely review claim status, check patient benefits and eligibility, see remittance advice, and access our other applications and updates any time.

Multi-Payer Updates

We’re constantly adding new features to the Eligibility and Benefits Inquiry. Benefit information may be found in multiple sections depending upon place of service, provider type and member coverage. Please see the Availity Knowledge Center for more on updates and enhancements.

Feature Announcements

We’ve made updates to Contact Preferences that include improved usability, notification if we’ve had issues with your email address, and the ability to opt out of receiving emails. Please check your contact preferences to make sure you’re receiving important contracting messages and announcements that apply to you. Look for updates under the News & Announcements and Notification Center sections of the Availity Portal.

To get your office started with Availity, please contact your eBusiness Regional Marketing Consultant or visit Availity.com.

INSIDE THIS ISSUE

BlueCross BlueShield of Tennessee, Inc.
- New Enhancements in Availity
- Shared Decision-Making Tools in Availability
- More Information About Code Editing Guidelines on Our Website

BlueCare Tennessee
- Improving Health in Tennessee
- Save the Date for a Tennessee Healthcare Symposium Near You
- Reminder: Updated Guidelines for Allergen Immunotherapy
- Coordinating Behavioral Health Services for School-Age Patients
- Tips for Combining Well-Child Checkups with Sick Visits
- Regional EPSDT Training Scheduled for Oct. 2
- BlueCare Tennessee Maternity Assessments Must be Submitted Through Availity
- New Prior Authorization Requirement for Removable Foot Inserts
- Prior Authorization Required for Secondary Claims
- Correction: Influenza and Tdap Vaccine Reimbursement Update
- Sterilization Consent Form Instructions Update

Medicare Advantage
- Free Behavioral Health Services Available for Qualified Medicare Advantage Members
- Online Provider Strategy September WebEx Opportunities
- Eye Exam Copays
- Coding for Annual Wellness Visits and Provider Assessment Forms

Pharmacy
- Changes to the TennCare Preferred Drug List
- Changes Related to NDC and J-Codes
- New Prior Authorization Requirement for Provider-Administered Specialty Medications
Shared Decision-Making Tools in Availity

Shared decision-making (SDM) is a model of two-way communication that involves providers and patients working together to make health care decisions. It helps make sure that all health care decisions are made with evidence-based information, your knowledge and experience, and your patient’s values and preferences.

We’ve uploaded four certified SDM aids to the Availity portal that may be helpful for orthopedic and OB/GYN providers. They’re designed to help patients with joint pain or a higher risk of complications during childbirth better understand their options for care:

- Hip Osteoarthritis: Is it Time to Think About Surgery?
- Knee Osteoarthritis: Is it Time to Think About Surgery?
- Pregnancy: Your Birth Options After Cesarean
- Pregnancy: Birth Options if Your Baby is Getting Too Big

To use these resources, simply log in to Availity and go to the BlueCross Payer Space. From there, choose the Resources tab and click the link to show all resources. Select the SDM tool you want to view, and it will open in a new browser tab.

If you have questions about using the Availity portal, please call your eBusiness Regional Marketing Consultant.

More Information About Code Editing Guidelines on our Website

Over the past several years, we’ve implemented payment policies to process claims efficiently and deliver payments to providers with more accuracy. We’ve aligned our payment policies with National Correct Coding Initiative (NCCI) edits, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards. We use these guidelines for professional (including durable medical equipment, medical supplies, prosthetics, orthotics and home infusion therapy services) and institutional claims during claims processing or claims adjustment.

Medically Unlikely Edit (MUE) is an example of an NCCI edit. MUE is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service for a HCPCS/CPT® code. All HCPCS/CPT® codes do not have a MUE.

BlueCross reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records, etc.) to determine appropriate application of our code editing rules.

You can find more information about our code editing guidelines and upcoming code edits by visiting our Code Editing section at bcbst.com/providers.
BlueCare Tennessee
This information applies to BlueCareSM, TennCareSelect and CoverKidsSM plans unless stated otherwise.

Improving Health in Tennessee
Good health outcomes start in the communities where your patients live, work and play. The Division of TennCare wants to learn more about the challenges your patients face in their communities to help you improve your patients’ health.

Starting Sept. 20, please take a few minutes to complete the provider survey at tn.gov. Your name will not be tied to your survey answers, but combined with information from all provider surveys to better understand community needs.

Save the Date for a Tennessee Healthcare Symposium Near You
The Tennessee Medical Association (TMA) is hosting four Tennessee Healthcare Symposiums for providers across the state next month. During these one-day events, you’ll have an opportunity to:

• Attend sessions on relevant health care topics, including TennCare updates and coding and documentation
• Meet with vendors and exhibitors to learn more about new health care products and services
• Schedule one-on-one time with payers to ask questions about claims, prior authorizations and more

Events will be held in Memphis, Nashville, Knoxville and Chattanooga. Please see below for dates and locations:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fogelman Center</td>
<td>Wilson County Expo Center</td>
<td>Rothchild Conference Center</td>
<td>Chattanooga Convention Center</td>
</tr>
<tr>
<td>3675 Central Avenue</td>
<td>945 Baddour Parkway</td>
<td>8807 Kingston Pike</td>
<td>1150 Carter Street</td>
</tr>
<tr>
<td>Memphis, TN 38152</td>
<td>Lebanon, TN 37087</td>
<td>Knoxville, TN 37923</td>
<td>Chattanooga, TN 37402</td>
</tr>
</tbody>
</table>

For more information or to sign up for an event near you, please visit the TMA’s Tennessee Healthcare Symposium event page.
Reminder: Updated Guidelines for Allergen Immunotherapy*

Several changes to allergen immunotherapy guidelines and limits took effect July 1, 2019. Please see below for a summary of notable changes that apply to your BlueCare, TennCare Select and CoverKids contracts:

1. **CPT® Code 95165 – Preparation and Provision of Antigen for Allergen Immunotherapy**
   Your patients can receive 150 doses of antigen (one dose of antigen is defined as 1 cc aliquot) per calendar year without a prior authorization. You must have a prior authorization from us to bill more than 150 units using code 95165. We can reimburse up to a three-month supply (approximately 37 doses/units) at one time.

2. **CPT® Code 95115 and 95117 – Allergy Injections**
   Please report ICD-10 codes on the claim(s) to support the injection code billed.
   - For 95115 (single injection), the claim should include at least one allergy-related diagnosis code.
   - For 95117 (multiple injections), the claim should include two or more allergy-related diagnosis codes.

3. **Home Administration**
   Evidence-based guidelines don’t support giving patients a self-injectable allergy serum they can use at home. If you make an exception, please discuss the anaphylactic risks of self-injection and make sure your patient can safely administer the serum before they leave your office. Also, please include a signed informed consent in the patient’s medical record. When filing claims for at-home immunotherapy administration, bill Modifier 32 with CPT® code 95165.

   In addition to the above guidelines and limits, providers caring for patients covered by BlueCare and TennCare Select should continue to bill claims for initial allergen immunotherapy treatment with a –GD modifier. Please see the Division of TennCare budget reduction changes memo that went into effect on Oct. 1, 2016, for more information.

   We’re updating the BlueCare Tennessee Provider Administration Manual on Sept. 30, 2019, to reflect these changes. Please refer to the manual for more information.

---

Coordinating Behavioral Health Services for Your School-Age Patients*

We recently updated the requirements for medically necessary behavioral health services delivered in a school setting. You no longer have to include covered behavioral health services in students’ individualized education program (IEP). Previously, we required children and young adults receiving in-school behavioral health services to have an IEP that included those services. We’re updating the BlueCare Tennessee Provider Administration Manual to reflect this change.

Please note this update only applies to behavioral health services. Students receiving other medically necessary, school-based services (including physical, occupational and speech therapies) must still have an IEP including that service. Also, this update only impacts IEP requirements. To receive school-based, medically necessary services, including behavioral health, children and young adults must have a doctor’s order for the service and a signed parental consent form. For more information about school-based services and related requirements, please see the third quarter update to the Provider Administration Manual.

**Note:** This doesn’t apply to CoverKids members.
Tips for Combining Well-Child Checkups with Sick Visits

Sometimes, the only chance you have to perform a wellness check is when patients visit your office because of an illness or other need. Combining wellness checks with visits for acute care and other services, such as sports physicals, helps make sure children throughout our state get the preventive care they need.

TennCare Kids’ screening guidelines allow you to receive reimbursement for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups performed at the same time as other visits. According to the Tennessee Chapter of the American Academy of Pediatrics (TNAAP), you can bill for both a sick and well visit on the same day if the following criteria are met:

- You may report an additional evaluation and management (E/M) service if you find a problem during a wellness check that requires you to provide care beyond the workup of a normal preventive visit. Please attach a Modifier -25 to the code for the additional E/M service when applicable when submitting the claim.
- Your documentation for the visit reflects the extra work done during the appointment. There doesn’t need to be a separate note, but documentation should clearly reflect a separate problem.

For more information about EPSDT exams, please visit our TennCare Kids Tool Kit. You can also find free TNAAP EPSDT and coding resources at TNAAP.org.

Note: This information doesn’t apply to CoverKids.

Regional EPSDT Training Scheduled for Oct. 2

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) is hosting a regional EPSDT training event at Le Bonheur Children’s Outpatient Center—Jackson on Wednesday, Oct. 2. Providers and local health departments serving children in Jackson and surrounding counties, including Chester, Hardeman, McNairy, Hardin, Decatur, Perry and Henderson counties, are welcome to attend.

For more information, please contact Janet Sutton, TNAAP ESPDT and Coding Program Manager, at (615) 447-3264 or janet.sutton@tnaap.org.

Note: TennCare Kids EPSDT exams don’t apply to CoverKids.

BlueCare Tennessee Maternity Assessments Must be Submitted Through Availity

Effective Oct. 1, 2019, you must submit your maternity assessments (OB risk assessments) online through the Availity payer spaces application. Fax forms will no longer be available after this date.

For more information or to schedule an on-site or webinar-based Availity training for your team, please contact your eBusiness Regional Marketing Consultant.

New Prior Authorization Requirement for Removable Foot Inserts

Starting Oct. 1, 2019, you’ll need a prior authorization for foot inserts coded using HCPCS L3000. This requirement will apply to all patients with BlueCare, TennCare Select and CoverKids coverage.

Prior Authorization Required for Secondary Claims

Please remember that for any service that has prior authorization requirements, the prior authorization requirements apply when you submit claims for secondary payment from BlueCare or TennCare Select. Prior authorization is not necessary if the primary carrier provided benefits and there are no plans to file a secondary claim.
Correction: Influenza and Tdap Vaccine Reimbursement Update

In August 2019, we began covering flu and Tdap vaccines for teens who are pregnant outside of the Vaccines for Children (VFC) program. The July BlueAlert incorrectly stated that we’d cover these vaccines for eligible teens under the age of 18. **We cover these vaccines until teens turn 19.**

If you’re an OB/GYN caring for a pregnant teen who’s under the age of 19 and covered by BlueCare or TennCare Select, we’ll reimburse you for the cost of these vaccines in addition to the administration fee for giving them.

We apologize for any inconvenience this error may have caused.

Sterilization Consent Form Instructions Update

The Division of TennCare has revised the Sterilization Consent Form Instructions on its website to align with the Title 42 Code of Federal Regulations. Please find a summary of notable changes below:

- A claim denial should only occur if the form isn’t completed and signed properly.
- The form becomes invalid if it’s altered.
- An expiration date on the form isn’t required for it to be considered valid.

To view the updated instructions and download versions of the consent form in English and Spanish, please visit the Miscellaneous Provider Forms page of tn.gov/tenncare.
Free Behavioral Health Services Available for Qualified Medicare Advantage Members

BlueCross has partnered with AbleTo to provide telephonic counseling and outreach for common behavioral health issues and emotional stress support to our Medicare Advantage members.

The program offers 16 telephonic sessions with a licensed therapist and a behavioral health coach during an eight-week course at no cost to the member. After enrolling in the program, members can access these services 24 hours a day, seven days a week.

To enroll, you or your patients may call 1-866-287-1802 between 8 a.m. and 10 p.m. Monday through Friday, or 10 a.m. to 6 p.m. on Saturday. AbleTo’s clinical team will do an initial consultation to see if the member’s condition is within their program’s scope. Any program updates will be communicated with our member’s PCP.

This program doesn’t limit any other behavioral health services your patients have through their Medicare Advantage plan.
Online Provider Strategy September WebEx Opportunities

If you’d like to learn more about our Medicare Advantage provider quality program, please join us for an online presentation that offers an introductory look at the program structure and Provider Assessment Form (PAF) incentive program. For your convenience, we’re offering two one-hour sessions – click on the date that works best for you:

- Sep. 19, 2019 at 10 a.m. (ET)
- Sept. 24, 2019 at 4 p.m. (ET)

Eye Exam Copays

Routine eye exam copays for BlueAdvantage members are referenced under the vision copay on the member’s ID card. Routine eye exam claims for BlueAdvantage members should be filed to EyeMed. However, non-routine, medically related eye exams such as services performed by an ophthalmologist apply the specialist copay that’s also listed on the member’s ID card. Please bill these services to BlueCross’ BlueAdvantage. You’ll also need to collect the appropriate copay based on the type of care you perform.

Coding for Annual Wellness Visits and Provider Assessment Forms

Chronic conditions and health status codes should be assessed, documented and coded at least annually, using the highest level of specificity. While the Z00.xx diagnosis code may be appropriate for both the Annual Wellness Visit (AWV) and Provider Assessment Form (PAF), we encourage you to include any chronic conditions assessed or treated during the visit. Any condition that’s been treated in the past and no longer exists can be coded using the appropriate history codes.

Our Medicare Advantage members are eligible to receive a wellness visit each calendar year. This offers an opportunity for your patient to receive a comprehensive preventive medicine evaluation and management focused visit. The PAF is an important tool for collecting information on your patient’s current health status and may be completed during the wellness visit. It’s a great opportunity to evaluate, treat and document your patient’s chronic conditions and health status.
Pharmacy

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

Changes to the TennCareSM Preferred Drug List

Please review notable changes to the TennCare Preferred Drug List (PDL) that may affect your patients’ medications.

Effective July 1, 2019

On July 1, 2019, the Division of TennCare updated the Provider Notice for Partial Fill Requirements that went into effect Jan. 1, 2019. This notice outlines the process for submitting partially filled controlled substance prescriptions to Magellan. To review the updated notice, please see the Provider Notice for Partial Fillable Forms – Effective 1-1-19 (Updated 7-1-19) announcement on the News & Manuals Provider page of bluecare.bcbst.com.

Effective Aug. 1, 2019

The below medications have been moved to non-preferred status and removed from the list of branded agents classified as generics, and requests for these medications will be denied:

- Canasa
- Gleevec
- Pataday
- Tamiflu capsules

You can transition patients taking one of these drugs to the following generic medications. These medicines now have preferred status:

- Mesalamine suppository
- Imitanib
- Olopatadine drops
- Oseltamivir capsules

The following medications have also been removed from the list of branded medications classified as generic drugs. Requests for these brand names will require a new prior authorization:

- Flector
- Forfivo XL
- Adcirca
- Albenza

Effective Aug. 1, 2019 (continued)

To avoid delays at the pharmacy, you can transition patients to these generic drugs, which have all been moved to preferred status and will pay at the point of sale for patients with existing prior authorizations:

- Diclofenac patch (generic for Flector)
- Bupropion XL (generic for Forfivo XL)
- Tadalafil (generic for Adcirca)
- Albendazole (generic for Albenza)

For more information, please see the Provider Notice for Brand as Generic Removals – Effective 8-1-19, which is also available on the News & Manuals Provider page of bluecare.bcbst.com.

Note: The TennCare PDL doesn’t apply to CoverKids members.

Changes Related to NDC and J-Codes

We’ve required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications since 2014. As of Sept. 1, 2019, we’re now rejecting claims submitted without a valid NDC. Please be sure to include the full 11-digit NDC code on the claim, including any leading zeroes. You may refer to our Provider Administration Manuals for more information.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On Aug. 30, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization for all lines of business:

- Ogivri
- Mvasi

Please see our website for more information on all provider-administered specialty medications that require prior authorization.
BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not 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 1-888-418-0008.

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.

Archived editions of BlueAlert are available online.

*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.

### Provider Service Lines:

Featuring “Touchtone” or “Voice Activated” Responses

<table>
<thead>
<tr>
<th>Provider Service Lines</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Service Lines</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>Commercial UM</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>Federal Employee Program</td>
<td>1-800-572-1003</td>
</tr>
<tr>
<td>BlueCare</td>
<td>1-800-468-9736</td>
</tr>
<tr>
<td>TennCareSelect</td>
<td>1-800-276-1978</td>
</tr>
<tr>
<td>CoverKids</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>CHOICES</td>
<td>1-888-747-8955</td>
</tr>
<tr>
<td>ECF CHOICES</td>
<td>1-888-747-8955</td>
</tr>
<tr>
<td>BlueCare Plus™</td>
<td>1-800-299-1407</td>
</tr>
<tr>
<td>SelectCommunity</td>
<td>1-800-292-8196</td>
</tr>
<tr>
<td>BlueAdvantage</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>BlueCard</td>
<td>1-800-676-2583</td>
</tr>
<tr>
<td>All other inquiries</td>
<td>1-800-705-0391</td>
</tr>
<tr>
<td>eBusiness Technical Support</td>
<td>Phone: Select Option 2 at (423) 535-5717</td>
</tr>
<tr>
<td>Email: <a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
<td></td>
</tr>
<tr>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET)</td>
<td></td>
</tr>
<tr>
<td>Friday, 9 a.m. to 6 p.m. (ET)</td>
<td></td>
</tr>
</tbody>
</table>

**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.