BlueCross BlueShield of Tennessee, Inc.

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

Clinical Practice Guidelines (Health Care Practice Recommendations) Updates
We've added a new medical Clinical Practice Guideline for rheumatoid arthritis to our Health Care Practice Recommendations web page.

To request a paper copy of our clinical practice guidelines, please call us at (423) 535-6705.

Updated Taxonomy Codes for Better Provider Specialty Identification
We recently updated our systems to meet a new BlueCross BlueShield Association mandate for all BlueCross Plans to use the National Uniform Claim Committee’s (NUCC) taxonomy code list to identify provider specialties. This update took effect for all lines of business April 14, 2019. We don’t expect this to impact claims processing or provider payments.
Claim Filing Update for Ambulatory Surgical Centers

Ambulatory Service Centers (ASC) should file institutional claims with the CMS-1450/ANSI-837 form (as stated in your BlueCross provider agreement) for services provided to our Commercial (including FEP), BlueCare, TennCare Select and CoverKids members. In the past, we’ve accepted both institutional and professional claims from an ASC. However, starting in May, we can only reimburse an ASC for institutional claims for these members.

If Medicare is the primary carrier on the claim and the explanation of benefits (EOB)/remit advice is included with the submission, we can make an exception to this rule. However in all other cases, we’ll return your claim and ask you to resubmit it as an institutional transaction.

Note: We’ll only accept paper claims if you have a technical or temporary issue or extenuating circumstances that prevent you from submitting claims online. To report this type of issue, please call our eBusiness Department at (423) 535-5717 or send an email to eBusiness_TechSupport@bcbst.com.

New Prior Authorization Requirement for Provider-Administered Specialty Medications

On April 30, 2019, we added the following new-to-market medications to our Provider-Administered Specialty Pharmacy List, which identifies drugs that require prior authorization:

- Gamifant
- Truxima
- Herzuma

You can find information on all the medications that require prior authorization on the Pharmacy Resources & Forms page on our website.

Billing Guidance for Two Specialty Pharmacy Devices

If you have patients with a defective Neulasta Onpro (J2505) injector or Liletta (J7297) hormone-releasing system, please contact the manufacturer to get a replacement or credit rather than billing us.

Here’s who you can contact if you have questions or problems with the devices:

- Amgen 1-800-772-6436 (Neulasta Onpro)
- Allergan 1-800- 678-1605 (Liletta)

Updates to the Provider Dispute Resolution Procedure Now on Hold

We recently ran a BlueAlert article about upcoming updates to the Provider Dispute Resolution Procedure. The article stated we’d revised the process so providers could choose 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 this procedure.

Behavioral Health in Pediatrics (BeHiP) Chattanooga Training Event May 10

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) will host a training event for pediatricians and other health care providers who want to learn more about screening, assessing and managing patients with emotional, behavioral and substance abuse concerns.

The event takes place Friday, May 10, from 6:00 p.m. to 8:30 p.m. at our office at 1 Cameron Hill Circle in Chattanooga. Dinner will be provided.

Seven years ago, TNAAP began working to improve care for patients with behavioral health concerns because there weren’t enough child and adolescent psychiatrists. The BeHiP program is developing a statewide, regionalized system of care that provides better outcomes for children with behavioral health concerns. Pediatric care is critical to its success.

Please visit the BeHiP website to learn more about the upcoming training and register for the event.
Commercial

This information applies to Blue Network PPO and Blue Network SSM unless stated otherwise.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans
Beginning July 1, 2019, CPT® codes 81211, 81213 and 81214 will no longer need prior authorization through eviCore’s Genetic Testing Program. However, the following codes will now need prior authorization:

<table>
<thead>
<tr>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>81163</td>
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<tr>
<td>81189</td>
<td>81336</td>
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</tbody>
</table>

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity and clicking Patient Registration, then Eligibility and Benefits Inquiry.

You can submit prior authorization requests through Availity.com. You can also submit your requests to eviCore by fax at 1-888-693-3210 or by calling 1-888-693-3211.

Billing Guidelines for Retinal Use of Avastin Change in July
Effective July 1, 2019, we’re changing billing guidelines for ophthalmologists and pediatric ophthalmologists caring for Commercial members. You will need to use HCPCS Code J7999 when billing intravitreal Avastin (Bevacizumab) to treat retinal disease – not J9035. We will deny ophthalmology claims submitted with the incorrect code.

For more information about our billing and reimbursement policies for compound medications and compounding services, please see the Provider Administration Manual.
Changes to the TennCare℠ Preferred Drug List

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

Effective Jan. 1, 2019
Epclusa was added to the list of preferred hepatitis C antiviral agents, and Mavyret remains a preferred treatment. Providers still need a prior authorization to prescribe hepatitis C antiviral treatment. However, several prior authorization requirements were also changed or lifted.

You can view the full provider notice outlining these changes here: Prescriber Notice for Hepatitis C Antivirals.

Effective April 1, 2019
The following medications are no longer on the list of generic drugs, and requests for these medications will be denied:

- Fosrenol chewable tabs
- Onfi oral suspension

You can transition patients taking Fosrenol chewable tabs to lanthanum carbonate chewable tabs. Patients taking Onfi oral suspension may transition to clobazam oral suspension. Both now have preferred status and are covered for patients with existing prior authorizations.

For more information, please see the Provider Notice for Brand as Generic Removals — Effective 4-1-19.

Note: The TennCare PDL doesn’t apply to CoverKids members.
**Division of TennCare Medicaid ID Pharmacy Requirements**

All pharmacies that dispense medicine to BlueCare, TennCareSelect and CoverKids members must have a valid Tennessee Medicaid ID. This includes pharmacies that participate in the MagellanRX and Express Scripts pharmacy networks, as well as future pharmacy benefit managers that serve TennCare or CoverKids members.

The Division of TennCare will send one more notice to pharmacies that haven’t registered reminding them to do so. Claims submitted by pharmacies that don’t register with TennCare after receiving this notice will be denied at the point of sale.

For more information, including directions for registering, please see the TennCare Medicaid ID Required for Pharmacies notice.

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**Balance Billing Guidelines for Members with Secondary TennCare Coverage**

Patients enrolled in BlueCare or TennCareSelect may also have other insurance. In these cases, TennCare is nearly always considered secondary to other third-party payers, but Division of TennCare billing guidelines still apply.

Excluding copays and special circumstances, providers can’t bill BlueCare Tennessee patients for TennCare-covered services. If you know at the point of service that you’re treating a patient who has primary insurance and secondary TennCare coverage, you may not bill the patient for balances, fees, etc. that aren’t covered by the primary payer if the service is covered by TennCare.

For more information about when you may bill BlueCare Tennessee patients, please see the related TennCare Policy Manual or refer to the BlueCare Tennessee Provider Administration Manual.

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**Best Practices for Keeping Kids on Track with Preventive Care**

During a busy day caring for patients, it’s not always easy to find time to contact families and remind them to schedule their children’s and teens’ well-child checkups. Consider the following best practices for appointment scheduling:

1. Schedule a full year of visits for newborns at their first appointment.
2. Before patients leave your office, schedule their next well-child exam.
3. Make the most of your electronic medical records system patient reminder tools, such as letters, text messages and reports.

Children and teens enrolled in BlueCare Tennessee are eligible for well-care visits on the same schedule recommended by the American Academy of Pediatrics. For more information, please visit our TennCare Kids Tool Kit.
Division of TennCare Offers Annual Episodes Design Feedback Sessions

See the invitation from TennCare below.

Annual Episodes Design Feedback Session

Tuesday, May 21st, 2019

RSVP HERE

TennCare is hosting our annual episodes feedback session for stakeholders to share successes, ask questions, and recommend changes to improve episode design. The feedback session will be live streamed across the state, and participants may share their feedback at all 6 locations:

- Nashville
- Johnson City
- Jackson
- Knoxville
- Memphis
- Chattanooga

There will be 3 sessions based on episode type:

- Behavioral Health and Outpatient Episodes
  - 8:30 am to 10:15 am Central
  - 9:30 am to 11:15 am Eastern
- Perinatal and Procedural Episodes
  - 10:30 am to 12:15 pm Central
  - 11:30 am to 1:15 pm Eastern
- Acute Episodes with Facility Quarterback
  - 1:15 pm to 3:00 pm Central
  - 2:15 pm to 4:00 pm Eastern

Please send any questions to Payment.Reform@tn.gov. For more information about this event please visit our website: [https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html](https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html).
New Claims Requirement for Patients in Research Studies

Medicare Advantage now requires a National Clinical Trial (NCT) identification number with claims when you provide services to a patient participating in a clinical research study, but only for the services that are part of the study. These include:

- Clinical trials
- Investigational device exemption (IDE)
- Coverage with evidence development (CED)

The NCT is required when a clinical research study claim includes:

- Condition Code 30 (for institutional claims)
- ICD-10 Z00.6 in either the primary or secondary position
- Modifier Q0 and/or Q1

When you submit electronic claims in the 837I or 837P format, please file the eight-digit NCT identifier number in Loop 2300 REF02 (REF01=P4). We won’t be able to process claims without this clinical trial number.
Quality Care Rewards

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

Online Quality Program Educational Sessions
If you’d like to learn about our Medicare Advantage Provider Quality program, join us for an online introduction to its structure and the Provider Assessment Form (PAF) incentive program.

Click on one of the sessions below to learn more:
- **Tuesday, May 28, 2019 at 10 a.m. (ET)**
- **Thursday, May 30, 2019 at 4 p.m. (ET)**

THCII Episodes of Care Program
New Quarterly Reports for both Medicaid and Commercial will be available sometime in May to Quarterbacks participating in the Episodes of Care Program.

If you’re a Quarterback having trouble accessing your Quarterly Report, please contact eBusiness Support (423) 535-5717 and press option 2 or by email at eBusiness_Service@bcbst.com for assistance.

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 the end of May. Please check to see if you have pending attestations.
Correct Use of Modifiers for Procedure-to-Procedure Edits

It’s important to us that your claims are processed and paid on time, so please be sure to use the correct modifiers with edits. Each National Correct Coding Initiative (NCCI) procedure-to-procedure edit has a modifier indicator of 0, 1 or 9.

- Modifier indicator 0 indicates NCCI-associated modifiers can’t 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 can be bypassed by a modifier, and the 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 column one comprehensive codes in some instances, it shouldn’t be appended to both codes in the code edit pair. This can delay your claims processing and payment. Please review the NCCI guidelines to prevent claim submission errors.

Starting July 1, 2019, NCCI guidelines will change to allow the modifier on either the column one or column two code, but not both. Although the modifier may be accepted on the comprehensive codes in some situations, it shouldn’t be appended to both codes in the code edit pair.

For more information about the upcoming changes, click here.
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.

*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

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

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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:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the “touchtone” option or press 1. Then press 1 again if you are a provider and follow the prompts to reach Network Contracts or Credentialing to update your information; and

- Update your Provider profile on the CAQH Proview™ website.