BlueAlert®

BlueCross BlueShield of Tennessee, Inc.

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

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Update to Clinical Practice Guideline for Asthma
We’ve added a new medical Clinical Practice Guideline for asthma on our Health Care Practice Recommendations web page.

To request a paper copy of our clinical practice guidelines, please call us at (423) 535-6705.
How Current CAQH Records Make Recredentialing Easier

Providers who serve patients in our networks must recredential at least once every three years. We want that process to be easy for you so we use the Council for Affordable Quality HealthCare (CAQH) database for recredentialing. You can easily review and update your information with them at Solutions.CAQH.org. It’s important that you keep your information current, because we’re also planning to use the CAQH database as the source for more provider information in the near future. This will make the exchange of information easier and more efficient for you and your office.

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), BlueCareSM, TennCareSelect and CoverKidsSM members. We’ve previously accepted both institutional and professional claims from an ASC. However, beginning June 1, 2019, we’re only reimbursing an ASC for institutional claims for these members. If Medicare is the primary carrier on the claim and you include the explanation of benefits (EOB)/remit advice with your submission, we can make an exception to this rule. However, in all other cases, we’ll need to 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 issue or temporary situation that prevents 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.
Pharmacy
This information applies to all lines of business unless stated otherwise.

National Drug Code Requirement
Since 2014, we’ve required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications. Starting Sept. 1, 2019, claims without the NDC may be returned unprocessed or denied. You can find more information about this requirement in our Provider Administration Manuals. For details about provider-administered specialty medications that require prior authorization, please visit our website.

New Prior Authorization Requirement for Provider-Administered Specialty Medications
On May 31, 2019, we added the following specialty medications to the Provider-Administered Specialty Pharmacy lists. They now require prior authorization.

- Asparlas
- Elzonris
- Erwinaze
- Oncaspar
- Ontruzant
- Ultomiris

Please see our website for more information on all provider-administered specialty medications that require prior authorization.
New Eligibility and Benefits Inquiry Enhancement in 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.

Now, we’ve added something new to the BlueCross Payer space. You can now see benefit-specific exclusions in the Eligibility and Benefits Inquiry section.

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

For technical questions about Availity, please call them at 1-800-282-4548. You can also contact our eBusiness team at (423) 535-5717, option 2 or by email at ebusiness_techsupport@bcbst.com.

BlueCross Partners with CIOX Health to Collect Medical Records
Federal law requires us to submit medical records to support the Risk Adjustment Data Validation Audit (RADV). To meet the requirement, we’re partnering with CIOX Health to help us collect medical records starting in mid-June. As a result, you may receive a letter with a list of requested patient records, along with instructions and options on how to send the medical records to CIOX.

Please follow the instructions carefully and contact CIOX with any questions. We appreciate your help with this important audit.

Prior Authorization Changes for Genetic Testing Program Begin Aug. 1
Starting Aug. 1, 2019, CPT® code 0057U will no longer need prior authorization through eviCore’s Genetic Testing Program. However, the following codes will need prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0084U</td>
<td>0089U</td>
<td>0101U</td>
<td>0104U</td>
</tr>
<tr>
<td>0087U</td>
<td>0090U</td>
<td>0102U</td>
<td></td>
</tr>
<tr>
<td>0088U</td>
<td>0094U</td>
<td>0103U</td>
<td></td>
</tr>
</tbody>
</table>

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity.com. You can find the information by clicking Patient Registration and then Eligibility and Benefits Inquiry. You can also submit prior authorization requests through Availity.

If you’d rather send these requests directly to eviCore, you can fax them to 1-888-693-3210 or by calling 1-888-693-3211.
Team Up for Well-Child Care
The daily schedule of pediatric providers can be unpredictable – even hectic. Most of the time, you’re in diagnose-and-treat mode, while your team works to schedule office visits. In the midst of these busy days, it’s not easy to pause and see which patients need preventive care and which visits can be converted to well-child checks.

Many offices see benefits from meeting as a team to review daily schedules, either at the beginning or end of each day. That way, they can more easily spot opportunities to deliver preventive care. These team huddles are a great time to:

• Plan ahead for patients who need higher levels of care and may require longer appointments
• Review best practices for coding and documentation
• Discuss visits that can be converted to well-child visits as time allows

With a little extra effort, you may find you’re able to save time and effort, while better meeting the health care needs of your patients.

Is it Time to Revalidate Your Medicaid ID?
The Centers for Medicare & Medicaid Services requires all providers to maintain a Medicaid ID to serve in our BlueCare, TennCareSelect and CoverKids networks. If your Medicaid ID is about to expire, please revalidate it at tn.gov/tenncare/providers/provider-registration.html. Otherwise, we’ll have to remove you from these networks and reassign our members to other network providers.
Defining New and Established Patients for Proper Coding

Providers who are contracted to bill claims using CPT® codes need to review for reporting when billing face-to-face services may differ if they’re treating a new patient versus an established patient. Here’s how they’re defined:

- **New patients** haven’t received professional services from you – or a physician in your group practicing the same specialty – within the past three years.
- **Established patients** have received professional services from you – or a physician in your group practicing the same specialty – within the past three years.

For more information, please see the [BlueCare Tennessee Provider Administration Manual](#). Coding resources are also available through the [American Medical Association](#).

Include Original Claim Number When Submitting Corrected Bills

When you need to submit corrected claims, please file them electronically using the ANSI-837, version 5010 format. It’s important to follow all of the steps, including entering the original claim number found on your electronic remittance advice in the 2300 loop REF segment. If you forget this important step, we may reject or deny your claim.

If you have questions or need help filing the corrected bill, our [Electronic Corrected Claim Guidelines](#) flyer contains step-by-step guidance. For more information, please see the [BlueCare Tennessee Provider Administration Manual](#).

Use the Provider Change Form to Update Your Patient Age Criteria

When BlueCare and TennCareSelect members age out of their providers’ patient age criteria, we reassign them to a new provider, based on the age criteria we have on file.

If you’d like to continue seeing a patient who’s been assigned to another provider because of the patient’s age, please update your age criteria by completing the Provider Change Form and emailing it to PNS_GM@bcbst.com.

On page four of the form, you can choose from three age ranges – 0-17, 18 and above, or no age limit. If you treat a different age range, please specify it in the Other Limitation (Please Specify) field at the bottom of the first page.

You’ll also need to complete a [Primary Care Provider Change Request Form](#) for each patient you’d like to keep who’s been reassigned to another provider.
Daily Limit Reminders for Home Health and Skilled Nursing Services

The maximum daily limit for Home Health Intermittent Skilled Nursing and Home Health Aide Visits billed with codes G0299, G0300 or G0156 is four units. One unit equals 15 minutes, so home health providers may spend up to one hour in the homes of patients receiving these services each day. For more information, please see below:

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>DESCRIPTION</th>
<th>REVENUE CODE</th>
<th>PROCEDURE CODE</th>
<th>BILLING UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td></td>
<td>0421</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td>0431</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td>0441</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td></td>
<td>0561</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Agency Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Visits are typically one hour or less.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Visit (RN)</td>
<td></td>
<td>0551</td>
<td>G0299</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td>Skilled Nursing Visit (LPN)</td>
<td></td>
<td>0551</td>
<td>G0300</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td>Home Health Aid Visit</td>
<td></td>
<td>0571</td>
<td>G0156</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td>Home Health Intermittent Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Visits are one hour or less.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Hour (RN)</td>
<td></td>
<td>0552</td>
<td>S9123</td>
<td>1 unit/1 hour</td>
</tr>
<tr>
<td>Skilled Nursing Hour (LPN)</td>
<td></td>
<td>0552</td>
<td>S9124</td>
<td>1 unit/1 hour</td>
</tr>
<tr>
<td>Home Health Aide Hour</td>
<td></td>
<td>0572</td>
<td>S9122</td>
<td>1 unit/1 hour</td>
</tr>
<tr>
<td>Private Duty</td>
<td></td>
<td>0589</td>
<td>T1000</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td>(Visits require constant nursing supervision to support and sustain the use of ventilator equipment or other life-sustaining medical technology.)</td>
<td>Private Duty Nursing</td>
<td>0589</td>
<td>T1000</td>
<td>1 unit/15 minute</td>
</tr>
</tbody>
</table>

Patients may have one Intermittent Skilled Nursing Visit each day. They may have up to two Home Health Aide Visits, as long as the total time spent in the home doesn’t exceed one hour.

Please bill extended home health visits that last more than one hour using the applicable S code above. Extended Skilled Nursing and Home Health Aide Visits have a maximum daily limit of eight units (eight hours) and require a prior authorization under the S code for accurate billing.

For more information, please refer to the BlueCare Tennessee Provider Administration Manual.

Note: This information doesn’t apply to CoverKids.

New PDN and Home Health Forms Now Available

In the April 2019 BlueAlert, we announced that home health providers would soon have access to several new forms for private duty nursing (PDN) and home health services. These forms are now online at the links below:

- Initial Member/Caregiver Training Checklist
- Private Duty Nursing/Home Health Plan of Care
- Private Duty Nursing Home Plan of Care Agreement
- Recertification Member/Caregiver Training Checklist

We’ll be reaching out to you soon to schedule training on how to use the new forms. Please note you won’t be required to use them until you’ve completed this training.

Note: These forms don’t apply to CoverKids.
In-Home Bone Density Screenings Available for BlueAdvantage Members

The first symptom of osteoporosis in an older patient is usually a broken bone. Seniors — especially women — are susceptible to osteoporosis, so it’s important to schedule a bone density test for any patients who have suffered a recent fracture.

We understand it’s not always easy for our BlueAdvantage patients to see their physicians for an in-office screening, so we work with our independent health partner, MedXM, to provide in-home bone density screenings. Our members who can’t travel may now receive this important test in the privacy of their own homes. Plus, eligible members can receive 50 wellness points through the MyHealthPath® program for getting a bone density test.

If your patients could benefit from this test, they may call BlueCross customer service to make an appointment.
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>Phone</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>BlueCard</td>
<td>1-800-676-2583</td>
</tr>
<tr>
<td>All other inquiries</td>
<td>1-800-705-0391</td>
</tr>
<tr>
<td>BlueAdvantage</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>eBusiness Technical Support</td>
<td></td>
</tr>
<tr>
<td>Phone: Select Option 2 at</td>
<td>(423) 535-5717</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
</tr>
</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.