COVID-19 Updates

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

COVID-19 Coverage

With the recent spread of COVID-19, or novel coronavirus, in Tennessee, we want to make you aware of some changes to our coverage. Updates include:

- **Telehealth consultations:**
  - From now until April 30, you can use CPT® codes 99441–99443 for telephonic provider-to-member consultation. This applies to all lines of business’ PCP or specialist benefits.
  - You can also bill for virtual and telephonic consults with your patients by using E&M codes 90791, 90792, 90832, 90834 and 90837. Please use place of service 02 for all of these options.
  - Pricing for these services would be consistent with your BlueCross fee schedule.

- We’ll cover our members’ copay and waive their cost-share for any appropriate FDA-approved tests and those currently pending FDA approval at this time.

- We’ll also cover any vaccines developed and approved to treat COVID-19 once they’re available.

For more information, please see the FAQs at provider.bcbst.com or contact your Network Manager.

COVID-19 Testing and Reimbursement

From now until Dec. 31, we’ll reimburse at 100% of the Centers for Medicare and Medicaid Services (CMS) fee schedule for both professional and facility claims for COVID-19 FDA-approved tests. This also includes tests that are currently pending FDA approval. The following codes are billable for all labs and providers across all BlueCross BlueShield of Tennessee product lines*:

- U0001 - (CDC)
- U0002 - (Commercial Labs)
- CPT® code (87635) to be priced at the U0002 payment or the lesser of billed charges once physicians can do their own testing.

We’ll also cover our members’ swabs and test results in a drive-thru setting as part of the lab payment. Please note...
COVID-19 Testing and Reimbursement \textit{continued}

that the test code includes both the swab and the results. You should use place of service code 99 when billing drive-thru testing. All reimbursement will be based on the testing code. Please note that we will only reimburse for our member’s COVID-19 swabs and test results, not screenings, in drive-thru testing. This information will be published in the 2nd Quarter BlueCross and BlueCare Tennessee Provider Administration Manuals.

*Codes are included on the preferred lab exclusion list for BlueCare\textsuperscript{SM}, TennCare Select and CoverKids\textsuperscript{SM}.

COVID-19 Response: TennCare Pharmacy Program and CoverRx Updates

The Division of TennCare recently made several temporary changes to the TennCare Pharmacy Program and CoverRx in response to the coronavirus (COVID-19) pandemic. Effective March 16, 2020, TennCare will temporarily:

- Allow out-of-network pharmacy and provider fills
- Waive copays for medications on the Attestation and Auto-Exempt lists
- Suspend refill-too-soon edits for most medications, excluding opioids and other controlled medications. To request an exception review for your patient, please call the Pharmacy Support Center at \texttt{1-866-434-5520}.
- Override pharmacy lock-in location changes, where applicable

For more information, please review the TennCare notice outlining these changes.

COVID-19 Testing and Reimbursement \textit{continued}
New Contact Types in Availity® will Give Providers More Message Delivery Options

Soon, you’ll have more choices about how you receive messages from us. This is because we’ve added three new options to Availity’s Contact Preferences section. The new contact types are:

- **Credentialing** – Information about your credentialing status
- **Network Operations** – Updates about network enrollment and your listing in the BlueCross Provider Directory
- **Network Updates** – General business announcements, newsletter updates and surveys

You can update your contact preferences with your email address for each of these communication types. Be sure to check your contact preferences to make sure you’re getting important messages and announcements that apply to you. Also, please continue to look for updates under the News & Announcements and Notification Center sections of Availity.

Have questions or need help with Availity? Please visit Availity.com or contact eBusiness Service at (423) 535-5717, option 2.

Individual Providers May Get Group Contract

New providers joining a practice that has one or more providers under a group NPI may soon receive a group contract – even if the other affiliated providers have individual contracts. By consolidating the contracts of providers who practice together, we’re able to improve efficiency for provider offices and BlueCross. This is because we’re able to deliver consistent reimbursement rates and reporting requirements to each provider in the practice. It also helps make sure providers all participate in the same networks, which is important for your group’s patients.

If you have questions about your new group contract or this group contracting initiative, please contact your local provider network representative.
Beware: Phishing Scams Threaten Your Practice’s Identity and Finances

Phishing attacks illegally trick people or businesses into giving up credit card information, Social Security numbers, passwords or other personal data to steal identities and empty financial accounts. Phishing attempts may come in the form of an email, phone call or text from criminals who often pose as legitimate companies.

Trust your feelings if something seems suspicious. Some schemes are easy to spot, while others are cleverly disguised. Phishing outreach often includes unique information about you, and can appear as either a reply to an email you didn’t send, or as an urgent request.

Here are few other things to look for:

- Misspelled words, grammatical mistakes or an inappropriate tone
- Emails from a business or person you don’t recognize
- Requests that ask you to download a file unrelated to the subject or click a link with an unfamiliar web address

If you receive an unusual email or phone call that appears to be from BlueCross, you can always call our Provider Service line at 1-800-924-7141 to confirm the request.

Code/Modifier Requirement Reminder

Effective March 16, 2020, we began rejecting and/or returning claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus lines of business. You can resubmit these claims for reimbursement after correcting them with valid combinations.

Also effective March 16, 2020, we began denying claims with invalid procedure code and modifier combinations for the BlueCare, TennCare Select and CoverKids lines of business. Once you correct the claims, you can resend them for reimbursement review.

You can find more information about billing modifiers in the Provider Administration Manual on the provider page at bcbst.com, or in the National Correct Coding Initiative (NCCI) policy manual at cms.gov. You can also call our Provider Service Line at 1-800-924-7141, Monday through Friday, 8 a.m. to 6 p.m. ET. For BlueCare, please call 1-800-468-9736 and for TennCare Select, the number is 1-800-276-1978.

Please note: We announced the March 16 effective date in our March BlueAlert newsletter. The effective date had previously been listed as March 1, 2020 in the Jan. and Feb. issues.

Change of Schedule for All Blue Workshops

Due to the recent spread of COVID-19, or novel coronavirus, to Tennessee, we’ve decided to reschedule our All Blue Workshop events. Once we have the new dates and locations, we’ll share the news through our BlueAlert newsletter. While we apologize for the inconvenience, we want you to know we take the health of our members, providers and employees very seriously. We had to take this important measure to make sure we could monitor the possible ongoing spread in Tennessee.

Please look for updates in the BlueAlert newsletter and on the All Blue Workshops page in the provider section of bcbst.com. You can also preview and print the workshop presentation from that web page. If you have questions, please contact your network manager.
Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so please take a look at your license if you’re not sure when to renew it. A current license tops our list of required provider credentials and we’re required to terminate providers from our network when their licenses expire. Providers who want to rejoin the network (following termination due to license expiration) will have to reapply and go through the credentialing process again. It’s also important to know that we’ll deny claims submitted by an unlicensed provider.

Commercial

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

Guidelines for Submitting Urgent and Elective Authorization Requests

You can get behavioral health utilization reviews for emergency services 24-hours-a-day, seven days a week. Emergency behavioral health services should be authorized at the time of admission or within two days. Non-urgent services must be authorized at least one business day before admission and no later than one business day after.
BlueCare Tennessee

This information applies to BlueCareSM, TennCareSelect and CoverKidsSM plans unless stated otherwise.

Top Tips for Recording Well-Child Care

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child checkups have seven key components. When patients visit your office for their well-child exams, please document all seven components, as well as assessments of their weight and physical activity.

Your patients’ medical records and the initial EPSDT records that you send to us should include all care administered during the exam, including seasonal flu shots. If you’re unable to complete all or part of an exam because a patient deferred or refused the exam, please note this.

Additionally, claims submitted for EPSDT visits must match your patients’ medical records and contain codes for all parts, including the physical exam, vaccines, lab tests, and hearing, vision and milestone and depression screenings.

For more information about the components of the EPSDT exams and documentation and billing requirements, please see our TennCare Kids Tool Kit.

Note: This article doesn’t apply to CoverKids.

Credentialing and Claims Filing Requirements for Nurse Practitioners and Physician Assistants

Since Jan. 1, 2017, we’ve required nurse practitioners and physician assistants who care for our members to be credentialed and re-credentialed every three years. We also require provider offices to list these professionals as rendering providers on claims when they care for patients.

When we put these requirements in place, we told providers we would begin denying claims submitted by non-credentialed nurse practitioners and physician assistants starting May 1, 2017. However, in the May 2017 BlueAlert, we announced we would postpone the claims denial until further notice. We’re still working through system logistics, which is why we haven’t provided an update. We’re sorry if this has caused any confusion.

While we aren’t denying claims at this time, we do need to remind providers that we may recover payment if we learn through routine monitoring and post-payment auditing efforts that billing and credentialing guidelines haven’t been followed. We’ll also refer providers who don’t meet these guidelines to the applicable state agency as required by our contractor risk agreement.

If you have questions about these policies, please contact your provider network manager.
BlueCare Tennessee Reimbursement Policy for CPT® Category III Codes*

Beginning May 1, 2020, the BlueCare, TennCare Select and CoverKids reimbursement rate for CPT® Category III codes will be $0.00. These codes are used to track the use of emerging technologies, services and procedures, and they don’t establish a service or procedure as safe, effective or medically necessary.

We’re introducing this policy based on Medicare guidelines established by the Centers for Medicare and Medicaid Services’ National Coverage Policy. If Medicare develops a price for a CPT® Category III code, we may allow payment. We may also allow payment if the service is approved through an initiative, such as telehealth or telemedicine, or one of our medical directors approves payment for a specific case following a medical review.

We’re updating the BlueCare Tennessee Provider Administration Manual to include this information. If you have questions, please contact the Provider Service line for your patient’s plan.

Claims Guidelines for Patients with Primary and Secondary Coverage

As you know, some patients have more than one insurer. For example, patients who are dual eligible have Medicaid and Medicare. Other patients may have Medicaid and a Commercial plan.

BlueCare Tennessee is the payer of last resort and considered secondary to Medicare and Commercial plans. To make sure you receive the appropriate payment, please file claims with Medicare or a patient’s Commercial insurer before billing BlueCare Tennessee. Billing us first may cause improper payments and result in the recoupment of payments.

We’ve recently updated our utilization management approval letters to include this reminder. If you have questions, please call Provider Service at 1-800-468-9736 for BlueCare and 1-800-276-1978 for TennCare Select.

Note: The information in this article doesn’t apply to CoverKids.
Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

Extension on Provider Assessment Form Rate Through July 31

As a reminder, providers are able to bill CPT® code 96160 for a Provider Assessment Form (PAF) annually for all BlueAdvantage (PPO)SM and BlueEssential (HMO-SNP)SM members. The reimbursement for these forms is $225 for dates of service between January 1 and June 30 and $175 for dates of service between July 1 and December 31. Because of the potential risk for most Medicare-aged members to seek routine care with the novel coronavirus presence, we are extending our $225 level reimbursement for these forms through July 31, 2020 in order to avoid these members having to come to your office in the next 30 days for Wellness Exams and PAF completion. Please contact your Medicare Advantage Quality Outreach Consultant with questions.

High Tech Imaging Authorization Vendors Differ by Coverage

As a reminder, the Medicare Advantage and DSNP plans use the Magellan Healthcare National Imaging Associates (NIA) radiology benefit management program for authorization review for non-emergent outpatient advanced imaging and cardiac imaging. This is a different clinical business partner than what is used by our Commercial and BlueCare plans for the same service.

Emergency room, observation and inpatient imaging procedures do not require prior authorization from NIA. If an urgent/emergent clinical situation exists outside of a hospital emergency room, please call 1-888-258-3864 to initiate an urgent request.

You can send requests for advanced imaging and cardiac imaging prior authorizations to NIA through Availity.com or by calling 1-888-258-3864. NIA does not accept authorization requests via fax.

Medicare Advantage Medical Record Request for Risk Adjustment

Medicare requires us to provide annual documentation to show the presence of some acute and many chronic conditions in Medicare Advantage populations through risk adjustment. Although we get a lot of this information from member claims data, we still need to get more details from medical records on certain members.

You may receive correspondence asking for some of your patient records for risk adjustment. Please follow the instructions included with the correspondence and respond to the request as quickly as possible. If you have questions about the medical records request or risk adjustment process, please call your quality outreach consultant or Risk Adjustment at 1-855-413-8776.
Pharmacy

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

Medicare Advantage & DSNP Prior Authorization Review Timeframes Updated for Part B Drugs

At the beginning of 2020, CMS updated the prior authorization review timeframes for Medicare Advantage plans. This includes expedited reviews and Part B (provider-administered medication) drug reviews.

Updated Timeframe Guidelines:

- Standard pre-service request: 14 calendar days from receipt of request
- Part B drug request: 72 hours from receipt of request
- Expedited: Pre-service request: 72 hours from receipt of request
- Expedited Part B drug request: 24 hours from receipt of request

Please submit all relevant clinical information with your initial request to Magellan Rx. This is particularly important for Part B drug authorization requests. This will help us meet the new timeframes and avoid potential denials or delays due to insufficient information.

Please note that while you can ask for a pre-service request extensions, they are not allowed for Part B drug requests.
Quality Care Rewards

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

Provider Star Ratings for Medicare Advantage and BlueCare Plus Now Available in Availity

The BlueCare Plus Quality+ Partnerships Program offered providers enhanced reimbursement for ratings of 3 STARs and above for quality scores and coding accuracy between Jan. 1 – Dec. 31, 2019. Participating providers can see their 2019 Star rating in Availity by accessing the Quality Care Rewards application and clicking on their 2020 BlueCare Plus VBC scorecard. The rating is at the top of the scorecard. Star ratings based on the previous year’s performance impact current reimbursement rates, effective April 1, 2020.

The Medicare Advantage Quality+ Partnerships Program offered providers enhanced reimbursement for ratings of 4 STARs and above for quality scores and coding accuracy between Jan. 1 – Dec. 31, 2019. Participating providers can see their 2019 Star rating in Availity by accessing the Quality Care Rewards application and clicking on their 2019 Medicare Advantage scorecard. The rating is at the top of the scorecard. Star ratings based on the previous year’s performance impact current reimbursement rates, effective April 1, 2020.

New fee schedules were included with the rebasing rate notification letters that we mailed at the end of March.

Contract amendments contain information about base rates, quality escalators and total earning potential. On May 1, you can find a complete listing of all providers with a 4-Star rating and above at provider.bcbst.com/working-with-us/quality-initiatives/.
BlueCross BlueShield of Tennessee, Inc. 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, Inc. or any of its licensed affiliates. 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.

Provider Service Lines:

Featuring “Touchtone” or “Voice Activated” Responses

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<thead>
<tr>
<th>Service Line</th>
<th>Phone Number</th>
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<tr>
<td>Commercial Service Lines</td>
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<tr>
<td>Commercial UM</td>
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<tr>
<td>Federal Employee Program</td>
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<tr>
<td>BlueCare</td>
<td>1-800-468-9736</td>
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<tr>
<td>CoverKids</td>
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<td>CHOICES</td>
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<td>ECF CHOICES</td>
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<td>BlueCare Plus</td>
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<td>SelectCommunity</td>
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<td>BlueAdvantage</td>
<td>1-800-924-7141</td>
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<tr>
<td>BlueCard Benefits &amp; Eligibility</td>
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<td>All other inquiries</td>
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<td>BlueCard</td>
<td>1-800-676-2583</td>
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<td>eBusiness Technical Support</td>
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<td>Phone: Select Option 2 at</td>
<td>(423) 535-5717</td>
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<td>Email: <a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
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<td>BlueAlert</td>
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<td>Important Note:</td>
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<tr>
<td>If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:</td>
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<tr>
<td>Email a completed Provider Change Form and any attachments to us at <a href="mailto:PNS_GM@bcbst.com">PNS_GM@bcbst.com</a>.</td>
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<tr>
<td>Update your provider profile on the CAQH Proview® website.</td>
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<tr>
<td>Questions? Call 1-800-924-7141.</td>
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