Redesigned Provider Website Set to Launch Later this Month

We’ve created a new, dedicated provider website to help you easily find the information you need from us faster. The new site will go live in mid-February, and the layout will have a format similar to the recently redesigned bcbst.com. The new provider site will have a dedicated URL so you can access it directly at provider.bcbst.com, plus you’ll still be able to get to the new site from bcbst.com.

Among the many additions and improvements to the site are redesigned pages that are easier to navigate, quick access to every section of the site using the main drop down menu and all forms and documents you use in one convenient place.

Review and Update Provider Information in CAQH

BlueCross has steadily increased the use of CAQH ProView® as our source for provider data, which now includes our Find a Doctor tool. Please continue to review and update your information in CAQH regularly. Your confirmation of this data will help us move away from sending out lengthy paper Data Verification Forms each quarter.

We’ll soon have a much shorter form that will cover only things not captured in CAQH. Items not captured in the CAQH ProView, such as Patient Acceptance for our networks, will still require your review. For those items, we’ll send you a notice so you can verify them in Availity®. Ancillaries and facilities will continue to receive the Data Verification Form via paper until we’re able to migrate all providers to this new process.

If you have any questions about this process, please contact Provider Network Services at 1-800-924-7141.
Code/Modifier Requirement Updates

Effective March 1, 2020, we’ll reject and/or return claims with invalid procedure code and modifier combinations for our Commercial, BlueAdvantage and BlueCare Plus lines of business. You can resubmit the claim for reimbursement after correcting it with valid combinations. Any BlueCare™, TennCareSelect and CoverKids™ claims submitted with invalid procedure code and modifier combinations will be denied.

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. Or you can 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 TennCareSelect, the number is 1-800-276-1978.

Applied Behavioral Analysis (ABA) Services Update

Beginning March 3, 2020, we’ll adopt MCG Health’s 23rd Edition Care Guideline for ABA services for all lines of business. The only exception will be for BlueCare Tennessee members. We’ll modify the guideline to allow diagnoses related to Intellectual/Developmental Disabilities and Traumatic Brain Injury, as well as Autism Spectrum Disorder.

You can find more information on our website at Utilization Management Guidelines or contact your Network Manager:
Register for the 2020 All Blue Workshops

Register now for the 2020 All Blue Workshop near you by clicking one of the events listed below. After Jan. 15, you can also register by visiting the All Blue Workshops page in the provider section of bcbst.com.

**March 5, 2020 – Chattanooga**
Embassy Suites Chattanooga
2321 Lifestyle Way, Chattanooga, TN 37421

**March 24, 2020 – Memphis**
Holiday Inn University of Memphis
330 Innovation Drive, Memphis, TN 38152

**March 25, 2020 – Jackson**
DoubleTree Jackson
1770 Highway 45 Bypass, Jackson, TN 38305

**April 8, 2020 – Nashville**
Cool Springs Marriott
700 Cool Springs Drive, Franklin, TN 37214

**April 14, 2020 – Kingsport**
MeadowView Marriott
1901 Meadowview Parkway, Kingsport, TN 37660

**April 15, 2020 – Knoxville**
Hilton Knoxville
501 Church Avenue, Knoxville, TN 37902

For 2020, we’re going paperless. We’ll post the materials on the All Blues page before the meeting, so you can print them ahead of time or access them online during the event.

2020 HEDIS® Medical Record Requests to Begin Soon

Each year, we’re required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA uses these measures to determine whether members received the care and screenings they needed and if the care improved their health.

You’ll soon receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well-child visits.

If you need help submitting your records using any of the following methods, please call us at **(423) 535-3187**.

- Remote access into your electronic medical records
- Fax
- Secure email
- On-site collection
- Our web-based portal

HEDIS® is a registered trademark of NCQA.
Commercial
This information applies to Blue Network PSM and Blue Network SSM unless stated otherwise.

Prior Authorization Changes Scheduled for April
The following prior authorization changes will be effective on April 1, 2020.

Musculoskeletal Program
CPT® codes 0375T and 27360 will no longer need prior authorization. However, code C9757 will require prior authorization.

You may submit prior authorization requests through Availity. com. You can also call TurningPoint at 1-866-747-0587 or fax your request to 1-866-747-0587.

Genetic Testing and High-Tech Imaging
CPT® code 0081U for genetic testing will no longer need prior authorization. However, the following codes will need prior authorization:

- 0153U
- 0156U
- 0157U
- 0158U
- 0159U
- 0160U
- 0161U
- 0162U
- 01542
- 01552
- 81277
- 81307
- 81308
- 81522
- 81542
- 81552

The following CPT® codes for high-tech imaging will require prior authorization:

- 78429
- 78430
- 78431
- 78432
- 78433
- 78434
- 78829
- 78830
- 78831
- 78832

You may submit prior authorization requests for genetic testing and high-tech imaging through Availity.com. You can also fax your requests to eviCore at 1-888-693-3210 or submit them by phone at 1-888-693-3211.

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

BlueCross Marketplace Plans Available in Nashville and Memphis in 2020
For the first time since 2016, we’re offering on- and off-Marketplace plans in every county across the state. These plans became effective Jan. 1, 2020. This means that Nashville and Memphis providers participating in Blue Network S will start seeing members with these plans. Please note that payment for covered services rendered to these members will be based on your existing Blue Network S rates. For more information, please contact your network manager.

Billing Accuracy and Cost Control
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. Please be sure to clearly identify all of the services and/or supplies you’ve provided on your itemized bill, either by description or with the valid corresponding CPT®/HCPCS code(s). If we can’t identify all of these services or supplies, we may not be able to pay for them.
Document Each Required Part of a TennCare Kids Exam

TennCare Kids’ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have seven key components:

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests
- Immunizations
- Health education/anticipatory guidance

When your BlueCare Tennessee patients visit your office for their well-child checkup, please document all seven required parts of the exam, as well as assessments of their nutrition and physical activity.

If you’re unable to complete a checkup because a patient is uncooperative, deferred or refused the exam, please be sure to include this information in the patient’s medical record.

For more information about the required components of TennCare Kids’ EPSDT exams and medical record documentation requirements, please visit our TennCare Kids provider page.

Note: This information doesn’t apply to CoverKids.

Coordinating Care for School-Based Health Services

School districts play an important role in helping families access health information and medical and behavioral services. They also help children with special needs who are covered by BlueCare Tennessee receive medically necessary, school-based, health-related services that support their ability to participate in their education.

We need your help to make sure children receive the care they need at school. To receive reimbursement for medically necessary, health-related services, school districts must meet certain requirements. These include getting a physician’s order for services from the child’s primary care provider or another provider in our network. If a school district or their third-party billing administrator contacts you about a treatment request, please respond as soon as possible. With your help, we can make sure children have timely access to the in-school, medically necessary services they need.

Note: This doesn’t apply to CoverKids.
Review CMS Guidelines for Coverage and Billing of Routine Foot Care

Our Medicare Advantage plans cover routine foot care according to CMS’s Local Coverage Determination (LCD) L37643. The appropriate CPT®/HCPCS codes (11055-11057, 11719-21 and G0127) and modifier usage (Q7, Q8, Q9) are explained in this LCD and in the associated Local Coverage Article (A56680 – Billing and Coding: Routine Foot Care). This information outlines proper billing and coverage determinations when treating Medicare Advantage plan members.

Receive Payment for Submitting Provider Assessment Forms

Payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueEssential members are available again in 2020. Please use CPT® code 96160 to file a claim for PAF completion. BlueAdvantage and BlueEssential will continue to reimburse the service with a maximum allowable charge of:

- $225 for dates of service between Jan. 1 and June 30, 2020
- $175 for dates of service between July 1 and Dec. 31, 2020

Please submit the completed PAF form through Availity or by fax to 1-877-922-2963. Your patient’s medical chart should include a copy of the form as part of their permanent record. For directions on uploading the PAF, please see the Quality Care Rewards section of this newsletter. You may submit a completed PAF for a particular member once per calendar year (you do not need to wait 365 days) and receive the above noted payment. For additional information about the PAF, please visit the Quality section on our provider website.

New Prior Authorization Forms Required Starting in March

You can find new BlueAdvantage and BlueEssential prior authorization forms that are more specific and easier to understand in the forms section under Medicare Advantage on our website. The new custom forms include:

- Inpatient/outpatient admission/surgery request
- Pre-determination
- Home health services
- DME requests
- Outpatient therapies
- Provider appeal (post service medical necessity appeals)

Please note, we’ll accept new and existing forms until Feb. 29, 2020. After that date, we’ll only accept the new forms.

Guidelines for Submitting Medical Necessity Provider Appeals

Here are a few reminders for submitting a provider appeal based on medical necessity.

Your appeal must be:

- Delivered to us by mail or fax
- Clear that it’s a provider appeal and not a reconsideration
- For a service that’s been rendered and denied
- Submitted within 60 days of the date the original claim was denied (the date the denial letter was sent)
- In chronological order
- Specific about what’s being appealed

Please submit associated clinical records with your appeal, including, but not limited to:

- Physician orders
- Daily physician progress notes from all specialties, including consultations
- Pertinent lab results (if not part of physician progress notes)
- Procedure notes and diagnostic test results (if not part of progress notes)
- Discharge summary
- History and physical
- PT/OT/ST notes
- Case management notes that specifically address discharge needs and disposition

Documents that may be necessary, though not required:

- Face/cover sheet
- Billing information
- Coding summary
- Nursing assessments

Entire medication administration record

*Normally we don’t need these unless there is something found in these sources not found in the physician documentation.
BlueCare Plus (HMO SNP)℠
This information applies to our BlueCare Plus Medicare Advantage, dual-eligible special needs plans.

Understanding BlueCare Plus Benefits and Billing
BlueCare Plus is a Medicare Advantage HMO Special Needs Plan (SNP) for individuals eligible for benefits under Medicare and Medicaid. BlueCare Plus plan options include supplemental benefits for dental, vision, and hearing services.

Claims for covered dental services should be filed with BlueCross BlueShield of Tennessee like any other dental claim. Benefits can be verified through Availity. Please call BlueCare Plus Provider Service at 1-800-299-1407 if you have questions about benefits or your network participation status.

Proton Beam Therapy Will Soon Need Prior Authorization
Starting March 1, 2020, proton beam therapy for BlueCare Plus members age 21 and over will require prior authorization. Before requesting prior authorization, please verify member benefits and eligibility at Availity.com by clicking Patient Registration, then Eligibility and Benefits Inquiry. You can also use Availity to submit your prior authorization request.
This information applies to all lines of business unless stated otherwise.

Coding Updates for Provider-Administered Drugs

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 started rejecting these types of claims if they were submitted with the wrong procedure code and NDC combination. This applies to all lines of business except BlueCare, TennCare Select and CoverKids.

To make sure your claims get paid correctly, we’ve provided additional information about NDCs and how best to process your claims.

About NDCs:

An NDC is a unique number assigned to every drug available for purchase in the United States and should always follow a 5-4-2 digit format:

The first set of digits represents the manufacturer/distributor. The second set describes the medication’s dosage form and formulation. The last set of numbers represents the package size.

Tips for billing with NDCs:

- NDCs are found on the drug packaging and on the vials. If the NDCs on the box and vial don’t match, use the NDC on the vial.
- NDCs always follow the same format: 5 digits – 4 digits – 2 digits. On the drug label, they may only have 10 digits, but they must have 11 digits to be billed properly.
- To create an 11-digit NDC, just add a leading zero to the front of the section that doesn’t have enough digits.
- For example, if the NDC on the bottle reads 1234-5285-02, add 0 to the front of the first section so the NDC becomes 01234-5285-02.
- The 11-digit NDC is what should be included in the claim.

<table>
<thead>
<tr>
<th>PACKAGE NDC</th>
<th>ADDED ZEROS (LEADING 0s)</th>
<th>11 DIGIT NDC</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234-1234-12</td>
<td>01234-1234-12</td>
<td>0123123412</td>
<td>The first section should have 5 digits, so we added a 0 to the front.</td>
</tr>
<tr>
<td>12345-123-12</td>
<td>12345-0123-12</td>
<td>12345012312</td>
<td>The second section should have 4 digits, so we added a 0 to the front of the second section.</td>
</tr>
<tr>
<td>2-22-2</td>
<td>00002-0022-02</td>
<td>00002002202</td>
<td>The first section needs 5 digits, so we added four 0s, the second section needs 4 digits, so we added two 0s, the last section needs 2 digits, so we added one zero.</td>
</tr>
</tbody>
</table>

You can find more information in the Provider Administration Manual on the provider page at bcbst.com. You can also visit cms.gov, the Centers for Medicare and Medicaid Services (CMS) website. If you have additional questions, please contact your local network manager.
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

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Phone 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>Friday, 9 a.m. to 6 p.m. (ET)</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 pm. (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>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td><strong>BlueCard</strong></td>
<td></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>
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<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></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>
<tr>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET)</td>
<td>Friday, 9 a.m. to 6 p.m. (ET)</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.