of Tennessee

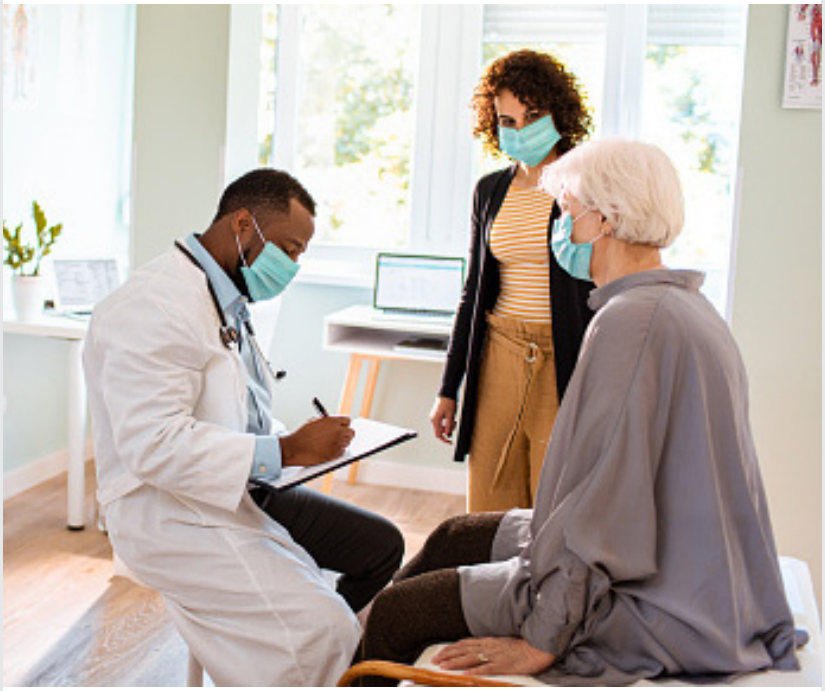
NOVEMBER 2020

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

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



COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

Hearing-Related Products and Services Billing Reminder

As a reminder, when billing for hearing-related services and equipment, please use the most appropriate "V" HCPCS code and number of units. Not all plans cover hearing aids for all members. Some plans have dollar limits for hearing aids. Be sure to verify benefits before providing services.

Please note the following billing guidelines:

- Reimbursement for codes classified as durable medical equipment (including hearing aids), medical supplies, orthotics and prosthetics without an established maximum allowable is based on the Medicare Administrative Contractor for Jurisdiction C (DME MAC) guidelines, BlueCross reimbursement guidelines and billing guidelines.
- Contracted providers agree to cooperate with reasonable requests from us and applicable payers if we need to investigate any member complaints.
- Providers agree to accept reimbursement made according to the terms of BlueCross provider contracts, plus any applicable member copayments/deductibles and coinsurance amounts as the maximum amount payable for covered services.

These guidelines apply to services billed on professional claims for our Commercial plans, with the exception of the Federal Employee Program, unless otherwise stated in the contract. Please refer to the Hearing Products policy guidelines in our **Provider Administration Manuals** for more information about submitting claims for hearing aids. Please note, the member's plan and evidence of coverage control covered benefits and member cost-share for such benefits.

New Prior Authorization Requirement for Neuropsychological Testing

BlueCare℠, TennCare*Select*, CoverKids℠ and Commercial BlueCross BlueShield of Tennessee members (with the exception of FEP) will require prior authorization for neuropsychological testing beginning **Jan. 1, 2021**. Providers with appropriate training are encouraged to seek an automated authorization for psychological and neuropsychological testing through Availity®. This option will make obtaining authorizations simpler.

Training is available. **Providers not trained in neuropsychological and/or psychological testing should bill appropriately for behavioral health screenings.**

As always, we recommend that you also record time spent for all activities related to psychological testing in your patient record. When submitting claims, please remember to include necessary modifiers.

To order copies of the CPT® codebook from the AMA, visit **commerce.ama-assn.org/store** or call **1-800-621-8335**. If you have questions, please contact your regional Provider Network Manager.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the Network Verification at Availity.com.

Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review. The Network Verification form, in the **Provider Enrollment, Updates** and **Changes** tile, is located in the BlueCross payer space on Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification Form until we can move all providers to this new process. If you have questions, please contact our Provider Service line at **1-800-924-7141** and select option 2 for Contracting and Credentialing.

Submitting Provider Changes is Now Easier Using Availity

We're moving away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes. It's available now in the BlueCross payer space at **Availity.com**. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with Availity. We'll continue to accept PDF versions of the Provider Change Form until the end of the year, but after that date all changes must be submitted through Availity.

Network Effective Dates Dependent on Receipt of Provider Information

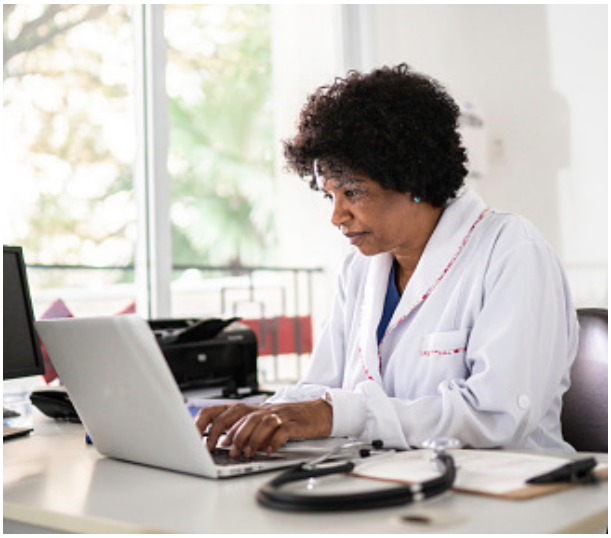
We work hard to make the provider enrollment process fast and efficient. Please submit all new provider information as promptly as possible, so we can deliver the earliest effective dates for your new providers. We can't enroll providers in a new practice until we have the information necessary to make our system updates. This includes the addition of providers to an existing group. Network effective dates are based on when the individual provider is enrolled with BlueCross, not necessarily when the provider joins the group.

Provider Dispute Resolution Procedure Reminder

Our provider dispute resolution procedure is clearly described in our provider administration manuals. You can find these manuals on our **provider website**.

Effective Jan. 1, 2021, we'll no longer allow providers to commence a dispute later than the stated time frame in our manuals. This isn't a policy change – just a notice that we're fully enforcing our long-standing policy. We encourage you to refer to the manuals to review the entire process.

If you have questions about our dispute resolution procedure, please contact your **Provider Network Manager**.



Process Your InstaMed Prepaid MasterCard Payments Before They Expire – No Additional Fees

In April, we launched a convenient online bill pay tool for Commercial and individual members to pay providers through their BlueCross account. Many members have taken advantage of this service, which lets them review claims and pay you directly for any deductibles or out-of-pocket costs using InstaMed, a nationwide health care payment network.

Depending on your level of participation, InstaMed sends you the member's payment electronically or by mail. Electronic payments are made as soon as the next day. Mailed payments, which include a pre-paid MasterCard, arrive within seven to 10 business days.

We've recently learned some providers aren't processing the InstaMed payments that were sent to them on time. This means providers have to reach back out to members for payment. Please know you don't need to create an InstaMed account to process the payment. You simply process it the same way you do other credit card payments. You'll receive your payments faster, and you won't be charged additional fees to cash or deposit your payment (outside of typical credit card processing fees).

If you already have an InstaMed account, there's nothing you need to do. However, if you want more information, want to register for or upgrade your account, please visit **InstaMed's website**.

Member ID Number Prefix Reminder

When submitting claims, please make sure the Member ID number is exactly as it appears on the Member ID card, including the prefix. We use prefixes to identify the member's type of coverage, obtain health plan contract information and route claims to the correct Home Plan through the BlueCard and Inter-Plan programs. Please note that as of **Oct. 1, 2020**, we've started rejecting claims with incomplete Member ID numbers.

Commercial

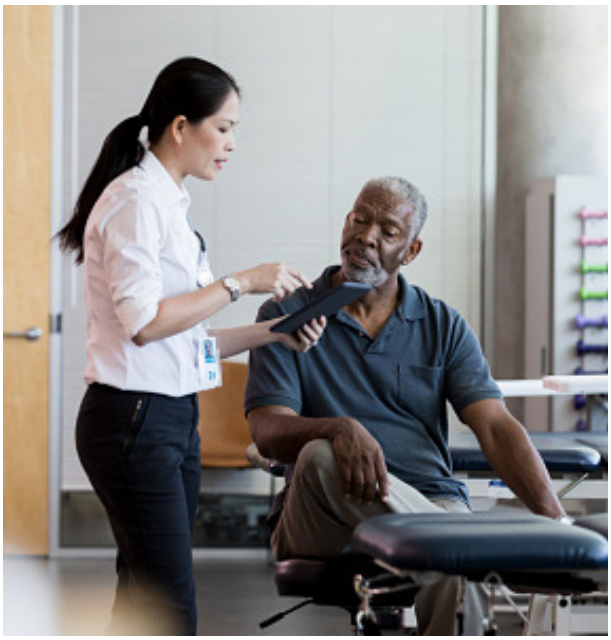
This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning **Jan. 1, 2021**, CPT® code 0016M will require prior authorization. Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity.com** and clicking **Patient Registration** then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity, or you may fax them to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

New High Performance Network Coming Soon



The Blue Cross Blue Shield Association is introducing a national network called Blue High Performance Network (Blue HPN) in January 2021. It's an alternative to BlueCard PPO and designed as a curated network that will provide improved, more affordable care. Quality measurement is a key feature, and plans are required to report on eight consistent national measures and eight market-specific clinical measures to address local gaps in care.

In Tennessee, we'll support Blue HPN through our existing Network S as a statewide network. Availability is limited to self-funded employer groups in Chattanooga, Knoxville, Nashville and Memphis. Blue HPN won't replace existing BlueCard networks, but will be offered alongside BlueCard PPO as a second option.

Blue HPN is designed as an in-network only, Exclusive Provider Organization (EPO) product, so full benefits are limited to in-network providers only. If members need care when traveling outside of Blue HPN service areas, access is limited to urgent and emergency care services. Blue HPN members will have Member ID cards with Blue High Performance Network displayed on the front, along with an "HPN in a suitcase" logo.

The Blue HPN launch will not affect Network S contracts or rates. Blue HPN providers will follow the same pre-service review and claims filing procedures used today for BlueCard PPO. For more information, please see the **BlueCross Provider Administration Manual**. It includes more details about Blue HPN, as well as images of the Member ID card. You can also contact your Network Manager with questions.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Flu Vaccine Reimbursement Update for Children and Teens

We want to make sure that vaccines are accessible for all children and teens in our state, so we're covering flu vaccines for patients under age 19 outside of the Vaccines for Children (VFC) program. This means that if you give a flu vaccine to a child or teen covered by BlueCare Tennessee and don't participate in the VFC program, we'll reimburse you for the vaccine and the cost of delivering it.

If you aren't in the VFC program, please bill modifier 32 on the flu vaccine line item on your claims to receive payment for the vaccine and administering it to patients age 18 and younger.

If you have access to the Tennessee Immunization Information System (TennIIS), please also report that you've administered the flu vaccine in the system.

If you're enrolled in the VFC program, please disregard this information and continue to follow your normal process for vaccine administration.

Please note this guidance goes into effect on Sept. 1, 2020, and it's effective for the 2020-2021 flu season only.

Note: The information in this article doesn't apply to CoverKids.

Coming Soon: Changes to the CoverKids Network

Effective Jan. 1, 2021, the Division of TennCare is consolidating CoverKids into the TennCare Contractor Risk Agreement. At this time, CoverKids members will be assigned to one of the three TennCare managed care organizations. Those transitioning to BlueCare Tennessee will begin using the BlueCare network and will have a primary care provider assigned to them.

Providers who don't currently participate in the BlueCare network, but who have cared for a CoverKids member during the last 12 months, will be invited to participate in the BlueCare network.

For more information, please see the Division of TennCare℠ letter and FAQ document located under Announcements on the **Provider News and Manuals page** of our website. If you have questions about this change, please contact your Provider Network Manager.

Resources to Support Well-Child Care

We want to make it easy for you to find the information you need to perform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. You can find the following resources on the Provider pages of bluecare.bcbst.com:

BlueCare Tennessee Provider Administration Manual – This manual, which is updated quarterly, features comprehensive information about your patients' benefits.

TennCare Kids Tool Kit – Our TennCare Kids Tool Kit contains best practices for delivering and coding EPSDT exams, along with information about patients' transportation benefit and reference materials for publicizing community outreach events.

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) also offers guidance about delivering well-child care, including EPSDT visits and coding.

For more information, please visit the **American Academy of Pediatrics website**. If you have questions about these TNAAP resources, please contact Janet Sutton, CPC, RHIT, TNAAP EPSDT and Coding Program Manager, at (615) 447-3264.

Note: The information in this article doesn't apply to CoverKids.

Improving Health Outcomes in Tennessee

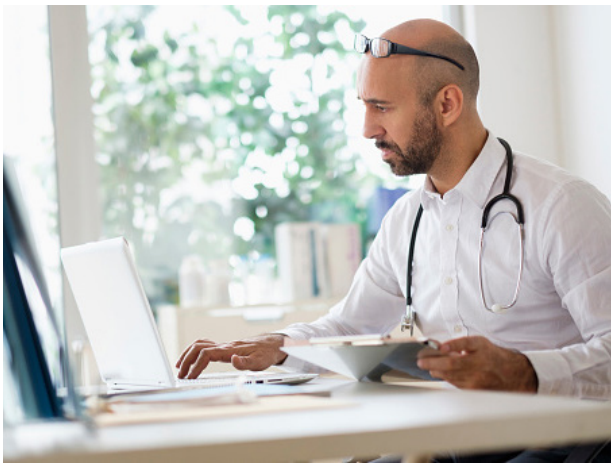
Good health outcomes start in the communities where your patients live, work and play. The Division of TennCare wants to learn more about the challenges your patients face in their communities to help you improve your patients' health. Please take a few minutes to complete the Provider CARES survey at **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.

Stay Up to Date on the BlueCare Tennessee Provider Appeals Process

If you disagree with the way we've processed a claim, you may use our claims reconsideration and appeal process to request a second look. To help make sure reconsideration and appeal requests are processed quickly and correctly, we've put together a few reminders to help with submission. Please note the below process differs from the process used for utilization management or clinical authorization appeals.

Level 1: Reconsideration – Reconsideration requests must be received within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or that contain multiple claims.**

Please note you must file a request for reconsideration before submitting an appeal, unless your request is related to a non-compliance denial.



Step 2: Appeal – An appeal must be received in writing within 60 days of the date of the initial denial notification. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each form should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeals process, please see the **BlueCare Tennessee Provider Administration Manual**.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO/SNP)℠ plans.

Extension of Primary and Behavioral Care Cost Waiver

In an effort to bring peace of mind, help remove barriers to care and encourage members to seek the routine and preventive care they need during the COVID-19 national emergency, coverage for Medicare Advantage members was enhanced as of May 19 and will now continue through **Dec. 31, 2020**. We'll continue to waive member cost share for doctor's office and virtual telehealth visits **specifically to network primary care practitioners and behavioral health care practitioners**. This date has been extended since we published September's BlueAlert, which said we'd extend this level through Sept. 30, 2020. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the-minute guidelines on treating our Medicare Advantage plan members.

Use Correct Modifier for Durable Medical Equipment Purchase (DME) and Rental Requests (RR)

When submitting authorization requests for DME, please make sure requests are submitted with the correct modifier for RR instead of purchase (NU). **All items with Medicare-capped rental requirements, should be submitted with the RR rental modifier.** We've seen instances where the authorization request is submitted with an NU modifier, but the claim is submitted with an RR modifier. You can find a list at CMS.gov of all items that are considered capped rentals. Incorrectly submitting authorization and claim requests with inappropriate modifiers could result in payment delay or claim denials.

Perform Medication Reconciliation after Each Patient Discharge

Medication reconciliation is important for your patients who have recently been discharged from a facility. Not only is this a CMS Star measure, it's a good way to check in with your patients and take the first steps to reduce readmission. A registered nurse, nurse practitioner, physician assistant, clinical pharmacist or physician may complete this service within 30 days of discharge. Please note nurses and pharmacists performing this service can only bill with CPT® code 1111F.

Your patients may have multiple admissions and discharges during the year. These tips can help you make sure they get the medications they need after each hospital visit:

- A list of your patients who've been discharged is available in the Quality Care Rewards application.
- Each discharge to a community setting requires medication reconciliation.
- Medication reconciliation isn't required when patients transfer to an acute or non-acute inpatient setting (i.e., a skilled nursing facility or long-term acute care hospital).
- The documented medication reconciliation should be completed and signed by an appropriate provider.
- Your documentation should show that you were aware of the patient's hospitalization and discharge. It should also address both the discharge medications and current medications, as well as reconciliation between the two.

For more information on medication reconciliation and appropriate CPT® codes, please contact your Medicare Advantage Quality Outreach consultant.

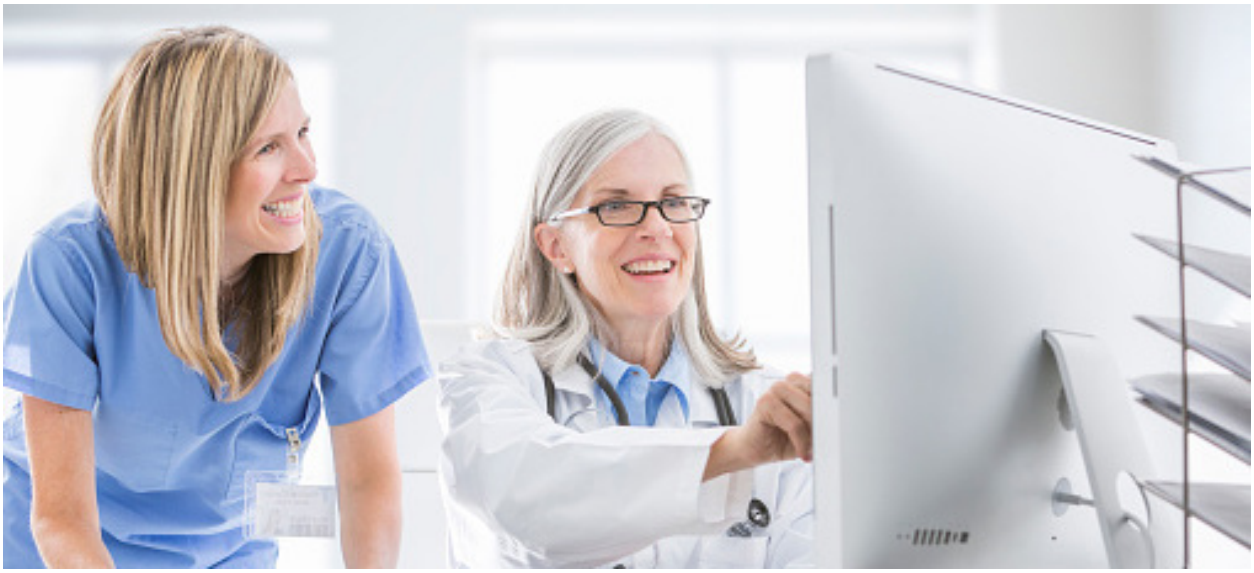
Medicare Advantage and BlueCare Plus Tennessee

This information applies to our BlueAdvantage (PPO℠), BlueEssential (HMO SNP)℠ and BlueCare Plus/BlueCare Plus Choice (HMO DSNP)℠ plans unless stated otherwise.

Complete Special Needs Plan Model of Care Training by End of 2020

Providers who care for BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plan members are required to complete our Model of Care Training after initial contracting and annually thereafter. This training promotes coordination of care for members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by clicking **here**.

All physicians are encouraged to complete the training and the last date to complete 2020 training and be compliant is **Dec. 31, 2020**.



New Provider Education WebEx Presentation

A new presentation on the Member Survey Experience is available as part of our BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series in Availity®. This presentation reviews core questions included in both the CAHPS and HOS patient/member surveys and provides recommendations and tips to improve the member experience. As a reminder, there are additional episodes on other topics such as medication reconciliation, Provider Assessment Forms, program measures and more. These presentations can serve as a resource for additional ways to enhance your performance in the MA Provider Quality+ Partnerships program.

To access the presentations after logging in to Availity, choose **BlueCross BlueShield of Tennessee** within **Payer Spaces** and then select **Resources**. On the Resources page you'll see a list of all the WebEx presentations.

Pharmacy

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

New Tool Supports NDC and J-Code Claim Filing

Effective Jan. 1, 2021, for all lines of business, claims with provider-administered drug charges must include the valid NDC code. Claims submitted without an NDC will be rejected. Claims submitted with an invalid combination of HCPCS and NDC will result in the line item being denied.

We've launched the RC Claim Assist tool to help you validate NDC and HCPCS combinations and dosages with unit conversions to file medical and pharmacy claims. Simply log in to Availity, go to Payer Spaces and click the RC Claim Assist link. You may be asked to register as a new user, but you won't incur any additional charges.

Changes to Commercial Plan Prior Authorizations

Beginning **Jan. 1, 2021**, the following drugs will transition from Magellan RX to our prior authorization list:

Tecartus	Yescarta	Brineura	Zolgensma	Givlaari
Kymriah	Spinraza	Luxturna	Exondys 51	Vyondys 53

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 may submit authorization requests through Availity, fax to Commercial Utilization Management at **1-866-558-0789** or call **1-800-924-7141**.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Coverage Review Insourcing

To better serve our members and providers, we'll be managing Commercial pharmacy coverage reviews internally starting **Dec. 7, 2020**. We will no longer use a third-party vendor. You may submit coverage review inquiries electronically through the CoverMyMeds tool in Availity. You can also go to CoverMyMeds.com and use your existing sign-on credentials. We'll share more information about any process changes or updates in future issues of BlueAlert.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at **1-800-924-7141** and follow the prompts for option 1.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply 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**.

Contact Availity Online

Availity makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.