Redesigned Provider Web Pages Set to Launch Early Next Year

We’re redesigning our provider website to make it easier for you to navigate our pages and find the information you need from us fast. Look for more information about our website redesign in future issues of BlueAlert.
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.

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.

**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
Commercial

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

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 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.
Every Visit is an Opportunity for Well-Child Care

When patients visit your office this winter due to coughs, colds and the flu, consider checking their medical records to see if they’re up to date on preventive care before their appointment. Sometimes, the only chance you have to perform a well-child exam is when patients visit your office because of an illness or other need. So TennCare Kids’ screening guidelines allow you to be reimbursed for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups performed at the same time as other types of visits.

According to the Tennessee Chapter of the American Academy of Pediatrics (TNAAP), you can bill for both a sick and well visit on the same day if the following criteria are met:

- You may report an additional evaluation and management (E/M) service if you find a significant problem on the same day as a wellness check that requires you to provide care beyond the workup of a normal preventive visit. Please attach a Modifier-25 to the code for the additional E/M service when submitting the claim.
- Your documentation for the visit reflects the extra work done during the appointment for the problem. There doesn’t need to be a separate note, but documentation should clearly reflect a separate problem.

For more information about EPSDT exams, please visit our TennCare Kids Tool Kit. You can also find free TNAAP EPSDT and coding resources at TNAAP.org.

Note: This information doesn’t apply to CoverKids.

Get Up to Date on Medicaid ID Re-validation Requirements

The Division of TennCare\textsuperscript{TM} requires providers in our BlueCare, TennCareSelect and CoverKids networks to re-validate their registration information every three years. This ensures our state meets CMS revalidation requirements.

The steps to complete re-validation are different for individual providers, groups and entities:

- Individual providers must keep the information in their Council for Affordable Quality Healthcare (CAQH) profiles current. To help make sure these profiles are up to date, CAQH requires providers review their information and re-attest to their data at regular intervals. To review your CAQH profile, please visit proview.caqh.org/Login.
- Groups, entities and atypical providers should use the Division of TennCare’s provider portal to verify their data:
  - Simply log in to pdms.tenncare.tn.gov/Account/Login and verify the data on each screen.
  - Click the Submit to TennCare button to submit your revalidation for review.

If a provider, group or entity doesn’t complete their re-validation within the required timeframe, the Division of TennCare will terminate their TennCare Medicaid ID. If this happens, the provider’s BlueCare, TennCareSelect and CoverKids contracts may also be terminated, and they’ll need to re-credential before they can care for patients with BlueCare Tennessee coverage.

If you have questions about the re-validation process, please email Provider.Registration@tn.gov or call the TennCare Provider Services Call Center at 1-800-342-3145 between 8 a.m. and 3 p.m. CT, Monday through Friday. You can also find additional information on the Division of TennCare’s Provider Registration page.
Medicare Advantage

This information applies to our BlueAdvantage and BlueEssential plans.

**Medicare Advantage Routine Foot Care**

As a reminder, our Medicare Advantage plans covers 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). Reviewing this information ensures proper billing and coverage determinations when treating Medicare Advantage plan members.

**Changes to Medicare Inpatient Only List**

CMS has made its annual changes to the Medicare Inpatient Only List. These changes impact how authorization requests are reviewed starting in 2020 for our Medicare Advantage plan hospital inpatient DRG approvals. This is because there must be a specific medical need for inpatient services pre-operatively to get acute inpatient DRG coverage.

**New Prior Authorization Forms Available Jan. 1, 2020**

More specific prior authorization forms are now available in the Medicare Advantage section of the provider website under Utilization Management. 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)

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

**Reminder: Radiation Therapy Including Proton Beam Therapy Requires Prior Authorization**

As a reminder, our Medicare Advantage plans require prior authorization for proton beam therapy, as well as for other types of radiation therapy. To avoid claim payment denials, please be sure to get prior authorization before starting these types of services for our Medicare Advantage plan members.

**Provider Assessment Form Reimbursement for 2020**

In 2020, you’ll again be eligible to get paid for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage and BlueEssential members.

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

To be reimbursed, please submit the completed form through Availity or fax a completed form to 1-877-922-2963. The form should also be included in your patient’s chart as part of their permanent record. For directions on uploading the PAF, see the Quality Care Rewards section of this newsletter. You don’t need to wait 365 days between PAF submissions as the benefit is each calendar year. For additional information about the PAF, please visit the Quality section on our provider website.
Criteria for Medicare Advantage Medical Necessity Provider Appeals

Per the Provider Administration Manual, please send medical necessity provider appeals through the postal service. You also may fax your submissions. To qualify as a provider appeal, the service must have already been rendered and denied.

Your information must:
- Indicate that it’s a provider appeal and not a reconsideration
- Be legible
- Be submitted within 60 days of the date the original claim was denied (the date the denial letter was sent)
- Have pages in chronological order
- Clearly state what is being appealed

We prefer this documentation:
- Physician orders
- Daily physician progress notes from all specialties, including consultations
- Pertinent lab results if not found in physician progress notes
- Procedure notes and diagnostic test results, if not found in progress notes
- Discharge summary
- History and physical
- PT/OT/ST notes
- Case management notes that specifically address discharge needs and disposition
- Entire medication administration record (MAR)

Documents that aren’t needed for medical necessity provider appeals.*
- Face sheet
- Billing information
- Coding summary
- Nursing assessments

*Normally we don’t need these unless there is something found in these sources not found in the physician documentation.
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:

5-digits 4-digits 2-digits
NDC: 01234 – 5285 – 02

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.
Tips for billing with NDCs (continued):

<table>
<thead>
<tr>
<th>PACKAGE NDC</th>
<th>ADDED ZEROES (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.

**Medication Therapy Management for Our Medicare Advantage Plan Members**

Many of your patients enrolled in our Medicare Advantage plans may be eligible for the free Medication Therapy Management (MTM) Program. Those eligible for the program must have multiple chronic conditions, take multiple medications and spend more on Part D than a CMS-designated threshold. The MTM program empowers people to manage their chronic conditions through a better understanding of their medication regimen. This year, we’re concentrating with CSS Health pharmacists to provide the MTM program for our members. This program is often underutilized but can be a huge benefit to your eligible patients, especially those in vulnerable populations. For more information, please visit the MTM page on our website.

**Update: BlueCare Tennessee Specialty Pharmacy Billing Change Delayed**

In the October and November 2019 BlueAlert newsletters, we announced that starting Jan. 1, 2020, we would only accept BlueCare, TennCare Select and CoverKids claims for provider-administered specialty pharmacy drugs from specialty pharmacy providers. However, we’ve delayed the implementation date for this change. Providers who administer specialty pharmacy drugs may continue to bill us for the costs of the drugs, in addition to receiving reimbursement for administration.

We do plan to make some changes to our billing process for specialty pharmacy drugs in the future. When we finalize our plans, we’ll be sure to notify you ahead of time.

Our relationship with you is important to us, so we apologize for any confusion this may cause. If you have any questions, please contact your provider network manager.

**New Pharmacy Benefits Manager for BlueCare and TennCare Select Members**

On Jan. 1, 2020, the Division of TennCare’s pharmacy benefits manager changed from Magellan Health Services to Optum Rx. Please note this change doesn’t affect your patients’ pharmacy benefits – it only impacts the company that manages the TennCare Pharmacy Program and processes the TennCare pharmacy claims.

The Division of TennCare notified your patients covered by BlueCare Tennessee about this change and sent them new pharmacy cards. If your patients haven’t received their ID cards yet, please let them know they can still fill their prescriptions at the pharmacy.

If you have questions about your patients’ pharmacy benefits or a prior authorization, please call Optum Rx at the appropriate number below:

- **Optum Rx Technical Call Center (Pharmacy Help Desk)** – 1-866-434-5520
- **Optum Rx Clinical Call Center (Prior Authorizations)** – 1-866-434-5524

For more information about the TennCare Pharmacy Program, please visit the Division of TennCare’s Pharmacy page.

**Note:** The TennCare Pharmacy Program doesn’t apply to CoverKids members.
Simple Tips to Improve Quality Care for Patients

When patients are trying to understand medical conditions and recommended treatments, they can sometimes feel overwhelmed by the information they’re receiving. This can sometimes affect whether their treatment is successful. Here are some easy tips that can help you make sure your patients are getting the information they need.

1. **Explain things in ways that are easy to understand.**
   When talking with patients about a medical condition or treatment plan, try to avoid medical jargon. Consider using shared decision-making tools to help patients learn more about their conditions and options for treatment.

2. **Make eye contact with your patients, and spend time listening carefully to them.**
   Ask your patients or their caregivers if they have concerns, as well as questions. The National Institutes of Health (NIH) recommends asking open-ended questions that require patients to reveal more than a simple yes or no. Additionally, talk with them about the care they receive from other providers to make sure they understand all of the information they’re receiving about their treatment plan.

3. **Be as respectful as possible about patients’ thoughts and beliefs, and try to continue conversations at the next visit if they refuse care.**
   For example, if parents don’t want their child to receive a needed vaccination, work with them to find one action item that you can agree upon, like scheduling a follow-up appointment.

4. **Use the teach-back method, which involves asking patients to explain what they need to do in their own words.**
   According to the NIH, this technique lets you see if patients need additional information or if they understand the information you presented.
Quality Care Rewards Application UPDATES: End of January 2020
Provider Assessment Form (PAF)/ Patient Assessment and Care Planning Form (PACF) Upload

The PAF and PACF upload functionality for Medicare Advantage and BlueCare Plus value-based contracting (VBC) will now allow you to upload an assessment that you normally would have faxed.

Users with access to these programs can now follow the steps below to upload these forms.

Note: the screens shown are still in development. The final version could be different.

Because we’re making this change, we’ve removed the PAF/PACF Tab on the Member Page. As well, please note that if a member is in the Medicare Advantage or BlueCare Plus VBC program, there will be two frames for their prior year and current year assessments.

1. Go to the Member Page

2. To upload, drag and drop the file into the box for the measurement year pictured below or click the link to browse. The file type can be a PDF, rich text file (rtf) or Word document. The maximum file size should be 2MB.
3. **Next, please do the following:**
   - Enter Date of Service – assessment completed with member
   - Enter Attesting provider NPI
   - Display Provider Name
   - Check the file name to make sure it’s correct. If it isn’t, you can delete it and start over.
   - Click Cancel or Save Upload

---

**Upload**

**Please enter the date of service**

07/07/2019

**Please enter the NPI to search for attesting provider:**

123456789

Must be nine digits

**Attesting Provider:**

Hall, John B.

**Uploaded File**

filename_date.pdf

Wrong file? Delete this file and upload a new one.

[Cancel] [Save Upload]
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 TennCare Select. 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. *Changes will be included in the next provider administration manual update as applicable.

**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 p.m. (ET)</td>
<td></td>
</tr>
<tr>
<td><strong>BlueCare</strong></td>
<td>1-800-468-9736</td>
</tr>
<tr>
<td><strong>TennCare Select</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 SM</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>
<td></td>
</tr>
<tr>
<td><strong>BlueCard</strong></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><a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
</tr>
<tr>
<td>Phone: Select Option 2 at (423) 535-5717</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET)</td>
<td></td>
</tr>
<tr>
<td>Friday, 9 a.m. to 6 p.m. (ET)</td>
<td></td>
</tr>
</tbody>
</table>

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

**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.