Health Insurance Marketplace
The Health Insurance Marketplace is open

While the Health Insurance Marketplace technically opened for business on Oct. 1, shopping for coverage hasn’t been without glitches. As the federal government continues to improve the functionality of the online experience, one thing remains clear – interest in coverage through the Marketplace remains high.

We are ready – and we want to help you feel as prepared as possible as well. In the coming weeks, BlueCross BlueShield of Tennessee will share key insights and information about specific elements of the Marketplace that we hope will benefit you and your patients. We’ll share what we know about financial assistance, what types of plans are available to consumers, how to identify a Marketplace member, how to verify benefits and eligibility and much more.

Importantly, we want to hear from you. Please contact us at bcbstexchange@bcbst.com with your comments or questions.

As always, thank you for your valued partnership. We look forward to working with you to help many thousands of Tennesseans gain health coverage.

Educational resources for your patients
You can help direct your patients to information and resources that may help them find affordable and comprehensive coverage. Our website, www.bcbst.com/knownow, is a great place to start.

BlueCross BlueShield of Tennessee, Inc. (BCBST) (Applies to all lines of business unless stated otherwise)

CLINICAL
Medical Policy updates/changes
The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the “Upcoming Medical Policies” link.

Effective Dec. 14, 2013
➢ Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies
➢ Laser Therapy for Miscellaneous Applications
➢ Genetic Testing for Lactase Insufficiency
➢ Radioembolization for Primary Tumors of the Liver and Metastatic Tumors to the Liver
➢ Myocardial Sympathetic Innervation Imaging for Individuals with Heart Failure
➢ Genetic Testing for Statin-Induced Myopathy
➢ Non Invasive Ventilator (Home Use)

Effective Feb. 12, 2014
➢ Denosumab

Note: These effective dates also apply to BlueCare/TennCare Select pending State approval.

Clinical Practice Guidelines adopted October 2013
BlueCross BlueShield of Tennessee has adopted the following guidelines as practice resources:

Treatment of Patients with Panic Disorder, Second Edition


Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder
<http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PHS0890856709621821.pdf>

Hyperlinks to these guidelines are also available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company website at http://www.bcbst.com/providers/hcpr/. Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

ADMINISTRATIVE
Reminder: Physician's Guide to Patient Ratings

Patient Review of Physicians is an online review system that Blue members nationwide can use as part of their decision-making process when selecting a physician or other professional provider. This system allows Blue members to post and view reviews based on actual patient experiences through an easy-to-use, online survey and results-reporting display. BCBST has taken a number of steps to ensure that Blue patient reviews deliver valid and trustworthy data:
➢ Use of a national question set
➢ Authentication of all Blue members
➢ Validation of all Blue members writing reviews (members must verify they have seen the provider)
➢ Moderation of all open text comments - For security and privacy purposes, reviews that contain user-generated content must undergo both software and human review before the content is displayed.
**BlueCross BlueShield of Tennessee, Inc. (BCBST)**

(Appplies to all lines of business unless stated otherwise)

**ADMINISTRATIVE (Cont’d)**

**Reminder: Physician's Guide to Patient Ratings (Cont’d)**

Providers can logon to **BlueAccess** and navigate to the “Transparency Review” section and choose “Provider Ratings Review” to access a summary of all provider reviews and perform a number of provider-specific actions, such as:
- sign up for e-mail or fax alerts when new reviews are received;
- hide up to two (2) reviews; and
- post a response to a review.


Not only is **Patient Review of Physicians** a valuable tool for providing insights into your patients’ experiences, it can also attract new patients. While patient reviews are just one of many factors to consider when patients choose a health care provider, research shows that online patient reviews are one of the most sought after pieces of information for consumers. Approximately 85-90 percent of patient reviews are positive, and some physicians use them as a means to promote their practice.

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**2013-2014 Reimbursement for influenza vaccine**

The timing of flu is very unpredictable and can vary from season to season. Flu activity most commonly peaks in the U.S. in January or February. However, seasonal flu activity can begin as early as October and continue to occur as late as May. Most, but not all health care plans, cover flu immunizations with no member cost share. Some grandfathered plans may not cover flu immunizations, or may cover them subject to member cost share. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

Each year the formulation of the “seasonal flu vaccine” is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control (CDC). This vaccine contains different “strains” of flu expected to be active for that year. The following influenza immunization guidelines apply for BlueCross BlueShield of Tennessee.

### Commercial

- **Vaccine and administration**
  - The influenza vaccine, including intradermal and nasal administered, are covered if offered under the member’s health care plan.

- **BlueCare or TennCareSelect**
  - **Vaccine and administration** Covered.
  - **Nasal administered vaccine** (recommended for healthy individuals ages 2-49) Covered.
    - **Note**: The nasal administered vaccine is available under the Vaccines for Children (VFC) Program for children ages 5 through 18 years.
  - **Intradermal administered vaccine** (recommended for persons 18 through 64 years of age)

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### Specialty pharmacy network changes

In August of 2013 BlueCross BlueShield of Tennessee added BioPlus Specialty Pharmacy, Amerita, Inc and CoramRx to our specialty pharmacy network. Beginning Jan. 1, 2014, the Caremark Specialty Pharmacies along with the Walgreens specialty pharmacies will no longer participate in the BlueCross specialty pharmacy network.

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**Reminder: Appropriate billing for external insulin pumps**

Effective Apr. 1, 2007, regardless of the date of service, and in accordance with the standard transactions and code set requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), BlueCross BlueShield of Tennessee began disallowing external insulin pump supplies billed with HCPCS codes A4230, A4231 and A4232.

To avoid delays in payment, providers are encouraged to refer to the billing guidelines for durable medical equipment in the Commercial and BlueCare Tennessee provider administration manuals and in the Active Medical Policies and Articles for External Infusion Pumps located online at [http://www.cgsmedicare.com/jc/pubs/news/2011/0601/cope15146.html](http://www.cgsmedicare.com/jc/pubs/news/2011/0601/cope15146.html).

**Note**: Per BlueCross BlueShield of Tennessee general billing guidelines, claims filed for external insulin pump supplies require the use of span dates. Failure to report span dates will result in claims payment delays.

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**Reminder: Recovery of overpayments**

BlueCross will issue notification when an overpayment is identified. The overpayment to physicians and ancillary providers will be recovered through an offset to their remittance advice, 45 days from the date of the overpayment notification letter. The 45 days is granted to allow these provider types to review their records and determine whether they agree with BlueCross’ overpayment determination. Providers who feel the audit decision is incorrect should follow the Provider Dispute Resolution Process (PDRP) by submitting their request within 30 days from the date of the notification letter. Information related to the PDRP is available on the company website, [www.bcbst.com](http://www.bcbst.com).

Providers, including facilities, should not send reimbursement by check to Blue Cross.

If you have questions, contact your local Network Manager or call the Provider Service line†.

**Note**: The Federal Employee Program (FEP) requires 90 days from the date of the notification of overpayment letter until the payment is recovered.

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*These changes will be included in the appropriate 4Q 2013 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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**ADMINISTRATIVE (Cont’d)**

**Electronic remittance advice changes (ANSI 835)**

Due to federal regulations related to the Affordable Care Act, BlueCross will soon be making changes to many of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes used in your electronic remits. These changes will more accurately and consistently portray adjudication results and will bring alignment among payers in a common usage requirement. To read more about these changes, please visit http://www.caqh.org/ORMmandate_EFT.php. If you have any questions about how these changes may impact your posting processes, please contact eBusiness Technical Support†.

**State of Tennessee**

**ADMINISTRATIVE**

**Prior authorization changes**

Effective Oct. 1, 2013, the State of Tennessee employee group 80860 will follow the BlueCross standard prior authorization list requirements as indicated in the Blue Cross BlueShield of Tennessee Provider Administration Manual.

**BlueCare/TennCareSelect**

**ADMINISTRATIVE**

**Update: Primary care provider (PCP) enhanced payments**

Effective Jan. 1, 2013, qualified PCPs, as detailed by CMS regulation, are to receive a rate increase effective until Dec. 31, 2014. This rate increase is also referred to as the “PCP Bump”. This rate increase also includes payments for services furnished by PCPs under the Vaccines for Children program. Payments to PCPs are being made to designated providers for current claims from Managed Care Contractors. Managed Care Organizations are also beginning the process of making retroactive rate adjustments for qualified providers. Increased payment for physician crossover services from TennCare will begin once required system changes are complete. Physician crossover payments related to these rate increases are currently targeted for January 2014 and will include retroactive payments for eligible providers for eligible services back to January 2013.

BlueCare claims that were received prior to Aug. 1, 2013, are being adjusted to reflect the enhanced reimbursement rates for qualified providers. On Sept. 27, 2013, we began running a program to systematically adjust the claims to reflect the correct rate. These batches were run on a nightly basis through the middle of October. Some of the claims pended for manual adjustment and these manual adjustments should be completed by the end of the year if not sooner. Payments will appear on providers’ weekly remittance advice as they are adjusted.


**Durable medical equipment/prosthetic and orthotic supply (DMEPOS) orders and requests**

Prior authorization and/or review of medical necessity may be required before DMEPOS services or supplies can be received by your patients. Providing this information to the DMEPOS supplier at the time of the request will prevent delays in service or supplies for your patients.

The supplier must submit the following on your patient’s behalf:
- Current physician’s order (within the last 12 months)
- Physician office notes supporting the request

Prior authorization is required before services are rendered. Services rendered more than 72 hours before submission of an authorization will be denied non-compliant.

A list of items that do not require prior authorization is available on the company website at <http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf>. The following hierarchy is followed when reviewing DMEPOS requests.

1. TennCare Exclusions
2. TennCare Medical Necessity Rules (available at http://state.tn.us/sos/rules/tenncare.htm)
3. Medicare Guidelines (including national and local coverage determinations)

**BlueCare Plus**

**ADMINISTRATIVE**

**BlueCare Plus HMO D-SNP**

Effective Jan. 1, 2014, BlueCare Plus is offering a new Dual Special Needs Plan (D-SNP) to help improve the coordination of care for Medicare and Medicaid enrollees. Member enrollment began Oct. 1, 2013. This Medicare Advantage HMO plan is managed by BlueCare Plus and enrolls dual-eligible members only. BlueCare Plus offers a Model of Care that provides the structure for delivering care management and services to the dual-eligible members with special health care needs.

Providers with questions regarding BlueCare Plus D-SNP may contact their local Network Manager, visit the Provider page on the BlueCare Plus website at http://bluecareplus.bcbst.com or call our Provider Service line at 1-800 299-1407.

**BlueCard**

**ADMINISTRATIVE**

**Reminder: Electronic Provider Access improves prior authorization review process**

Effective Jan. 1, 2014, a new tool, Electronic Provider Access (EPA), makes it easier for providers to conduct prior authorization reviews for out-of-state members electronically. Currently, providers who want to conduct prior authorization review for out-of-state members generally have to call the member’s Home Plan directly for authorization or call 1-800-676-BLUE. EPA will be added to the current...
**BlueCard**

**Administrative (Cont’d)**

Reminder: Electronic Provider Access improves prior authorization review process (Cont’d)

BlueCard/FEP application (currently used for out-of-state eligibility and claim status) in BlueAccess. This will allow providers to enter the alpha prefix from the member’s ID card and be automatically routed to that plan’s homepage to conduct prior authorizations. If no electronic option is available for that plan, providers will be given specific instructions on how to obtain an authorization.


If you have any questions about this process, please contact eBusiness Technical Support.

**BlueAdvantageSM**

**Administrative**

Verisk Health, Inc. risk adjustment chart collection

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to confirm diagnoses or ICD-9 codes submitted via claims are supported in the medical records. BlueCross BlueShield of Tennessee is pleased to announce Verisk Health, Inc. has been selected to gather medical records on its behalf and on behalf of BlueCross BlueShield out-of-state plans. BlueCross will use Verisk Health to retrieve medical records for us and out-of-state Blue’s plans to support HEDIS, risk adjustment and government required programs related to the Affordable Care Act.

Verisk will provide an efficient centralized process to coordinate medical record requests from BlueCross BlueShield across the country and help reduce multiple requests for patient data.

For your convenience medical records may be submitted to Verisk in the following ways:

- Via uploading the record’s image to our secure portal at [https://www.submitrecords.com](https://www.submitrecords.com). Simply enter your secure password: secure897 and select the files to be uploaded using the file naming convention that is included in your request letter
- Via secure fax to 1-888-205-0196

**Cover Tennessee**

**Administrative**

Reminder: Upcoming changes to Cover Tennessee program

As a result of State of Tennessee budget reductions and changes due to the new federal health care law, changes are being made to the Cover Tennessee Programs during the coming months. Members have been notified of these changes via letter. The letters are available on the company website at [http://www.bcbst.com/health-plans/cover-tennessee/](http://www.bcbst.com/health-plans/cover-tennessee/). The following are some changes to both the CoverKids and the CoverTN programs.

**CoverKids**

Effective Oct. 1, 2013, CoverKids and HealthyTNBabies members began being served through the TennCareSelect Network of providers.

- Member benefits remain the same.
- Value Options will administer behavioral health benefits.
- Reimbursement for pregnant women in their second or third trimester will be based on contracted Network S rates.
- National Drug Code (NDC) is required for all charges for provider administered drugs.
- “CoverKids” will appear on the top right corner of the member ID card. The network name (TennCareSelect) will appear in the bottom left corner.

Also, beginning Jan. 1, 2014, CoverKids will no longer offer the buy-in program to families with incomes over 250 percent of the federal poverty level.

**CoverTN**

Because the federal health law will no longer allow health plans with annual caps, effective Jan. 1, 2014, CoverTN coverage will no longer be available. These members are being notified via letter, which will also be available on the company website. These members are being advised that they may obtain coverage through an employer group or through the new Health Insurance Marketplace.

Providers with questions may call Provider Service at 1-800-924-7141.

*These changes will be included in the appropriate 4Q 2013 provider administration manual update. Until then, please use this communication to update your provider administration manual.

**Provider Service lines**

**Featuring “Touchtone” or “Voice Activated” Responses**

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the “touchtone” option or just say “Network Contracts or Credentialing” when prompted, to easily update your information.

**Commercial Lines** 1-800-924-7141

*(includes CoverTN; CoverKids & AccessTN)*

**Operation Hours**

Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**Medical Management Hours**

Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueCare** 1-800-468-9736

**TennCareSelect** 1-800-276-1978

**CHOICES** 1-888-747-8955

**SelectCommunity** 1-800-292-8196

**BlueCare/TennCareSelect Medical Management Hours**

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 5:15 p.m. (ET)

**BlueAdvantage** 1-800-841-7434
Monday – Friday, 8 a.m. to 5 p.m. (ET)

eBusiness Technical Support

Phone: Select Option 2 at 423-535-5717

E-mail: eBusiness_service@bcbst.com

Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

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