BlueCross BlueShield of Tennessee, Inc.  
(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 Sept. 14, 2014

- Donor Lymphocyte Infusion for Hematologic Malignancies

Note: These effective dates also apply to BlueCareSM/TennCareSelect pending State approval.

Medical Policy Reminder: Please remember to utilize the following policy: <First-Trimester Detection of Down Syndrome Using Fetal Ultrasound Markers Combined with Maternal Serum Assessment>.

ADMINISTRATIVE

All Blue 2014 Provider Workshops… Coming Soon to a City Near You!

The annual state-wide All Blue Workshops are designed to simplify your day-to-day interactions with us. At the workshops, provider staff can talk with BlueCross professionals who will share important information on current issues. While you are there, visit our Resource Centers and take advantage of one-on-one discussions with BlueCross representatives.

Watch for your invitation in the mail! For additional information including dates, times, locations and easy online registration, please visit our website at www.bcbst.com/providers/workshops.

Get Ready to Get Paid

Why perform ICD-10 testing now?

BlueCross is offering free online testing tools to assist providers in preparing for the ICD-10 coding change. The tools provide a way for you to use your clinical and coding knowledge and test it against the new coding regulations.

Test now to take advantage of the opportunity to identify possible areas of improvement. Testing now also provides time to ensure you are prepared, to mitigate issues and, of course, to get paid accurately after the transition date.

Go to our website for more information on the testing process and other ICD-10 resources to assist in your successful transition to ICD-10. <http://www.bcbst.com/providers/icd-10.page>

For questions regarding ICD-10 or testing, email us at ICD10_GM@bcbst.com.

Enhanced phone features allow providers to check status of prior authorization requests

The fastest way to get a prior authorization request reviewed and approved is by submitting the request online at bcbst.com in the secure BlueAccessSM portal. Many requests submitted online are approved automatically – with no wait time.

Some providers prefer to call our automated phone system to gain authorization requests or check on the status of a request. Those providers may notice a few changes to the process. Being prepared with key details up front will help ensure you get the information you need quickly.

When using the automated phone system for prior authorizations, you will be asked to enter your provider ID number, a phone number, the member’s ID number, and the member’s date of birth. If you are calling about a new
You can now check the status of a prior authorization through our automated system as well. Again, you will need to enter your provider ID number, a phone number, the member’s ID number, the member’s date of birth and the reference number for the original authorization request.

If necessary, you will be transferred to a representative who will assist you with the request.

Remember, entering this same information online through BlueAccess will provide you with a much faster response or approval from BlueCross. Get started today at www.bcbs.com/providers.

**Reminder: Group NPI Requirements**

In the May 2013 *BlueAlert*, BlueCross advised of upcoming changes to professional claims editing that would reject claims not following ANSI 5010 standard for group NPI submissions: “The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity.”

BlueCross is currently targeting Sept. 1, 2014, to enable electronic editing that will reject any claims being filed with incorrect billing provider NPI information per this rule. If you have not already done so, please take this opportunity to engage with your vendors and clearinghouses on any necessary changes you may need to make to help ensure your claims will not be rejected so your revenue cycle will not be impacted. For questions on these changes, please contact eBusiness Technical Support†.

**Tennessee Health Care Innovation Initiative**

The State of Tennessee launched the Tennessee Health Care Innovation Initiative in May 2014. This initiative is meant to help transform the payment system from fee-for-service to value-based models of care. BlueCross BlueShield of Tennessee posted the first round of reports for asthma exacerbation, perinatal and total joint replacement (hip and knee) to principal accountable providers (or quarterbacks) in the BlueAccess secure portal on May 12, 2014.

New reports for asthma exacerbation, perinatal and total joint replacement (hip and knee) for dates of service calendar year 2013 will be available in BlueAccess during the first week of August, 2014. These reports are still within the six-month period where there will be no change in reimbursement.

Lines of business included in these episodes are State of Tennessee, BlueCare, TennCare Select, Commercial, CoverKids and fully-insured.

If you have any questions related to these reports, please contact our Provider Service Line at 1-800-924-7141 and choose Option 4.

**Quality Interactions® - A new round of valuable training courses for ALL lines of business**

Due to overwhelmingly positive responses from our provider network, BlueCross BlueShield of Tennessee is offering an additional opportunity to experience Quality Interactions, a program designed to help health care providers treat an increasingly diverse patient population. Developed by the Manhattan Cross Cultural Group, Quality Interactions programs are available for physicians, nurses, and non-clinical staff.

Quality Interactions is based on the conceptual framework that personal accounts are the most effective source in obtaining information for true cultural perspectives. Rather than deploying pre-conceived assumptions about various cultural groups, Quality Interactions teaches a set of concepts and skills that assist in working successfully in cross-cultural situations.

Participants will improve their ability to:

- Respect and value cultural diversity
- Communicate clearly in cross-cultural interactions
- Understand and explore cultural differences
- Effectively engage an individual in a cross-cultural interaction

The training program uses a case-based format supported by evidence-based medicine and peer-reviewed literature. It is accredited for up to 2.5 hours of CME, CEU, or CCM credits.

There is no cost to BlueCross BlueShield of Tennessee and BlueCare Tennessee providers. A limited number of licenses are available for these courses, so please register quickly to take advantage of this valuable learning opportunity. The deadline is Dec. 31, 2014.

To register, please visit the Provider page of the company website, bcbs.com and click on the “Quality Interactions Cross Cultural Training” link which will provide instructions to register for the class. The BlueCross organizational code is 88750.

The training course offers a great way to get valuable professional credits, at no cost, and to gain useful knowledge to work with the culturally diverse population of Tennessee.
Reminder: Commercial prior authorization requirements

As of June 30, 2014, hyperbaric treatments require prior authorization for commercial plans in an inpatient or outpatient setting. A listing of specific services that require prior authorization is available on our company website at <http://www.bcbs.com/providers/utilization-management-resources.page>.

Remember, you can submit authorization requests through BlueAccess. Please contact your eBusiness Marketing Consultant for all of your BlueAccess registration and training needs †.

Contact information to request prior authorization:
Behavioral Health
1-800-888-3773
Diagnostic Imaging/Radiology
1-888-693-3211
Durable Medical Equipment
1-866-558-0789
Medical & Surgical
1-800-924-7141
Musculoskeletal Management
1-800-388-8978

Reminder: Multi-page claims

When filing claims with multiple pages on a CMS-1500 claim form, please remember:
- Staple each page of the multi-page claim together. (This will help us identify multi-page claims.)
- Staple only the pages of the individual claim together as one. Do not staple several multi-page claims together as one.

This information can be found in the Billing and Reimbursement section of the provider administration manuals.

- List diagnosis code(s) for all conditions related to the patient’s illness on each page.
- Place the total amount only on the last page of the claim. The total on the last page should reflect the sum of the line items for all pages.
- Use the words “Continued on the next page” or “Page X of X”) in Block 28 on each page (except on the last page, which reflects the total charge in Block 28).
- Connect them to follow-up care, which can be easily done by faxing a referral to the Tennessee Tobacco QuitLine, 1-800-646-1103.

Physicians may receive reimbursement for tobacco counseling lasting three to 10 minutes and additional reimbursement for counseling lasting longer than 10 minutes (see codes 99406, 99407, G0436, G0437).

Tobacco cessation: What every clinician should know

Given the many deaths caused by smoking, clinicians should offer evidence-based treatment to every patient who uses tobacco which includes asking patients about tobacco use at every visit and offering a combination of counseling and medication to support patients in quitting. An estimated 85 to 90 percent of Chronic Obstructive Pulmonary Disease (COPD) deaths are caused by smoking.

The Centers for Medicare & Medicaid Services guidelines for meaningful use of electronic health records (EHR) systems now require documentation of every patient’s tobacco use status, as well as evidence that patients who smoke are being offered counseling and/or medication.

Because clinic and physician reimbursement are tied to compliance with these guidelines, larger numbers of patients should be offered cessation counseling. Practitioners can encourage cessation efforts by implementing a three-minute, evidenced-based assessment:
- Ask patients about their tobacco use at every visit;
- Discuss the benefits of quitting and encourage the use of nicotine replacement therapy when appropriate; and

- Smoking cessation is the most effective way of preventing or slowing the progression of COPD and other tobacco-associated diseases. Tobacco cessation saves lives and increases quality of life.


BlueCare Tennessee

ADMINISTRATIVE

This information applies to BlueCare and TennCareSelect plans, excluding dual-eligible BlueCare PlusSM (DSNP) unless stated otherwise

TENNderCare Medical Record Documentation Requirements-
COMPREHENSIVE PHYSICALS

In accordance with their periodicity guidelines, the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care requires evidence of a comprehensive unclothed/suitably draped physical examination in a TennCare-eligible child’s medical record.

All required components of the physical exam should be performed and documented in the medical record with the date of the exam. If the child is uncooperative or the examination was deferred/refused, be sure to include this information in the medical record.
BlueCard
ADMINISTRATIVE

Quick tips for a smooth out-of-area claims experience

At BlueCross BlueShield of Tennessee we strive to process claims quickly and accurately. Did you know that you can make a difference in how quickly claims are processed?

Following these helpful tips will improve your claims payment experience:

- Include the member’s complete identification number when you submit the claim. This includes the three-character alpha prefix.
- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). While new identification numbers can be issued at any time during the year, January and July are especially heavy months for this activity. Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at www.bcbst.com or by calling 1-800-676-BLUE (2583). Be sure to provide the member’s alpha prefix.
- Verify the member’s cost sharing amount before collecting payment. Please do not collect full payment up front.
- Indicate on the claim any payment you collected from the member. In cases where there is more than one payer and a Blue Cross and/or Blue Shield Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claim status by submitting an electronic HIPAA 276 transaction (claim status request) to BlueCross BlueShield of Tennessee or by contacting us at 1-800-705-0391.
- If you have any questions about claims filing for Blue members, refer to BlueCross BlueShield of Tennessee Provider Administration Manual or:
  • Talk to your Provider Relations Consultant
  • Visit us online at: [http://www.bcbst.com/provider/bluecard/](http://www.bcbst.com/provider/bluecard/)
  • Contact us at 1-800-705-0391†

Medicare Advantage
ADMINISTRATIVE

This information applies to
BlueAdvantage HMO/PPO plans, excluding dual-eligible BlueCare PlusSM (DSNP) unless stated otherwise

Reminder: Beginning Sept. 1, 2014, BlueAdvantage (PPO) and BlueChoice (HMO) programs will introduce several care management programs for members in acute inpatient care settings.

Reminder: Medicare Advantage Readmission Reduction Program

In conjunction with the Centers for Medicare & Medicaid Services’ (CMS) Hospital Readmissions Reduction Program, beginning Sept. 1, 2014, BlueCross Medicare Advantage Plans will reimburse for readmissions to acute care hospitals that occur within 31 days from the index admission discharge as follows:

Prior authorization update for allergy testing

As of Sept. 1, 2014, the following allergy testing codes will no longer require prior authorization for BlueCare Tennessee members:
- 95017
- 95018
- 95076
- 95079

Reminder: Billing Vaccines for Children codes with modifier 32

Modifier 32 should only be used when notification is received from the Centers for Disease Control and Prevention (CDC), Vaccines for Children (VFC), or the Bureau of TennCare stating that there is a shortage of the vaccine. Providers who normally receive influenza vaccine through the VFC program may use their purchased supply when this happens and submit claims using a Modifier 32 to receive fee for service reimbursement. If your VFC supply becomes low, and no official shortage has been communicated, be sure to order sooner to restock instead of using your private stock.

A same or similar diagnosis readmission occurring within three (3) to 31 days from a complication of the original hospital stay or admission resulting from a modifiable cause relating to the acute care facility’s discharge diagnosis to the same or similar facility, or facility operating under the same contract, is not eligible for two DRG inpatient payments. The facility will be reimbursed for a single inpatient DRG (the higher weighted of the two admissions) only. All other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for Medical Necessity.

A same or similar diagnosis readmission that occurs within 48 hours of an acute care hospital discharge from the same or similar facility, or facility operating under the same contract, will not be reimbursed regardless of the length of stay. CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the member not being clinically stable at the time of the original discharge.

BlueCross readmission guidelines have been developed to be less stringent than the Readmission Reduction Program guidelines for original Medicare by not penalizing a facility for all diagnoses that could lead to a readmission or adjusting all Medicare payments, but rather applies the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the individual member that is readmitted. The goal of this program is to engage providers and facilities in addressing transition of care options. CMS considers 31 day readmissions to be an indicator of quality of care.

**Reminder: Medicare Advantage Inpatient Level of Care Management Program**

Starting **Sept. 1, 2014**, and consistent with the criteria in MCG (formerly Milliman Care Guidelines®), BlueCross BlueShield of Tennessee will reimburse for higher acuity level of care beds (critical care level of care) during acute inpatient hospitalizations as follows:

- CMS will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with a higher acuity level of care bed and nursing care. This review is performed by a Plan Medical Director.
  - If criteria are not met, then the day may be approved as Medically Necessary, but the intensity of care will be reimbursed at an acute level of care rather than critical care level of care.
  - This review can occur during any portion of the hospitalization, including during the initial Diagnosis Related Group (DRG) period.

**Note:**
1. The Member cannot be held liable for payment of services received when not approved.
2. Standard facility appeal remedies are applicable.

**Reminder: Inpatient DRG Day Outlier Management Program**

Beginning **Sept. 1, 2014**, and consistent with the criteria in MCG, BlueCross BlueShield of Tennessee will reimburse acute inpatient hospitalization days outside of the initial DRG day approval as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur during the time period after which the DRG days have elapsed, and are subject to the facility providing concurrent clinical information for review as contractually required.

- If clinical information is requested three (3) times using at least two (2) different notification methods, then the days will be denied for a lack of clinical information necessary to establish ongoing Medical Necessity. In situations where no clinical information has been provided for the days in question, these denied days will not be eligible for reconsideration review or peer to peer discussion and the facility can follow standard facility appeal remedies.

The member cannot be held liable for payment of services received when not approved.

**Reminder: Revenue Code 510 Hospital-Based clinic services**

Effective **Oct. 1, 2014**, and consistent with reimbursement guidelines of other payers as well as current BlueCross
BlueShield of Tennessee Commercial and BlueCare Tennessee contracts, Medicare Advantage will no longer reimburse for charges under revenue code 510 (hospital-based clinic setting as defined in 42 CFR 410.2) when provided in conjunction with an E&M professional service charge.

their case managers - produced impressive outcomes. In a number of cases, practitioners confirmed that as a result of screenings, serious medical conditions were identified in time to successfully initiate treatment.

BlueCare Tennessee partners with Million Hearts® in preventive campaign

BlueCare Tennessee has partnered with Million Hearts®, a national initiative that was launched by the Department of Health and Human Services to prevent one million heart attacks and strokes by 2017. As part of its commitment to help Million Hearts® reach its goal, BlueCare Tennessee will:


(2) Help find those at risk of heart attacks and stroke by implementing a member outreach campaign places preventive reminder calls to members identified with gaps in care. A postcard reminder will be mailed to members who are not reached telephonically.

(3) Implement a campaign to promote smoking cessation to BlueCare Tennessee adult members who smoke or use smokeless tobacco products. Members will receive messages on targeted topics including available options to quit smoking and improve member health outcomes. BlueCare Tennessee will identify members who have stopped taking smoking cessation agents and these members will be contacted and encouraged to resume treatment and/or discuss other smoking cessation options.

As a health care provider, you play a key role in helping patients reduce their risk for heart disease and stroke and lead longer, healthier lives.

Archived editions of BlueAlert are available online at <http://www.bcbst.com/providers/newsletters.shtml>.

*These changes will be included in the appropriate 3Q 2014 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)
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
BlueCare PlusSM 1-800-299-1407
BlueChoiceSM 1-866-781-3489
SelectCommunity 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 5:15 p.m. (ET)

BlueAdvantage 1-800-841-7434
Blue Advantage Group 1-800-818-0962
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)