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 Aug. 9, 2014**

- Collagenase Clostridium Histolyticum
- Gene Expression Profile Analysis for Prostate Cancer Management
- Positron Emission Tomography (PET) for Miscellaneous Applications

**Note:** These effective dates also apply to BlueCare<sup>SM</sup>/TennCareSelect pending State approval.

**Modified Utilization Management Guideline updates/changes**

BlueCross BlueShield of Tennessee’s website has been updated to reflect upcoming modifications to select Modified Utilization Management Guidelines. The Modified Utilization Management Guidelines can be viewed on the Utilization Management Web page at http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm

**Effective August 19, 2014**

**The following as relates to Ambulatory Care:**

- **Proton Beam Therapy**

**The following as relates to Home Care:**

- **Hyperemesis Gravidarum**

**The following as relates to Inpatient and Surgical Care:**

- BlueCross modifications related to Disorders of Fluid, Electrolyte, and Acid-Base Balance (ICD-9 276) will be removed.
- BlueCross modifications related to Other and ill-defined Conditions Originating in the Perinatal Period (ICD-9 779) will be removed.
- BlueCross modifications related to Prostatectomy, Laparoscopic Radical Observation goal length of stay will be removed.
- BlueCross modifications related to Radius/Ulna Fracture, Closed or Open Reduction will be removed, therefore the MCG Care Guideline will be used.
- BlueCross modifications related to Shoulder Arthroplasty will be removed, therefore the MCG Care Guideline will be used.

**Note:** Effective dates also apply to BlueCare and TennCareSelect pending state approval.

**New drugs added to commercial specialty pharmacy listing**

Beginning July 1, 2014, the following drugs have been added to our Specialty Pharmacy drug list. Those drugs requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:

- Cyramza (PA)
- Entyvio (PA)
- Sylvant (PA)

Self-administered via pharmacy benefit:

- Oralair (PA)
- Otezla (PA)
- Zykadia (PA)

Providers can obtain PA for

- Provider-administered drugs that have a valid HCPCS code by logging onto BlueAccess<sup>®,</sup> the secure area of www.bcbst.com and select Service Center from the Main menu, followed by Authorization/Advance Determination Submission. Physicians not registered with BlueAccess or needing assistance using our website should contact eBusiness Solutions†.
Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.

Self-administered specialty drugs by calling Express Scripts at 1-877-916-2271.

NOTE: BlueCross BlueShield of Tennessee updates its web authorization forms on a quarterly basis. If a HCPCS code is not available now, it may be in the near future.

ADMINISTRATIVE

ICD-10 self-help testing tools

In our ongoing effort to prepare for the transition to ICD-10 codes, BlueCross is offering an online, scenario based ICD-10 testing tools. Providers will be able to choose ICD-10 codes for a number of different scenarios based on your specialty or type of facility. Since this testing program is web based, online testing tools offer flexibility to be used anytime.

The professional provider testing tool consists of scenarios that are clinical narratives used for ICD-10 coding to detect valid and invalid codes. You can view results and compare your answers to other providers in your specialty.

The institutional provider testing tool consists of medical record numbers that represent high dollar and high volume scenarios from previously processed ICD-9 claims. Providers can recode and compare the associated claims based on ICD-10 coding guidelines.

We welcome you to take advantage of the additional time to test since the ICD-10 compliance date has been extended.

Check the ICD-10 page on our website http://www.bcbst.com/providers/icd-10.page for upcoming changes and access to the ICD-10 testing tools. For questions about the tools and to test with us, please send email to ICD10_GM@bcbst.com.

Reminder: Coding Requirements

A valid HCPCS/CPT® Code is required when billing certain revenue codes (RC) as indicated in the BlueCross BlueShield of Tennessee Provider Administration Manual. These CPT®/HCPCS Codes should always be billed on a CMS-1450 in Form Locator 44. Without the correct RC and CPT®/HCPCS Codes, BlueCross will not accept the claim for consideration of benefits. If a required CPT®/HCPCS Code is missing, the claim may be denied and/or returned to the facility for proper coding.

BlueCross uses the Uniform Billing Editor published by Optum (or its successor) Appendix 3, “Numeric List of HCPCS Codes with Recommended RC Assignments,” as a guide to determine appropriate billing services rendered.

iCES billing update

Durable medical equipment network providers for BlueCare Tennessee and CoverKids may bill for diabetic pump supplies on a monthly basis. These supplies can be on one line of the claim. Example: A4221 can now be billed with four units.

Reminder: Commercial prior authorization requirements update for hyperbaric treatments

Effective June 30, 2014, hyperbaric treatments were added to the list as requiring prior authorization for commercial plans in an inpatient or outpatient setting. The updated list is located on the company website at http://www.bcbst.com/providers/utilization-management-resources.page>.
Authorization is not a confirmation of coverage or benefits. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member’s eligibility at the time services are rendered.

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

BlueCare Tennessee

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

Reminder: TENNderCare medical record documentation requirements

Network practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care practitioner.

Clinical personnel review medical records of Primary Care Practitioners that provide preventive care to members under the age of 21 to evaluate compliance with Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) requirements and share additional education and resources. Reviews are performed every two years, but may also be requested anytime by the Clinical Risk Management Department. Reviews are conducted according to TennCare Audit Instructions-Medical Record Review Instructions that are published in the Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual unless more current published American Academy of Pediatrics (AAP) guidelines are available. The AAP manual provides detailed information for each EPSDT element and is available at http://www.tnaap.org/EPSDT/EPSDTmanual.htm.

Age appropriate elements, identification of risk factors, periodicity for procedures and immunizations should be provided at each TENNderCARE encounter based on the most current American Academy of Pediatrics Recommendations for Pediatric Health Care. Documentation should provide reasons for not performing any element, or member refusal of any or all elements of this exam. Additional information regarding EPSDT elements and documentation requirements is available in the BlueCare Tennessee Provider Administration Manual at www.bcbs.com.

Reminder: Reporting home health missed shifts

Home health agencies are reminded to notify BlueCare Tennessee of any missed shifts for hourly skilled and aide services. If missed shift is for the same day or you know in advance that a shift will be missed please report this information immediately by calling 1-800-423-0131 for BlueCare members and 1-800-711-4104 for TennCareSelect members. All other missed shifts must be reported by faxing the missed shift information to 1-423-535-5254, or 1-865-588-4663. Please remember all missed shifts should be reported within 24 hours.

If the home health agency is not able to staff a shift after normal business hours, the agency should call the BlueCare Tennessee NurseLine at one of the following numbers:

- BlueCare 1-800-468-9736
- TennCareSelect 1-800-276-1978

Additionally, home health agencies are required to notify BlueCare Tennessee in advance if aware of the following:
- Any planned missed shift
- A nurse/aide is going to be late
- The agency is unable to staff the shift

Note: It is considered a missed shift if the home health agency is authorized to provide a shift, but no services are provided for that shift. The home health agency should only submit claims for services actually rendered.

BlueCard

Prior authorization review for inpatient facility services required for out-of-state members*

Beginning July 1, 2014, all Blue Plans will require participating providers to obtain prior authorization review for out-of-state members to receive inpatient facility services. Participating providers obtaining prior authorization review for inpatient facility services should:
- Notify the appropriate Home plan within 48 hours of a change to the original prior authorization
- Notify the appropriate Home plan within 72 hours for emergency or urgent admissions

If prior authorization is required and is not obtained for inpatient facility services, the facility will be financially

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responsible for their services and the member will be held harmless.

As a reminder, Electronic Provider Access (EPA) Out-of-Area Pre-service Review is now an available tool to request an authorization from a member’s Home plan. This tool is located in the BlueCard/FEP section of BlueAccess.

For more information, please contact us at 1-800-705-0391.

Medicare Advantage ADMINISTRATIVE

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

New CMS requirement for non-covered services/supplies*

In accordance to notification from the Centers for Medicare & Medicaid Services (CMS), the Advanced Beneficiary Notice (ABN) used in the original Medicare program is not applicable to Medicare Advantage programs. Therefore, when informing a BlueAdvantage member that a service is not covered or is excluded from their health benefit plan, the decision is considered an organization determination under 42 CFR, 422.566(b) and requires the appropriate CMS notice of denial of coverage (CMS-10003). A “waiver” is no longer sufficient documentation of this notification. BlueChoice HMO or BlueAdvantage Plan network providers should request a pre-determination from BlueAdvantage on the member’s behalf before any non-covered service/supply is provided.

For additional information and to download the Denial of Coverage Notice, see the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html.

Expanded Population Health/Condition Management Program (previously Disease Mgt.)

Starting on July 7, 2014, BlueCross BlueShield of Tennessee Medicare Advantage plans are pleased to announce an expansion of our Condition Management Programs for members with:

- Diabetes
- CHF/CAD/Hypertension/High Cholesterol
- Asthma/COPD
- ESRD on Hemodialysis

These programs include information about the member’s diagnosis and health coaching to encourage compliance with your plan of care and prescription adherence. The latest techniques of motivational interviewing and readiness to change assessments are built into the health coaching models. If you have a member with one of these diagnoses and you would like to refer them for enrollment, please contact Julie Thomas, Medicare Products Case Management and Population Health Supervisor at (423) 535-6827.

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

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:

- 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 sort-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.

**Note:**
1. Members cannot be held liable for denied charges associated with a readmission within 31 days of a previous admission as indicated above.
2. Standard facility appeal remedies are applicable.

**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: 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 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.

**Inpatient DRG Day Outlier Management Program**

Starting September 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.

**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.

**Breast cancer screening: Patients say they’re waiting on you**

According to focus group results, over half of the members questioned said they wait for their doctors to tell them it is time for them to get a mammogram. Please recommend your patients have their mammograms as appropriate. As you know, early detection saves lives.

**New member engagement program available**

Join BlueCross BlueShield of Tennessee in leading your BlueAdvantage (PPO)℠ and BlueChoice (HMO)℠ patients down the path to better health with the new **My Healthpath Program** described on the company website at [http://www.bcbst.com/providers/quality-initiatives/My-Healthpath-Member-Engagement-Program.page](http://www.bcbst.com/providers/quality-initiatives/My-Healthpath-Member-Engagement-Program.page)?
Medicare Advantage Quality Care Rewards Program and Tool

On June 1, 2014, Blue Cross Blue Shield of Tennessee began a new Physician Quality Program. This program recognizes primary care physician practices that close individual patient’s quality gaps in care.

In 2014, a quality bonus payment of up to $125 per attributed patient will be paid when all of an individual patient’s quality gaps in care are closed. Your gap closure rate will be used to calculate your practice’s star rating and then be applied to your rebased fee schedule in 2015. To find out more about the Quality Care Rewards Program and for resources related to closing gaps in care, please visit the following link:

http://www.bcbst.com/providers/quality-initiatives.page

We know that data is essential to your practice in closing quality gaps in care. As such, you now have the ability to view and export gaps in care information, view financial information related to the Quality Care Rewards program and self-report data to directly close gaps in care on this site. The Medicare Advantage Provider Quality Incentive Program tool is accessible through BlueAccess at https://www.bcbst.com/secure/providers/.

Please contact your eBusiness Marketing Consultant for all of your BlueAccess registration and training needs †.

BlueCross BlueShield of Tennessee offices will be closed July 4 in observance of Independence Day.

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)