PROVIDER NEWS FLASH

June 2014

BlueAlert℠

Marketplace

Health Insurance Marketplace provider resources available

More than 134,000 Tennesseans who purchased health insurance through the Health Insurance Marketplace, or HealthCare.gov, chose BlueCross BlueShield of Tennessee plans. As part of our commitment to our members and to you, our provider partners, we have developed numerous educational materials to help explain the new benefit plans.

The "Health Care Provider Guide to the Health Insurance Marketplace" is a summary of many of the main components of the Marketplace. In addition to the series of materials we released in the months leading up to and through open enrollment, this guide addresses many of your questions and provides additional details about the Marketplace.

You may refer to an electronic copy online – along with other Marketplace educational materials – at <www.bcbst.com/providers/health-insurance-marketplace.page>. Should you have additional questions about the Marketplace, please contact your provider service representative or email us at BCBSTExchange@bcsbt.com.

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 July 12, 2014

- Genetic Testing for Dilated Cardiomyopathy (DCM)
- Intraocular Radiotherapy for Age-related Macular Degeneration (AMD)

Effective Aug. 19, 2014

- Romidepsin
- Bariatric Surgery
- Genetic Testing (CFTR Mutations) for Cystic Fibrosis

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

A reminder about acetaminophen combination drugs

The FDA is reminding health care professionals and pharmacists to stop prescribing/dispensing prescription combination drug products that contain more than 325 milligrams (mg) of acetaminophen per tablet, capsule, or other dosage unit.

These products have been voluntarily withdrawn and are no longer considered safe by the FDA. Pharmacists are recommended to contact the prescriber if they receive a prescription for a combination product with more than 325 mg of acetaminophen per dosage unit.

Best Practice for ADHD treatment

Psychopharmacological treatment is recommended by The American Academy of Child and Adolescent Psychiatry (AACAP) for members diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

- Child patients initially diagnosed with ADHD and prescribed ADHD medication should receive one follow-up visit with a prescribing practitioner within 30 days of the initial visit;
- Child patients who remain on ADHD medication should have at least two more visits with their prescribing practitioner within 270 days (nine months) following the 30-day visit.

Appropriate follow-up care for children prescribed ADHD medication is measured by the Healthcare Effectiveness Data and Information Set (HEDIS). This measure is defined as the percentage of children from ages 6-12 with newly prescribed ADHD medication who meet the above standards of care.

Other problems often co-occur with ADHD, such as: conduct problems, anxiety and depressive disorders, or substance use, which can make the diagnosis and treatment more difficult. In these instances, a referral to a behavioral health provider should be considered. If you would like assistance referring a patient for behavioral health services, please call 1-800-367-3403 for BlueCare, TennCare*Select*, CoverKids and BlueCare Plus (HMO SNP)℠; and 1-800-776-2466 for Commercial, Medicare Advantage and AccessTN.

ADMINISTRATIVE

Reminder: Physician Quality Information Portal available until June 30, 2014

The Physician Quality Information Portal on BlueAccess® will be available for physician review and self-reporting until June 30, 2014. After June 30, provider ratings will be updated to reflect the self-reported submissions. The updated provider ratings will be included in our provider directories that are available on the company website for our members.

Tennessee Health Care Innovation Initiative

The State of Tennessee is launching the Tennessee Health Care Innovation Initiative. This initiative is to begin transforming the payment system from fee-for-service to value-based models of care. To learn more about the initiative please visit the following link: http://www.tn.gov/HCFA/strategic.shtml. Tennessee insurers, including BlueCross BlueShield of Tennessee are participating in this multi-payer approach to transforming the payment system.

Part of the initiative will focus on episodes of care. With input from Tennessee clinicians and insurers, the initiative is implementing a first wave of three episodes; perinatal care, total joint replacement (hip and knee), and acute asthma exacerbations. Over time, additional episodes will be added; each developed with input from Tennessee clinicians.

For each episode of care there is a principal accountable provider, also called the quarterback. The quarterback is represented as the tax identification number (TIN) of the provider, who is in the best position to provide cost and quality care for an episode. For example, the quarterback for a perinatal episode is the TIN of the provider delivering the baby (Ob/Gyn, family practitioner, nurse midwife.) The quarterback is the TIN of the facility where the patient went to the emergency department or for an inpatient stay related to an asthma exacerbation episode. For the total joint (hip or knee) replacement the quarterback is the TIN of the surgeon.

Reports regarding the quarterback's performance within an episode of care are generated by the insurers participating in this initiative. If you are a provider with a shared TIN as the designated quarterback, but do not treat these episode types (perinatal, asthma, hip and knee replacement), you will still have access to the provider reports for that TIN.

This initiative will not change the way providers currently deliver health care and submit claims. Patients will seek and receive health care as they do today and BlueCross will continue to reimburse for services in the same manner. Lines of business included in these episodes are State of Tennessee, BlueCare℠, TennCare*Select*, Commercial, CoverKids and fully-insured.

As of May 12, 2014, BlueCross began generating reports reflecting the quarterback's TIN episodes of care through BlueAccess. To view these reports, select the Tennessee Health Care Innovation Initiative link in BlueAccess and choose the quarterback's TIN and line of business.

For questions related to this program, e-mail payment.reform@tn.gov, or contact the BlueCross BlueShield of Tennessee Provider Service Line†.

Appropriate billing for revenue code 0360

During routine audit processes, BlueCross' Provider Audit Department discovered many facilities are billing revenue code 0360 (*Operating Room Services)* incorrectly. Facilities are reporting this revenue for procedures not performed in the operating room, but were actually performed in the emergency room (ER) or wound care clinic. Procedures performed in the ER should be billed with revenue code 0450, while procedures performed for wound care should be billed with revenue code 0519. The facility must also be contracted for wound care to bill for these services. Additional information on wound care guidelines may be found in the provider administration manuals which are available on the Provider page on the company websites, www.bluecare.bcbst.com and www.bcbst.com.

Reminder: Qualitative Drug Screen changes

Per the American Medical Association (AMA), and in accordance with recommended updates from the Centers for Medicare & Medicaid Services (CMS), proper coding of a multiplex drug screening test kit is a single unit of 80104 not multiple units of 80101. This guideline for billing Qualitative Drug Screens was implemented by the State Bureau of TennCare on Oct. 1, 2013. To be consistent with these policies, BlueCross will no longer accept certain 80000 series drug screen CPT® Codes for dates of service July 1, 2014, and after for its commercial line of business. Commercial claims submitted under codes 80100, 80101, and 80104 will no longer be reimbursed. Specifically, CPT® Codes

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80100, 80101, and 80104 will be non-covered for more appropriate HCPCS/ CPT® Codes G0431 and/or G0434. CPT® Codes G0431 and/or G0434 will be limited to one test unit per date of service.

Additional information about this policy will be included in the next available update to the *BlueCross BlueShield of Tennessee Provider Administration Manual*.

Note: This policy change does not apply to BlueAdvantage℠.

Reminder: CMS-1450 (UB-04) billing

When filing a CMS-1450 (UB04) please be mindful of Admission Type (Form Locator 14), Admission Source (Form Locator 15), and Discharge Status (Form Locator 17). We have seen an increase in claims rejecting for either missing or invalid codes. Please refer to your UB04 manual for additional information on these form locators.

Reminder: Duplicate claims handling for Medicare crossover

Effective Oct. 13, 2013, when a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting the claim to BlueCross. If filed as a paper claim, CMS remit must show the date CMS processed and released. If submitted electronically, there is a claim segment to show the other carrier paid date. Medicare primary claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date will be returned or rejected by BlueCross BlueShield of Tennessee.

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for you to receive payment or instructions from the Blue Plan.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the member's benefit policy to be applied. To view a list of frequently asked questions, please visit our website at http://www.bcbst.com/providers/news/ and click on the *Medicare Crossover Duplicate Claims FAQs*.

Commercial prior authorization requirements update for hyperbaric treatments

Effective June 30, 2014, **hyperbaric treatments** will be 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

Reminder: Important change to most BlueCross BlueShield of Tennessee pharmacy plans

Beginning June 2, 2014, compounded medicines made from bulk powders and select bulk chemicals will no longer be covered by many BlueCross commercial pharmacy plans.

Safety concerns of compound medications have had nation-wide news attention, prompting legislation on both the national and state levels. The clinical efficacy of these products is questionable.

The dramatic increase in compounds seems to be a national trend that is getting the attention of payers and sponsoring plans. The majority of compound medications are not proven to be clinically effective or medically necessary. Due to availability of commercial products, lack of approval by the FDA, questionable drug efficacy, and exceptionally high cost, bulk powders and select bulk chemicals are being excluded from the formulary of BlueCross BlueShield of Tennessee's fully insured plans.

If you have questions, please call the Provider Service line†.

Electronic dental secondary claims

Did you know BlueCross accepts electronic dental secondary claims? Save time and money by avoiding the mailing of paper claims and explanation of benefit statements. Contact your software vendor or clearinghouse with the information at the following link to get started: <http://www.bcbst.com/providers/ecomm/bcbst_5010/Electronic_Secondary_Claim_Guideline.pdf>.

If you have further questions, please contact eBusiness Solutions†.

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BlueCare Tennessee
ADMINISTRATIVE

Prior authorization requirement change for CPT® code 92558

As of May 1, 2014, CPT® code 92558 (evoked otoacoustic emissions, screening "qualitative measurement of distortion product or transient evoked otoacoustic emissions", automated analysis) no longer requires prior authorization for BlueCare or TennCare*Select* members.

iCES billing update

Durable Medical Equipment providers 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.

New requirements for certain medications

Beginning June 1, 2014, the medications listed below will only be covered if they are patient administered and have an approved authorization from Magellan Pharmacy Solutions. To request an authorization for patient-administer medication please call 1-866-434-5524. If these medications are provider administered, the prescriber should bill the medications through the member's medical benefit plan:

- ✓ Mesnex ®
- ✓ Neupogen®
- ✓ Neumega®
- ✓ Neulasta®
- ✓ Leukine®

We value our relationship with you and look forward to continuing to work together to help ensure TennCare members receive quality, affordable health care.

Medicare Advantage
ADMINISTRATIVE

Medicare Advantage LPPO Physician Quality Program

Starting June 1, 2014, BlueCross BlueShield of Tennessee is beginning a new Physician Quality Program. This program will recognize primary care physician practices that close individual patient's quality gaps in care.

Bonus and fee schedule reimbursement payments are based on practices achieving targeted goals for a pre-defined set of eighteen potential quality measures for physicians who treat BlueCross' Medicare Advantage members enrolled in our LPPO Network.

The program consists of two key components: **Pay for Gap Closure** and the **Practitioner Assessment Form**.

Pay for Gap Closure
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.

Practitioner Assessment Form
The Practitioner Assessment Form is independent from the Physician Quality Program. A service fee of $155 will be paid annually per patient for each practitioner assessment form that is completed. In order to be paid for this service, providers must fax the completed assessment form to 1-877-922-2963 and file a claim for the service using E/M code 99420.

Note: Bonus payments for procedure-based performance measures will be reconciled on a quarterly basis.

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

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*These changes will be included in the appropriate 2Q or 3Q 2014 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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†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**
TennCare*Select* **1-800-276-1978**
CHOICES **1-888-747-8955**
BlueCare Plus℠ **1-800-299-1407**
BlueChoice℠ **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)

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