Marketplace

Health Insurance Marketplace provider resources available

More than 130,000 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.
(Appplies 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 June 14, 2014

➢ Vincristine Sulfate Liposome injection
➢ Analysis of MGMT (O6-methylguanine-DNA methyltransferase) Promoter Methylation
➢ Non-invasive Prenatal Testing Using Cell-free Fetal DNA (cffDNA)
➢ Genetic Testing for Epilepsy
➢ Kinesio Taping
➢ Orthoptic Training for the Treatment of Vision or Learning Disabilities
➢ Treatment of Congenital Port Wine Stains and Hemangiomas
➢ Cranial Electrotherapy Stimulation and Transcranial Magnetic Stimulation

Effective June 18, 2014

➢ Temozolomide

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

Medical Policy for Positron Emission Tomography

The medical policy titled Positron Emission Tomography (PET) for Miscellaneous Applications has been reviewed and revised, and is now consistent with MedSolutions guidelines. A draft of this revised policy can be accessed on BlueCross’ Draft Medical Policies site at: http://www.bcbst.com/DRAFTMPs/.

Clinical Practice Guidelines adopted April 1, 2014

BlueCross BlueShield of Tennessee has adopted the following guidelines as practice resources:


AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline From the American Heart Association and American College of Cardiology Foundation (2011) <http://circ.ahajournals.org/content/124/22/2458>


Standards of Medical Care in Diabetes – 2014 American Diabetes Association <http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf+html>


Recommended Immunization Schedules for Persons Aged 0 through 18 Years (United States, 2014) <http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.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.

Managing low back pain

When a patient has low back pain (LBP), is immediate imaging important? According to a study conducted at The University of Tampa the evidence indicates that immediate, routine lumbar spine imaging in patients with LBP, without features indicating a serious underlying condition did not improve outcomes compared with usual clinical care that did not include immediate imaging. The report states that clinical care without immediate imaging seems to result in no increased odds of failure in identifying serious underlying conditions in patients without risk factors for these conditions. In addition to lacking clinical benefit, routine lumbar imaging is associated with radiation exposure (radiography and CT) and increased direct expenses for patients and may lead to unnecessary procedures. This evidence from this study confirms that clinicians should refrain from routine, immediate lumbar imaging in primary care patients with nonspecific, acute or sub-acute LBP with no indications of underlying serious conditions.

Specific consideration of patient expectations about the value of imaging was not addressed here; however, this aspect must be considered to avoid unnecessary imaging while also meeting patient expectations and increasing patient satisfaction.

Reference:

ADMINISTRATIVE

ICD-10 compliance date delay

In April, a newly enacted federal law delayed the ICD-10 compliance date until at least 2015. Nonetheless, BlueCross BlueShield of Tennessee will continue taking steps to prepare for the ICD-10 transition while we await further direction from the Centers for Medicaid & Medicare Services (CMS).

Despite the delay, BlueCross BlueShield of Tennessee will provide a self-help testing tool. This self-help testing tool is available and we are ready to test with you. Facilities and physicians will be able to execute test scenarios to assist with ICD-10 readiness. Please e-mail your request to use the self-help testing tool at ICD10_GM@bcbst.com.
BlueCross will keep you updated with additional details as it relates to the ICD-10 compliance date deadline in future issues of the BlueAlert.

Independent laboratory reporting requirement *

All free-standing clinical laboratories whose claims are submitted with place-of-service 81 will soon be required to provide lab test results electronically to BlueCross. Beginning in July 2014, representatives from BlueCross Medical Informatics will begin contacting each contracted Lab to assist in their compliance with this new requirement. If you have questions about this new requirement, please call the Provider Service Line† or your local Network Manager.

Commercial prior authorization requirements update *

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>.

If providers are treating diabetic wounds they will need to be prepared to provide \( P_{\text{te}}O_2 \) levels when requesting this service.

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

New HIPPS Code billing requirement

Beginning with dates of service July 1, 2014, the Centers for Medicare & Medicaid Services (CMS) will require the HIPPS codes when billing BlueAdvantageSM and BlueCare PlusSM plans as is currently being required by Original Medicare. CMS is, however, encouraging you to begin billing our plans with the HIPPS codes before July 1 if possible. The HIPPS codes integrate the RUG codes you may be using.

Examples
- Claim Line 1: Include HIPPS codes with revenue codes 0022 Skilled Nursing, 0023 Home Health and 0024 Rehabilitation with a zero dollar charge.
- Other claim lines: If you are contractually obligated to bill other revenue codes, bill them on line two and after.

First and interim bill: Include Request for Anticipated Payment (RAP) HIPPS code. Note: For in-network providers, bill as per your contract agreement adding the appropriate line for the HIPPS codes.

Final bill:
- HIPPS codes are available at CMS.gov under HIPPS Master Code (to access open the zip file and select the appropriate Excel spreadsheet.)
- Bill for the last unpaid date(s) of service using final bill type 3x9.

Claim rejections after July 1, 2014
Claims received for processing with dates of service of July 1, 2014, and after that do not include HIPPS coding with revenue codes 0022, 0023 or 0024 will be rejected and require resubmission with the appropriate HIPPS code.

If you have questions, call the appropriate Provider Service line†:
- Blue AdvantageSM PPO 1-800-841-7434
- BlueChoice (HMO)SM 1-866-781-3489
- BlueAdvantage Group 1-800-818-0962
- BlueCare Plus (HMO SNP)SM 1-800-299-1407

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.

**Reminder: What is a healthy weight?**

According to national guidelines, a healthy weight depends on three factors:
- body mass index (or BMI)
- waist measurement, and
- risk factors for obesity-related diseases and conditions

BMI scores are valid – but may overestimate body fat in athletes and very muscular people, and underestimate body fat in seniors and those who have lost muscle mass. Waist size is a good indicator of abdominal fat level, another predictor of heart disease and illness risk. Combining the two measurements shows a more appropriate risk for developing obesity-associated diseases than either factor alone. Additional risk factors include:
- High blood pressure
- High LDL-cholesterol
- Low HDL-cholesterol
- High triglycerides
- High blood sugar
- Family history of premature heart disease
- Physical inactivity
- Cigarette smoking

Specific racial or ethnic backgrounds may pre-dispose your patients to some of the risk factors, such as hypertension for Caucasians and obesity for African-Americans. Remember, if your patients can lose just 5 to 10 percent of their body weight it can have a significant positive impact on their health risk.

**Reminder: Billing monthly supplies and accessories**

Due to frequent changes in membership and eligibility, no more than one month of medical supplies and accessories should be dispensed at a time. Prospective billing for dates of service beyond the occurring month is not eligible for reimbursement. Regular submission of claims for supplies that exceed the usual utilization may prompt a request for medical records to support the need for additional supplies.

Additional supplies must be requested by a member or caregiver before being dispensed. Supplies should not be automatically dispensed on a predetermined regular basis. For more information regarding medical supplies and accessories, please refer to the Billing and Reimbursement section of the BlueCare Tennessee Provider Administration Manual. Additional information on this topic can also be found in the MedAdvantage section of the manual.

**Invalid HCPCS codes causing delays**

Many Durable Medical Equipment (DME) prior authorization requests are being submitted with invalid HCPCS codes. Please verify codes prior to submission to assure timely response, as BlueCross systems cannot process invalid codes.

**PWK fax process**

As communicated earlier, BlueCross BlueShield of Tennessee is committed to the increased use of electronic processes, including increasing the submission of claims to us in the electronic format. As part of this effort, we are working to remove barriers that prevent providers from submitting 100 percent of their claims to us electronically. One such barrier that has been identified is the inability to send required documentation in an electronic format when the claim is submitted.

We are pleased to announce that we are implementing the PWK process which will allow BlueCross providers to send required documentation at the same time they submit claims electronically. This process uses standard functionality within the ANSI 837 transaction to link the claim to your documentation. Additional information regarding the PWK process is included in a letter that will be mailed to providers and will also be posted with the PWK Fax Cover Sheet in the provider section of the company website at [www.bcbs.com/providers](http://www.bcbs.com/providers).

If you have questions about this process, you can speak with one of the technical support specialists in eBusiness Technical Support by calling (423) 535-5717, option 2, or 1-800-924-7141, Monday through Thursday 8 a.m. to 5:15 p.m. (ET), or Friday 9 a.m. to 5:15 p.m. (ET). Also contact us via e-mail at [eBusiness_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com).

**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
directories that are available to our members on the company website. The updated provider information available.

The bi-annual update to Physician Quality Information will be available on May 1, 2014 for private physician review on our secure BlueAccess® Web portal. Physicians have a 60-day review period, during which time they can submit self-report information at the patient level to help improve their rating. After the 60-day review period, provider ratings will be updated to reflect the self-reported submissions. The updated provider ratings are also included in our provider directories that are available to our members on the company website.

BlueCross Formulary change

Beginning May 1, 2014, RibaPak will no longer be covered by most patients’ pharmacy benefit plans. Generic ribavirin remains on the BlueCross Formulary. However, patients currently taking RibaPak may complete their treatment on this product.

If you have clinical rationale why a new patient should be placed on RibaPak, rather than generic ribavirin, you may request an exception to the formulary by faxing a letter to 1-888-343-4232.

If you have questions about our formulary policy change, please call Provider Service†.

Additional information is available in the Billing and Reimbursement Section of the BlueCross BlueShield of Tennessee Provider Administration Manual. Questions should be directed to your regional Provider Network Manager.

BlueCare Tennessee ADMINISTRATIVE

PCP Rate Bump Changes for 2014

Effective Jan. 1, 2013 through Dec. 31, 2014, qualified PCPs, as detailed by the Centers for Medicare & Medicaid Services (CMS) regulation, are to receive a rate change for eligible CPT® codes. This rate change is also referred to as the PCP Bump or the PCP Rate Enhancement Payment. The 2014 rates are currently available. Several codes reflect a decrease from the 2013 rate. Claims that have been impacted by the 2014 rate change will be identified and adjusted retroactively to Jan. 1, 2014.


Reminder: Billing Telemedicine Originating Site Fees

For dates of service on or after Sept. 1, 2013, providers who deliver services via Telemedicine may be eligible to bill Originating Site fees.

Reimbursement for services rendered via Telemedicine are made in accordance with BlueCare Tennessee, the Centers for Medicare & Medicaid Services (CMS), and TennCare Guidelines. Qualifying codes under BlueCare Tennessee are consistent with CMS, and TennCare guidance. By filing claims for encounters rendered via Telemedicine, providers are attesting that claims were rendered according to these rules and guidelines.

Reminder: Filing corrected bills appropriately

Corrected bills must be submitted within 120 days of the BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

Claims that have been processed (providers receive a Remittance Advice that includes the claim) and were paid incorrectly because of an error or omission on the claim may be filed as a “Corrected Bill.” A true corrected bill includes additional/changed dates of service, procedure or diagnostic codes, units, member name, ID and/or charges that were not filed on the original claim.

Please refer to the Billing and Reimbursement section of the BlueCare Tennessee Provider Manual for the required method for electronic claims and for paper claims.

Note: Claims returned or rejected should not be submitted as corrected claims. Only claims that have completed adjudication should be submitted as corrected bills. When sending a Corrected/Replacement Claim you must re-send the claim in its entirety including the corrections.

New online portal for Best Practice Network providers

BlueCare Tennessee will be launching Care Team Connect (CTC), a new online portal in second quarter of 2014. This new portal will offer detailed information to providers about their patients who are in state custody. Best Practice Network
providers who serve children in state custody will now have easy access to view their patient’s medical history. We will be contacting you to discuss the registration and training process. In the meantime, contact Heather Smith at (615) 386-8564 in West Tennessee, or Sandra DeBord at (865) 588-4641 in East Tennessee with any questions.

BlueAdvantage

**Administrative**

Medicare Advantage LPPO Physician Quality Program

Starting June 1, 2014, BlueCross BlueShield of Tennessee will begin 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 18 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.

**BlueCard**

**Administrative**

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 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 a tool now available 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.


*These changes will be included in the appropriate 1Q or 2Q 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

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

**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)