Drugs added to commercial Specialty Pharmacy listing

Effective April 1, 2015, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
- Blincyto (PA)
- Keytruda (PA)
- Lemtrada (PA)
- Odpivo (PA)

Self-administered via pharmacy benefit:
- Duopa (PA)
- Evotaz
- Ibrance (PA)
- Lenvima (PA)
- Lynparza (PA)
- Prezcobix
- Vitekta

Providers can obtain prior authorization for:
- 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 updates web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications

Individuals with schizophrenia or bipolar disorders are at high risk to develop diabetes among other serious health conditions. The risk for diabetes is even greater if those patients are prescribed antipsychotic medication which can cause weight gain and changes in metabolism. Screening patients with these conditions who are also taking antipsychotic medications may lead to earlier identification and treatment of diabetes.

BlueCare/TennCare Select, CoverKids and BlueCare Plus (HMO SNP) are alerting Community Mental Health Centers and other community-based behavioral providers about the importance of screening for impacted members and encouraging them to share relevant clinical and medication information with Primary Care Providers. Members who require the screening should have one of the following tests completed:

- Glucose test (CPT® 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951)
- HbA1c test (CPT® 83036, 83037 CPT® II 3044-3046-F).

Thank you for your assistance in helping our members with serious behavioral health conditions to achieve and maintain improved health status.

Provider survey link: www.surveymonkey.com/s/G7HZWSL

Financial planning tool available for review

BlueCross believes in equipping our members with information that helps them make better, more-informed decisions about their health. This includes cost and quality information about providers in our commercial networks.
Updated cost and quality information is now available for your review. You can log into BlueAccess, our secure web portal, to view your data.

1. You have a 60-day period to review this data before it is published.
2. You have the ability, within this 60-day window, to contest any data you believe to be inaccurate before it is published for members to view.
3. We have been publishing physician quality information since 2008; procedure costs have been made available since 2013.

On June 1, 2015, our members will have access to this financial planning tool which also includes single procedure costs. The new financial planning tool will apply the member’s cost-sharing, offering the member a more accurate estimation of his/her cost obligation.

Provider cost and quality data is not affected by overlaying this member cost estimator.

Questions can be directed to NCCQquestions@bcbst.com.

Aspire services available for members facing serious illness

BlueCross is pleased to announce a new partnership with Aspire Health beginning March 1, 2015, to provide an extra layer of home-based support to our Commercial members in Networks P and S and BlueAdvantage members (in Hamilton, Shelby and Davidson counties in Tennessee and contiguous counties) facing an advanced illness.

Aspire’s team of physicians, nurse practitioners, social workers and chaplains are on call 24 hours-per-day, 7 days-per-week and primarily see patients in their homes to help with symptom management and advanced care planning, thereby preventing unnecessary emergency room visits and hospitalizations.

BlueCross members enrolled in Aspire keep their primary care physician and other specialists. Aspire’s intervention has been shown to have high patient and family satisfaction, improved quality of life for patients facing an advanced illness, and reduced hospitalizations by over 50 percent. Aspire services are currently available in Chattanooga, Memphis and Nashville. To refer a patient, please call (844) 232-0500 or visit www.aspirehealthcare.com to learn more.

**Health information privacy**

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, BlueCross BlueShield of Tennessee makes every effort to protect its members’ individually identifiable health information.

The HIPAA Privacy Rule establishes national standards to protect individuals’ medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses, and 3) those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Members and patients have the right to access their health information and to know how it is being protected. As such, BlueCross requests providers maintain a notice of privacy practices and encourages them to publish such notices prominently on their websites.

**REMINDER: Network enrollment for new providers**

Health care providers practicing in Tennessee and bordering Tennessee counties who would like to participate in BlueCross BlueShield of Tennessee networks should complete the Provider Enrollment Form available on the company website at www.bcbs.com/providers/contracting-credentialing.page.

BlueCross has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners CAQH ProView™, a universal credentialing application tool. With a single, uniform, online application, practitioners can enter their credentialing information and later access, manage and revise that information at their convenience. The Universal Provider Datasource (UPD) credentialing application tool is available at no cost to practitioners and is located at proview.caqh.org.

**COMING SOON: Behaviorally Effective Healthcare in Pediatrics online training**

In the next month the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) will be launching an online training program for Behaviorally Effective Healthcare in Pediatrics (BEHIP). There is no cost for the eight online training modules. The modules will provide pediatric health care providers with tools and strategies to screen, evaluate and manage patients with common behavioral health concerns. The modules range from 30 minutes to 1 hour to complete and cover the following topics:

- Introduction to Behavioral Health in Pediatrics
- Postpartum Depression
- Disruptive Behavior and Aggression
- Inattention
- Anxiety
- Depression
- Substance Abuse
- Coding & Workflow for Behavioral Health

Continuing Medical Education (CME) credit will be available for this training. For more information, contact the TNAAP Training Coordinator, Rebecca Robinson at rebecca.robinson@tnaap.org.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Vanderbilt University School of Medicine and the Tennessee Chapter of the American Academy of Pediatrics. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

**REMINDER: Request a peer-to-peer consultation when you call**

Often providers call and would like to request a peer-to-peer consultation with a physician regarding one of our Commercial or Medicare Advantage members. To request this conversation, when you call us at 1-800-924-7141, you can simply say or choose the word “peer” from the options available in our HealthCare Management menu.

**BlueCare Tennessee**

This information applies to BlueCare and TennCareSelect plans, excluding dual-eligible BlueCare Plus (HMO SNP)** unless otherwise stated.

**Speech therapy clarification**

BlueCare Tennessee established a process to facilitate the coordination of TENnderCare services when members under 21 years of age have been identified as needing to receive
therapy services in an educational setting. BlueCare Tennessee requires a copy of the child’s Individualized Education Program (IEP) and a signed Release of Information/Parental Consent. This process is in support of the TENNderCare Connections process for IEPs. Speech therapy is covered as medically necessary in accordance with TENNderCare requirements and must be performed by a licensed speech therapist. BlueCare Tennessee will NOT pay for speech therapy provided in a group setting in a school unless the group setting is specifically written in the IEP, specifically ordered by the Primary Care Provider and performed by a licensed speech therapist.

REMINDER: Are you seeing your assigned members?

We are proud to offer you access to the *NEW* BlueCross BlueShield of Tennessee Primary Care Provider (PCP) Member Roster application. It is accessible to providers through BlueAccess, our secure provider portal. The PCP Member Roster application has new functionality including searching for providers tied to a group, export and print capabilities. The data is updated weekly. Generally, the turnaround time for PCP changes is within five (5) days; however, due to Statewide Implementation, we are experiencing a higher than normal volume. If a request has been submitted, please do not re-submit another one. Your patience is appreciated.

If the member ID card does not show the correct PCP assignment, a new feature is available to members offering them the ability to print a temporary ID card to use while they are waiting on a copy of their permanent member ID card. Before denying the patient access to your services, please verify eligibility on BlueAccess and remind them of the temporary ID card feature.

We all know how important it is for PCPs to help coordinate our members’ health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/ TennCareSelect member you see is assigned to your patient listing or to another participating PCP in your group prior to treatment.

When you treat a member that is not on your PCP Member Roster you will see code WW3 on your remit. Beginning Aug. 1, 2015, this service will be denied when you treat a member that is not assigned to you, a physician in your office or your on-call physician.

REMINDER: Billing requirements for behavioral health providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering the service to BlueCare Tennessee, BlueCare PlusSM or CoverKids members is different than the billing provider. In the case of an agency billing for services not provided by a licensed clinician, the medical director or other supervising professional may be entered on the claim as the rendering provider.

Failure to provide this information could result in a denial or reduction in reimbursement.

REMINDER: Complete the TENNderCare checkup when performing sports physicals

Many children play sports, which is also a good opportunity to provide the TENNderCare checkup. To be considered a TENNderCare checkup, the following should be performed at the visit:
- Health history
- Complete physical exam
- Lab tests as needed
- Shots as needed
- Vision/hearing screening
- Developmental/behavioral screening as appropriate
- Advice on how to keep healthy

For more information about TENNderCare checkups and billing, please refer to http://www.tnaap.org/.

Medicare Advantage

This information applies to BlueAdvantageSM HMO/ PPO plans, excluding dual-eligible BlueCare PlusSM unless stated otherwise.

Acute inpatient concurrent review updates and coverage extension requests

Medicare Advantage currently reviews all inpatient services for medical necessity against the Centers for Medicare & Medicaid Services (CMS) and MCG, formerly Milliman Care Guidelines criteria. Initial inpatient authorizations are for seven (7) days regardless of diagnosis with a clinical update due on day eight (8) for any extension approvals. All days after day eight (8) are reviewed for ongoing medical necessity and individual days may not be approved for coverage if the intensity of service is not met or for delay in clinical services. At no time will the DRG payment be reduced, but this may impact any outlier payments.

Clinical updates need to include information supporting the need for continued acute inpatient services such as:
- Physician progress notes
- Physician orders
- Rehab service notes
- Discharge planning

Medicare Advantage providers earn high marks on quality

In 2014, BlueCross launched an effort to improve the care our members receive by working with health care professionals to close important gaps in care and gather all relevant medical records to achieve the highest possible quality ratings. The effort was a success, as 197 individual Medicare Advantage providers and 11 provider groups improved their Star quality ratings and will see increased reimbursement rates effective April 1, 2015.

In addition, another 3,293 providers maintained the same Star ratings, meaning they once again achieved quality scores ratings that continue their current level of reimbursement for another year.

BlueCross deployed teams with specific expertise in clinical quality, helping providers better understand how to interpret their current scores and offering proven tactics to help providers improve scores going forward. Please speak with your provider relations consultant if you are interested in scheduling a consultation to learn how to improve quality ratings.

For more information about the quality care initiatives currently underway, please visit www.bcbst.com/providers.

ADMINISTRATIVE

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REMINDER: Medical record acquisition

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross partnered with VeriskHealth and MedSave USA to obtain medical records on our behalf to meet this requirement. VeriskHealth will retrieve records from providers in East Tennessee and MedSave USA for records in Middle and West Tennessee.

Both VeriskHealth and MedSave will formally request medical records twice during 2015. We ask that you please follow the return
 PROVIDER NEWS FLASH

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instructions provided with the list of requested records. Please recall your BlueAdvantage contract requires the return of these records.

Medical records can be returned to VeriskHealth by either:

- Uploading the record image to the secure portal at https://www.submitrecords.com/ and simply enter your secure password: bcbst87 then select the files to be uploaded using the file naming convention included in the request letter.
- Faxing to: 1-888-226-3395
- Mailing to:
  BlueCross BlueShield of Tennessee
  10897 S. River Front Parkway
  Suite 400T
  South Jordan, UT 84095-9984

Medical records can be returned to MedSave USA by either:

- Faxing to: 1-866-790-4192
- Mailing to:
  MedSave USA
  49 Wireless Blvd, Ste. 140
  Hauppauge, NY 11788
  Attn: MedSave USA/BCBSTN

Chronic care management now available for all Medicare beneficiaries

The Medicare 2015 Physician Payment Rule states that chronic care management is now available for all Medicare beneficiaries as of Jan. 1, 2015. The service is billable under CPT® Code 99490.

Several requirements must be met for this service to be eligible for payment, including:

- Chronic Care Management services must be approved by the beneficiary in advance, in writing.
- Five (5) specific capabilities must be met to qualify for the provision of Chronic Care Management services, including 24/7 access to a care plan.
- These services can only be billed once per month, per patient and must be no less than 20 minutes in duration and directed by a physician or qualified health professional.

Additional requirements are outlined on the Centers for Medicare & Medicaid Services (CMS) website. www.cms.gov/site-search/search-results.html?q=chronic%20care%20management

For additional information please contact the BlueCross Provider Service Line†.

Guidelines for submitting a Patient Assessment Form

In 2015 physicians are again eligible to receive reimbursement for completing and submitting a Patient Assessment Form for their attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service when filed using Evaluation & Management Code 99420 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2015
- $200 for dates of service between April 1 and June 30, 2015
- $175 for dates of service between July 1 and Sept. 31, 2015
- $150 for dates of service between Oct. 1 and Dec. 31, 2015

To receive reimbursement, complete the Provider Assessment Form in its entirety and submit electronically via BlueAccess or complete the form available at http://www.bcbst.com/providers/blueadvantage-ppo and return via fax to 1-877-922-2963.

The form should also be included in your patient's chart as part of his or her permanent record.

For additional information about the Patient Assessment Form please visit our website at http://www.bcbst.com/providers/blueadvantage-ppo and www.bcbst.com/providers/quality-initiatives.page

Health Outcomes Survey focuses on physical activity and improving/maintaining members' physical health

Physical activity is an important part of staying healthy and maintaining a high quality of life.

The annual Health Outcomes Survey (HOS), administered by the Centers for Medicare & Medicaid Services (CMS) as part of provider and payer quality scores, includes two measures focused on physical activity:

- Monitoring physical health
- Improving or maintaining physical health

Members will be asked if their physician has spoken with them in the past 12 months about their level of physical activity. They will also be asked if a physician encouraged them in the last 12 months to increase or maintain their level of physical activity.

It is very important to speak to Medicare Advantage members about the benefits of physical activity on their long-term health.

*These changes will be included in the appropriate 2Q 2015 provider administration manual update. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters.shtml
**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 at 1-800-924-7141 to easily update your information.

**Commercial Lines** 1-800-924-7141
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**TennCare** Select
1-800-276-1978

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

**BlueCard**
1-800-676-2583

**All other inquiries**
1-800-705-0391
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage**
1-800-745-4484

**BlueAdvantage Group**
1-800-818-0962
Monday–Friday, 8 a.m. to 5 p.m. (ET)

**SelectChoice**
1-800-993-3305

**SelectCommunity**
1-800-888-9736
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueChoice**
1-866-781-3489

**Commercial Lines**
1-800-324-4714

**BlueCard Benefits & Eligibility**
1-800-676-2583

**eBusiness Technical Support**
Phone: Select Option 2 at (423) 535-5717
Phone: Select Option 2 at 1-800-818-0962

**Monday–Friday, 8 a.m. to 6 p.m. (ET)**

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

**Friday, 9 a.m. to 5:15 p.m. (ET)**

To easily update your information, choose the "Touchtone" option at 1-800-924-7141. Network Contracts or Credentialing when prompted.