of Tennessee

MARCH 2015

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

(Articles apply 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 the policies listed below can be accessed at www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective April, 2, 2015

- Proteomic Testing for Targeted Therapy in Non-Small Cell Lung Cancer
- Patient-Specific Cutting Guides and Custom Knee Implants
- Serum Biomarker Testing for Lupus

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

ADMINISTRATIVE

Behavioral Health Network being built

Effective Jan. 1, 2016, BlueCross will assume responsibility for behavioral health contracting and credentialing for its Commercial and Medicare Advantage lines of business.

Additional information will be sent directly to behavioral health providers. In the meantime, professionals can begin preparing for the transition by visiting the website for the Council for Affordable Quality Healthcare, Inc. (CAQH) to ensure credentialing and profile information is complete and current. Providers may contact their local Behavioral Health Provider Network Manager with any questions

Filing corrected bills*

Electronic submission is the preferred method for filing corrected bills. Corrected bills are claims that have been **processed** (providers receive a remittance advice that includes the claim) and paid incorrectly because of an error or omission on the claim.

Although electronic submission is the preferred method, sometimes it's necessary to file paper corrected claims. The guidelines currently tell providers to bill either qualifier 7 (replacement of a prior claim) or 8 (void/cancel of a prior claim) in block 22 of a CMS 1500 claim form. However it is also important to include the original claim number in block 22 in the section (ORIGINAL REF. NO) next to the qualifier. This space is intended for the original processed claim number found on your remittance advice. Failure to include the proper indicator and original claim number may result in a claim denial.

Commercial appeals*

To help ensure appeals are handled in the most timely manner, it is important to submit to the correct location according to **type** of appeal request indicated below.

- Appeals related to a **claim** should be sent to:

  BlueCross BlueShield of Tennessee
  1 Cameron Hill Circle, Suite 0039
  Chattanooga, TN 37402-0039

- Commercial appeals related to an **authorization** with a **medical necessity** adverse determination should be accompanied by a copy of the denial letter OR a copy of the appeals form located at: www.bcbst.com/providers/forms/Commercial-Utilization-Management-Appeal.pdf.

  Requests can be faxed to (423) 591-9451 or mailed to:

  BlueCross BlueShield of Tennessee
  1 Cameron Hill Circle, Suite 0017
  Chattanooga, TN 37402-0017

Vaccine hesitant parents

Parents often rely on pediatricians to help them navigate a confusing sea of child health information. Immunizations and vaccines are just one area of concern for families. Making time to talk with parents about vaccines during the well-child visit may be challenging. The Centers for Disease Control and Prevention (CDC), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP) have created materials to help with assessing parents' needs, identifying the role they want to play in making decisions for their child's health, and then communicating in ways that meet their needs. These resources are collectively called *Provider Resources for Vaccine Conversations with Parents*. See the resources available: www.cdc.gov/vaccines/hcp/patient-ed/conversations/index.html.

For conversations with parents who are hesitant about having their child vaccinated, AAP also offers videos which explain risk communication theory and model conversations. They can be viewed individually or as part of a larger group for discussion. The videos are available here: www2.aap.org/immunization/pediatricians/communicating.html.

Medical record requests

You may occasionally receive requests for records which may be used for a variety of reasons including audits and medical necessity reviews. These requests must be handled as a priority and all requested information must be submitted. Failure to do so may result in payment being denied or recovered.

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Remember, as a BlueCross network provider you are contractually obligated to submit medical records for our members at no charge.

Electronic claim filing

As a reminder, on Jan. 1, 2015, BlueCross began executing the electronic claims filing requirement as outlined to the BlueCross Minimum Practitioner Network Participation Criteria. All claims should now be filed electronically. To review the letter mailed to providers in December 2014, please go to: www.bcbst.com/providers/ecomm/Electronic-Claims-Provider-Notice-1211.pdf
Our eBusiness team is available to assist providers in making the transition to a fully electronic submission environment. No claims will be denied or returned on the sole basis of being a paper claim; if you receive returns or rejections and have questions, please contact eBusiness Technical Support for assistance†.

Tips for calling the Provider Service Line (1-800-924-7141)

(Our phone options recently changed)

When calling our Provider Service line, choose from the following options for information regarding BlueCross members covered by our Commercial lines of business:

- Option 1 – Automated eligibility information
- Option 2 – To verify benefits prior to services
- Option 3 – Automated claims status information
- Option 4 – To discuss questions regarding a specific claim

By selecting the correct option that fits your reason for calling, it will help reduce wait times and ensure calls are routed to the right agent the first time.

Guidance on 2015 drug testing code changes

The Centers for Medicare & Medicaid Services (CMS) released guidance in October 2014 for clinical laboratory fee schedules that proposed a delay for pricing the new 2015 CPT® codes for drugs of abuse tests until further information and education is obtained. Instead, providers are advised to use alphanumeric "G" codes to replace the 2014 CPT® codes that are being deleted for 2015.

BlueCross BlueShield of Tennessee and BlueCare Tennessee are adopting the CMS recommendation to use 2015 G-codes for all drug testing – both screening and confirmatory tests – for all lines of business. The G-codes help address overutilization of drug testing, offer established rates and ensure a more efficient and streamlined claims payment process.

Starting April 1, 2015, BlueCross and BlueCare Tennessee payment systems will automatically deny claims using 2015 CPT® codes for drug screenings and confirmatory tests.

For more information and a list of the 2015 G-codes, please refer to the CMS documentation "Clinical Laboratory Fee Schedule (CLFS)" located at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2015-CLFS-Codes-Final-Determinations.pdf

Appropriate billing for newborn hearing test

The technical component for newborn hearing tests (as well as other diagnostic studies) that are performed on patients in an inpatient setting should not be billed by a professional provider. The Diagnosis Related Group (DRG) payment methodology reimburses the facility where the patient is an inpatient for the technical portion of all diagnostic testing and should not be reported by the physician interpreting the results. Physicians should report **only** the professional component for procedures in the inpatient setting. As a reminder, CPT® code 92586 is a technical component code per the Medicare Physician Fee Schedule, therefore, should not be reported by a physician when the patient is in an inpatient setting.

Claim denials due to incorrect submission

In January 2014 BlueCross implemented the CMS1500 Claim Form (02/12 Version). Due to changes to several boxes on this new version of the claim form we have experienced a high volume of rejections. Please see the information at the following link www.bcbst.com/providers/news/ for more information. Details for completing all boxes on the CMS1500 form can be found in the NUCC CMS1500 Claim Form Manual available at nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v2.pdf. These requirements align with the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1).

REMINDER: Refer members to in-network providers

Our members get the most from their health benefits when they visit participating network providers. As one of our network providers, please remember you are contractually obligated to refer our members to other contracted network providers. This is especially important when referring members to hospitals, or for lab, DME and any other ancillary services. Our "Find a Doctor" tool on bcbst.com can be used to easily locate other participating network providers.

REMINDER: CAQH streamlines the credentialing process

BlueCross BlueShield of Tennessee has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners ProView™ formerly Universal Provider Datasource (UPD), a universal credentialing application tool. With a single, uniform online application, practitioners can enter their information free of charge to access, manage and revise that information at their convenience.

As of Jan. 1, 2015, BlueCross requires new credentialing applications from licensed health care professionals to be submitted through CAQH. The CAQH website, http://proview.caqh.org/, provides step-by-step instructions for online registration and how to get started using ProView.

Note:

- Credentialing for participation in all BlueCross networks, except CHOICES, is available through the CAQH credentialing tool.
- Facilities are not eligible for credentialing through CAQH at this time.

REMINDER: Recovery of overpayments

BlueCross will issue notification when an overpayment is identified. The overpayment to physicians and ancillary providers will be recovered through an offset to their remittance advice, 45 days from the date of the overpayment notification letter. The 45 days is granted to allow providers time to review their records and determine whether they agree with BlueCross' overpayment determination. Providers who feel the audit decision is incorrect should follow the Provider Dispute Resolution Process (PDRP) by submitting their request within 30 days from the date of the notification letter. Information related to

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the PDRP is available online in the provider administration manuals at www.bcbst.com.

Providers, including facilities, should not send reimbursement by check to BlueCross.

Note: The Federal Employee Program (FEP) requires BlueCross to continue notifications up to 120 days from the date of the initial overpayment notification letter until the payment is recovered.

BlueCare Tennessee

ADMINISTRATIVE

REMINDER: Are you seeing your assigned members?

We all know how important it is for Primary Care Providers (PCPs) to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group.

We are proud to offer you access to the ***NEW*** BlueCross *PCP Member Roster* application which is accessible to providers through BlueAccess℠, our secure provider portal. The PCP Member Roster application has new functionality including the ability to search for providers tied to a group, as well as export and print capabilities. The data is updated weekly.

When you provide health care to a BlueCare Tennessee member that is not on your PCP *Member Roster* you will see code WW3 on your remittance advice. Beginning Aug. 1, 2015, reimbursement for service will be denied if you treat a BlueCare Tennessee member that is not assigned:

1. to you,
2. a physician in your office, or
3. your on-call physician.

Behavioral health transition of care team

BlueCare Tennessee has created a Transition of Care Team (TOC) to facilitate care coordination between facilities and other health care providers to improve care for our members and reduce avoidable hospital readmissions.

Our goal is to:

- Identify members' health care barriers, such as environment and non-compliance with medications.
- Transition the member into a population health program.
- Work with the facility discharge planner to verify the discharge plan is understood by the member so they can better adhere to the treatment plan.

Controlling high blood pressure

BlueCare Tennessee is committed to providing health care providers with important information that supports controlling high blood pressure. Our members received information in February about controlling high blood pressure and continuing on antihypertensive medications (ACE and ARBs) if prescribed. Please help reinforce these messages by talking with our members about controlling high blood pressure and the impact dietary or lifestyle changes can make for them. Members diagnosed with high blood pressure may not realize the importance of watching their sodium intake or be aware of the importance of medication adherence.

Some providers may receive an on-site visit from our Provider Relations Consultants to share an educational packet that you might find useful in treating your BlueCare and TennCareSelect patients diagnosed with high blood pressure. Members may be more likely to respond to suggestions from their health care provider, so your help with these awareness efforts is appreciated. Educational information for you to print and share with your members is available online at bluecare.bcbst.com/Health-Programs/Population-Health/Heart-Health.html.

Medicare Advantage

(These articles apply to BlueAdvantage (PPO)℠, BlueChoice (HMO)℠ and BlueCare Plus (HMO SNP)℠ unless otherwise stated.)

ADMINISTRATIVE

Medicare & Medicaid Services Prescription Information

(Provider Information Based on SE1434)

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F "*Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" on May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals including dental providers who write prescriptions for Part D drugs to be enrolled in an approved status or have a valid opt-out affidavit on file for their prescriptions to be covered under Part D.

BlueAdvantage and BlueCare Plus prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications or opt out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning Dec. 1, 2015.

For additional information please go to: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

Skilled Nursing Facilities HIPPS Codes

Skilled Nursing Facilities (SNFs) should submit a HIPPS code from the admission assessment completed during the covered SNF stay, only if an assessment was **not** completed for BlueAdvantage members.

Stays more than 14 days – If the admission assessment was completed prior to the covered portion of the stay, submit a HIPPS code from:

- another assessment completed during the covered portion of the stay;
- the most recent assessment completed prior to the covered portion of the stay; or
- a code from the most recent assessment if no assessment was completed.

Stays of 14 days or less – and no admission assessment was completed before discharge for a stay, submit a code:

- from another assessment from the stay; or
- use default code 'AAA00'.

Submit a default code only if:

- the beneficiary was discharged prior to the completion of the initial assessment; or
- no other assessment was completed during the stay.

Refer to the Dec. 4, 2014, Centers for Medicare & Medicaid Services memo at www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/encounterdatahippsmemo.pdf

Stars ratings now available; Provider reimbursement rates changing April 1

The Medicare Advantage Quality Incentive Program offered providers enhanced reimbursement for closing defined gaps in care through Dec. 31, 2014. Providers may now visit BlueAccessSM to view their current Stars rating based on the clinical data received from their practice. After logging in to BlueAccess through www.bcbst.com/providers and accessing the Quality Rewards tool, this home screen will appear with the provider's Stars rating.

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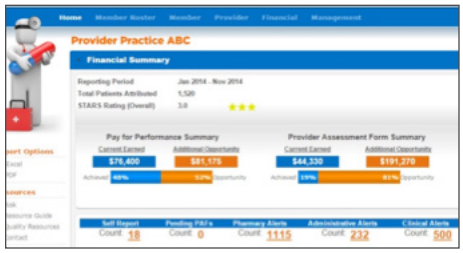
Providers can click on the "Financial" tab on the main menu to see their new fee schedules.



Star ratings, as calculated by the previous year's performance, will impact provider's current reimbursement rates, effective April 1, 2015. Providers should refer to their contract amendments for information about their base rate, the quality escalator and total earning potential.

Patient Assessment Form incentive changing in 2015

BlueCross is again offering an incentive to physicians who complete and submit a Patient Assessment From for BlueAdvantage and BlueChoice members. The incentive will work a little differently in 2015 when physicians will have the opportunity to earn the highest bonus by completing and submitting the forms during the first quarter. See the incentive schedule below to see what bonus your practice can receive.

- $250 for dates of service between January 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 September 31, 2015
- $150 for dates of service between October 1 and December 31, 2015

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

Peer-to-peer option added to call-in prompts

Effective immediately when calling the BlueCross BlueShield of Tennessee Provider Service line† concerning a BlueAdvantage/BlueChoice claim denial, you have the option of setting up a peer-to-peer conversation with a medical director using the menu of choices at the beginning of the call. Simply say "Peer" when prompted and you will be transferred to a staff member who will schedule the call.

Incentives available for Blue Advantage and BlueChoice members in 2015

In 2015 Blue Advantage Members can earn rewards on up to six free screenings that can be provided in your office or through convenient in-home screenings for members who find it hard to travel outside the home. A $15 gift card is available for each of the screenings listed below:

- Mammogram (Women only.)
- Colorectal Cancer Screening (Men and women. In-home test kit available.)
- Bone Mass Measurement (Women only. In-home screening available.)
- Diabetes Retinal Eye Exam (Diabetic members. In-home screening available. See article about Diabetic Retinal Exam for explanation of incentive amounts.)
- HbA1c (Diabetic members. In-home test kit available.)
- Kidney Function Screening (Diabetic members. In-home test kit available.)

Patient incentive available for diabetic retinal exams in 2015

For diabetic patients, a retinal exam is critically important to protecting against vision loss. Unfortunately, many diabetic patients neglect to have this simple procedure. Encourage your patients to schedule one today to ensure a lifetime of good eyesight and remind them they'll get rewards when they do.

If a BlueAdvantage or BlueChoice member receives the exam from an optometrist or ophthalmologist, they will receive a $40 gift card. If they receive the eye exam with our in-home service, they will receive a $15 gift card.

Additional information can be found online at www.bcbst-medicare.com/2015/health-and-wellness/my-healthpath/index.page?nav=header

QUALITYCARE REWARDS

(Articles apply to all lines of business unless stated otherwise)

HEDIS® Focus: March is National Colon Cancer Awareness Month

HEDIS® quality standards are designed to offer a consistent way of measuring the quality of care provided to members of a health plan. This measure focuses on patients age 50 to 75 years of age who have received colorectal cancer screening. There are three acceptable types of screening; fecal occult blood testing (annually), flexible sigmoidoscopy (every five years) and colonoscopy (every 10 years).

Ways to improve compliance with this measure:

- Discuss the importance of colorectal cancer screening and identify the screening method that best suits your patient's needs.
- There are two types of fecal occult blood testing: guaiac (gFOBT) and immunochemical (iFOBT). If guaiac testing is used, three samples must be submitted. If immunochemical testing is used, **only one sample is required**. If the type of testing is not documented, it will be assumed that guaiac testing was done (requiring three samples).
- Results are not required if documentation is clearly part of medical history. If not, documentation of results will be required. *(This is to ensure the test was completed and not simply ordered).*
- A digital rectal exam is not counted as evidence of colorectal screening

*These changes will be included in the appropriate 1Q 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

www.bcbst.com/providers/newsletters.shtml.

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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**
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)

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–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

BlueAdvantage **1-800-841-7434**

BlueAdvantage 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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