MAY 2015

BlueAlert[SM]

BlueCross BlueShield of Tennessee, Inc.

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

MEDICAL POLICY/GUIDELINES

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 June 17, 2015

- Denosumab

Effective June 13, 2015

- BioEngineered Skin Soft Tissue
- Complementary and Alternative Medicine
- Multitarget Polymerase Chain Reaction (PCR) Testing for the Diagnosis of Bacterial Vaginosis
- Subcutaneous Implantable Cardioverter Defibrillator

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

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REMINDER: Changes to *BlueAlert* coming soon

In an effort to simplify your interactions with BlueCross, we are excited to introduce a new and innovative way to view the latest publication of the *BlueAlert* provider newsletter on our company websites, www.bcbst.com and bluecare.bcbst.com, The enhanced newsletter will provide an easy-to-navigate electronic format allowing quick access to more information by simply clicking links and hyperlinks referenced in the articles.

Additionally, you will soon be notified via postcard when the new BlueAlert format is available online. Each month, the postcard will highlight important articles that are included in the newsletter and how to access it.

We look forward to providing you with this new upgrade as we move forward in a more efficient, electronic environment.

COMING SOON: Member scorecards

Soon, members will receive scorecards about preventive screenings that are appropriate for their specific age and gender. The scorecards encourage our members to contact their physician to schedule an appointment to discuss where they stand with their preventive screenings, etc. The scorecard provides members with information related to which screenings may be appropriate, why the screening is important and provides the member with their "status" of the screenings, including which screenings are past due, up-to-date or that need to be completed by the end of the year. The goal is to empower members to play an active role in their health.

Note: Scorecards will be mailed to our Commercial, CoverKids, BlueCare Tennessee and BlueCare Plus (HMO)[SM] members.

REMINDER: Physician Quality Information Application available until July 13, 2015

The Physician Quality Information Application on BlueAccess[SM] will be available for physician review and self-reporting until July 13, 2015. After July 13, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available on the company website for our members.

REMINDER: Avoid claim denials by following prior authorization guidelines

Services rendered without obtaining authorization prior to services being rendered are considered "non-compliant". Prior authorization reviews can be initiated by the member, designated member advocate, practitioner, or facility. However, **it is ultimately the facility and practitioner's responsibility to contact BlueCross to request an authorization.**

When a request for authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross' non-payment is applicable to both facility and practitioner rendering care. The member is held harmless if eligible at the time services are rendered and the covered services are received from a network provider.

When prior authorization is required, providers must obtain authorization prior to scheduled services and within 24 hours or the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to noncompliance. **BlueCross members cannot be billed for services denied due to non-compliance by the provider.**

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REMINDER: FREE Continuing Medical Education hours! Behaviorally Effective Healthcare in Pediatrics online modules

The Behaviorally Effective Healthcare in Pediatrics (BEHIP) training program is offering **free online Continuing Medical Education (CME) credit!** These training modules provide pediatric health care providers with tools and screening strategies to assess and manage patients with common behavioral health concerns. The eight modules take 30 minutes to one hour to complete and include the following topics:

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

This training opportunity is offered by the Tennessee Chapter of the American Academy of Pediatrics. BEHIP is funded with the support of BlueCare Tennessee.

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.

For more information, please contact TNAAP Training Coordinator Rebecca Robinson at rebecca.robinson@tnaap.org.

BlueCare Tennessee

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

Bureau of TennCare offers online Non-discrimination Compliance Training

Non-discrimination Compliance Training is now available to assist providers with understanding federal/state civil rights laws applicable to TennCare and Cover Tennessee Programs. This training tool will also cover the importance of cultural knowledge in health care.

The training is applicable to BlueCare/TennCare*Select*, CoverKids and BlueCare Plus℠ and can be accessed on the following web pages: www.bcbst.com/providers/cover-tennessee.page or bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Training-and-Tools.html.

Tennessee Health Care Innovation Initiative

Tennessee Health Care Innovation Initiative reports will be available soon and will be based on the provider's Contract Entity rather than the Tax Identification Number. Along with this change TennCare has included the following to the Wave 1 episodes of care reports:

- Stop Loss amounts will be applied in the Overall Performance summary, and
- Rendering provider name, NPI and patient date of birth will be added to the lists of episodes.

To view your reports, please log on to BlueAccess, our secure provider portal. Once in BlueAccess scroll down to Tennessee Health Care Innovation Initiative. You will also see informational reports on the Wave 2 episodes of care, which include:

- Acute COPD exacerbation,
- Screening and surveillance colonoscopy,
- Outpatient and non-acute inpatient cholecystectomy,
- Acute percutaneous coronary intervention (PCI) and Non-acute PCI.

For more information on the Wave 1 and Wave 2 episodes of care, see the State of Tennessee's website at www.tn.gov/HCFA/strategic.shtml.

Update to Lab Exclusion List

Changes to the *2015 Quest/BlueCare Tennessee Lab Exclusion List* follow:

- Addition of 88341 – Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure

This change is effective May 1, 2015. All other codes remain unchanged.

Note: This change also applies to CoverKids members.

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 resubmit. 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/TennCare*Select* 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: Allowable incontinent supplies

As of July 1, 2014, Budget Reduction Requirements from the Bureau of TennCare requires review of incontinence supplies (diaper products) over 200 per member per month. Therefore, BlueCare Tennessee must perform a retro review of claims that exceed the allowable monthly supply. The review will require the physician order and clinical records supporting the incontinence supply request.

BlueCare Tennessee expects to announce the selection of the supplier of incontinence products on May 15, 2015. Please continue to monitor our website for any updates.

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Medicare Advantage

This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus℠ unless stated otherwise.

ADMINISTRATIVE

Annual Survey includes questions about member experiences with physicians

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted by the Centers for Medicare & Medicaid Services (CMS) every year and contains several questions directly related to a member's experience with their doctors. The specific questions are:

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often was it easy to get appointments with specialists?

The responses CMS receives from Medicare Advantage members become part of BlueCross' network contracted physician's annual STAR quality rating score.

For more information about the CAHPS survey please visit the Quality Care Rewards page on bcbst.com.

Provider Performance Module data refresh

BlueAdvantage and BlueChoice (HMO)℠ Provider Performance Module data, available in BlueAccess, will be updated at the end of each month instead of the 15th of each month. This will synchronize data updates for all BlueCross products. Additionally, the validation source of the data will be synchronized to minimize variation.

Risk Adjustment - Key to strong Medicare program

Proper risk adjustment coding and documentation by providers helps strengthen the Medicare program. This ensures accurate attribution of chronic disease conditions and diagnoses are reported to the Centers for Medicare & Medicaid Services (CMS), thereby allowing stratification in health status of enrolled beneficiaries and to allow BlueCross to continue enhancing member benefits and access to care.

The Risk Adjustment methodology also helps BlueCross:

- Identify patients who may benefit from chronic disease and comprehensive case management programs
- Provide support services that enable members to maintain a high quality of life
- Enhance communication throughout the member's health care team

For more information, please see the Provider Performance Module available in BlueAccess.

Help your Medicare Advantage patients get fit with SilverSneakers

Are your Medicare Advantage patients getting enough physical activity to stay healthy and fit? The Centers for Disease Control and Prevention (CDC) recommends older adults get at least two hours and 30 minutes of activity such as brisk walking every week, plus activity that works the muscles in the legs, hips, back, abdomen, chest, shoulders and arms on two or more days per week.

Medicare Advantage members' annual exams are good times to talk with them about the importance of exercise and help them decide how to be more active. They may ask how to increase activity, how often they should work out, what to expect at a gym or fitness center, and whether there are any restrictions on what they can do.

We encourage you to remind our Medicare Advantage members that they can get the activity they need with the **Healthways SilverSneakers® Fitness Program**, provided for them at **no extra cost**. SilverSneakers offers various options to keep members actively engaged with:

- a fitness membership with access to more than 13,000 fitness locations nationwide, use of all basic amenities, SilverSneakers group fitness classes, fun social activities, and a Program Advisor™;
- SilverSneakers FLEX™ classes at parks, recreation centers and older-adult living communities; and
- online resources such as activity trackers, fitness advice, downloadable recipes and meal plans, and support from the SilverSneakers community.

For more information on the program please visit www.silversneakers.com.

Recommend participation in SilverSneakers, and then challenge each Medicare Advantage member to tell you how much better he or she feels at the next exam!

More information is available on the CDC website at cdc.gov/physicalactivity/everyone/guidelines/olderadults.html.

Prior authorization requirements for fusion for degenerative joint disease of the lumbar spine

The following documentation is required to request authorization for fusion for degenerative joint disease of the lumbar spine:

- Continued pain and difficulty maintaining activities of daily living (ADLs) despite:
  - activity modification
  - a documented home exercise program or supervised physical therapy
  - anti-inflammatory medication
- Results of pertinent imaging studies, full motor and sensory examination of lower extremities
- Response to conservative treatment, such as injection therapy
- Levels planned for instrumentation

Both Tennessee specific Local Coverage Determination criteria and MCG (formerly Milliman Care Guidelines®) are used to make medical necessity determinations for these services.

BlueAdvantage looks to curb hospital readmissions

Beginning April 1, 2015, BlueCross rolled out a member facing readmission reduction program that targets BlueAdvantage and BlueChoice members.

Specific discharge diagnoses or extended hospital/skilled nursing stays trigger a call to our member from a BlueCross case manager within 48 hours of discharge. Members are initially assessed to determine any specific barriers to care that could contribute to readmission. If no barriers are identified, their case is closed. If specific barriers to care are present, the case manager works to close the barriers and provides the member with information on physician-recommended follow-up care and medications, along with any needed help scheduling appointments and transportation.

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Chlamydia screening

The Centers for Medicare & Medicaid Services (CMS) estimates that almost three million sexually active adolescent and young adult women have chlamydia infections. The majority of women are asymptomatic and if untreated, chlamydia may lead to more serious conditions such as pelvic inflammatory disease, infertility, and ectopic pregnancy. BlueCross monitors quality associated with chlamydia screening.

Women between 16 and 24 years of age, identified as being sexually active should have a chlamydia screening every year. Here are some tips for improving quality with chlamydia screening:

- *Make sure to obtain a sexual history for a girls and young women who could potentially be sexually active. Obtain this history in private without the parent being present.*
- *If you identify a young female patient as being sexually active, perform chlamydia screening annually.*
- *Performing chlamydia screening during a routine cervical cancer screening is also a good idea, but be aware that the National Committee for Quality Assurance (NCQA) does not recommend routine cervical cancer screening for women under the age of 21.*
- *Make sure to code the procedure accurately and timely.*

Follow-up care for the initial treatment of ADD/ADHD

Stimulant medications prescribed for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) may have some serious medical side effects. Best practice is to ensure timely follow up after these types of medications are prescribed. The American Academy of Pediatric & Adolescent Psychiatry (AACAP) recommends the prescribing practitioner follow up after one month of initially prescribing a stimulant type medication for ADD/ADHD. BlueCross monitors quality related to the prescribing of these types of medications. Here are some tips to help you meet the quality standard:

- *Make sure your office staff schedules a follow up visit* **within 30 days** *of the initial diagnosis. If the visit is scheduled outside the 30-day window, it will not meet the standard.*
- *During the summer months, a 90-day supply of medication is sometimes prescribed for the convenience of the family.* **Follow up is recommended prior to end of the 90-day prescription**. *According to the quality measure, a gap of more than 120 days between follow-up visits will mistakenly identify your patient as being "newly diagnosed" (requiring an initial follow-up visit).*
- *Make sure to code the procedure accurately and timely.*

Colorectal cancer screening

The American College of Gastroenterology (ACG) classifies colorectal cancer screening into two categories, **prevention** and **detection**. According to ACG the preferred colorectal cancer **prevention** screening is colonoscopy and should be offered as the primary test every 10 years, beginning at age 50 and at age 45 years in African Americans.

Please remember to document the results of any colorectal screening test or procedure (unless the documentation is part of the medical history).

Colonoscopy is not available in every clinical setting because of economic limitations and not all patients are willing to undergo colonoscopy for screening purposes. For patients who decline colonoscopy or another cancer prevention test, ACG recommends an annual **fecal immunochemical testing** (FIT) as the preferred colorectal cancer **detection** screening and phasing out the older guaiac-based fecal occult blood testing (gFOBT). A digital rectal exam is NOT counted as evidence of colorectal screening.

Benefits of FIT detection screening includes:

- Superior performance characteristics when compared with older guaiac-based testing
- Requires no dietary restrictions prior to testing
- Single specimen/ease of collection
- Better patient compliance rates

The ordering provider can fax a prescription or send with the patient to either LabCorp* or Quest Diagnostics* patient service centers that are available across the state. The patient will obtain the kit, collect the specimen at home and mail back to the service center in the self-addressed, stamped envelope. More information pertaining to these service centers is available on their websites.

www.labcorp.com/wps/portal/findalab

secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do

***Please refer our members to the appropriate in-network lab.**

*Any changes will be included in the appropriate 2Q 2015 provider administration manual update.

Archived editions of BlueAlert are available online at

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

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta? Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCareSelect 1-800-263-5479. (Arabic); Bosanski (Bosnian) ;(Kurdish-Badinani); (Kurdish- Sorani); Soomaali (Somali); Người Việt (Vietnamese); Español (Spanish) call 1-800-758-1638. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim? Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

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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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