of Tennessee

JUNE 2017

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual is being updated to reflect the following revised policies. The full text of these policies can be found online by clicking Upcoming Medical Policies.

Effective July 8, 2017

- Bio-Engineered Skin and Soft Tissue Substitutes (Revision)
- Diagnosis and Treatment of Facet Joint Pain (Revision)
- Molecular Markers in Fine Needle Aspirates of the Thyroid (Revision)
- Treatment of Tinnitus (Revision)

Effective Aug. 23, 2017

- Home Apnea Monitoring / Home Cardiorespiratory Monitoring (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

Availity - New Provider Portal Coming Soon

BlueCross is making enhancements to our online tools to keep pace with advancements in technology and to provide you with the resources you need. We have partnered with Availity, a leading provider of electronic health care transactions, to offer you a wider range of web-based products and services. Availity offers a multi-payer portal solution allowing you to use a single sign-on to work with BlueCross and other participating health care plans online.

Initially, the new portal will be used for reviewing remittance advices, claims status, eligibility and benefits. More features will be phased in throughout the year. As changes emerge, you will see eBusiness and other BlueCross resources leading efforts on education, provider engagement and training. We will continue to keep you updated about our transition to Availity through BlueAlert, online messages and updates through BlueAccess℠. Availity will eventually replace BlueAccess for providers.

INSIDE THIS ISSUE

Upgrade to Web Authorizations Improves MCG Selection and Documentation

BlueCross has enhanced its online authorization tool. The upgraded tool improves the MCG guideline selection and documentation process for your web authorization requests.

What are the changes?

- New easy to use format
- Most authorizations submitted online have MCG criteria applied.
- Sticky note icons are now included at the end of the guidelines. Additional clinical information can be included by clicking the sticky note icon (250 character limit per note).
- Guidelines that include "…" allow additional criteria to be presented.

Please remember to always load the primary diagnosis first.

When did the changes go into effect?

The changes were implemented on May 1, 2017. If you're not currently using online authorization submission or are using the tool but would like additional training and support, please contact the eBusiness Technical Support or the eBusiness Marketing team.

Importance of Collaboration and Communication Between Medical and Behavioral Health Professionals

High-quality care for your patients needing behavioral health treatment is the result of effective collaboration with behavioral health professionals. By working together, your patients benefit through:

- Integrated interventions
- Patient safety (e.g. potential drug interactions, substance use and interaction with prescriptions, psychosocial support in the home for medical interventions)
- Adjustment in the treatment plan, if necessary
- Improved effectiveness, such as encouraging compliance with other provider recommendations

Collaboration helps you as the medical professional in treating your patients who are also being treated for behavioral health concerns by:

- Increasing awareness of what knowledge and skills you both can offer the patient
- Improving decision-making by understanding the whole person and what might be the most realistic and effective intervention(s) for that individual
- Boosting clinical effectiveness and job satisfaction through learning about other professionals' approach to patient care
- Creating and maintaining good relationships with patients and fellow professionals

You can find more information and other resources by visiting the National Center for Biotechnology Information (NCBI) website.

Antipsychotic Use Has Potential to Impact Patient Health

We recommend that behavioral health providers notify their patient's PCP when antipsychotic medications are being considered. The American Psychiatric Association (APA) recommends an assessment of the patient's health due to the increased risk for weight gain and type 2 diabetes associated with the use of antipsychotics. Targeted assessments should include: Weight, waist circumference and/or BMI, blood pressure, heart rate, blood glucose level and lipid profile. Continued assessment of these factors should occur throughout the course of treatment, and collaboration is encouraged between treating providers. The efficacy and safety of antipsychotics should be monitored proactively.

See APA Practice Guidelines for more information.

Prior Authorization Required for Bavencio and Ocrevus

As of April 28, 2017, Bavencio and Ocrevus were added to the Provider-Administered Specialty Pharmacy Lists and require prior authorization for all lines of business.

You can find information on all provider-administered specialty medications requiring prior authorization on our website(s).

BlueCare Tennessee
BlueCare Plus (HMO SNP)SM
Commercial/CoverKids
Medicare Advantage

Updated THCII Preview and Performance Reports Now Available

The Tennessee Health Care Innovation Initiative (THCII) preview and performance reports are now available on Blue Access for your review. You can use them to identify specific opportunities to further improve quality and reduce the cost of care.

- View your reports by logging in to BlueAccess at bcbst.com/providers.
- Scroll down to Tennessee Healthcare Innovation Initiative to locate your reports. Note: Reporting is segmented by Tax ID."

Applies only to BlueCare Tennessee, CoverKidsSM, State Employee Health Plan and Fully Insured.

Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Beginning immediately, CPT® code 27279 requires prior authorization through the Musculoskeletal Program administered by OrthoNet.

Before submitting prior authorization requests, please verify member benefits/eligibility through BlueAccess or by calling the Provider Service Line.

Prior authorization requests can be submitted through BlueAccess or by fax to 1-800-747-0587. When submitting requests online, the musculoskeletal code must be the primary procedure code.

Reminder: Prior Authorization Required for CPT® Code 81545

Effective July 8, 2017, a prior authorization is required for CPT® Code 81545 (Molecular Markers in Fine Needle Aspirates of the Thyroid) for Commercial lines of business. For a list of services that require prior authorization, see the BlueCross website.

Reminder: New Requirements in Effect for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to be credentialed and contracted before providing services to our members. This includes nurse practitioners and physician assistants who are employed by a physician group already contracted with BlueCross. This requirement went into effect on Jan. 1, 2017.

BlueCross had previously indicated that claims submitted by non-credentialed, non-contracted nurse practitioners and physician assistants would be considered out of network and would be denied beginning May 1, 2017. In order to allow more time to comply with this requirement, BlueCross will not process these claims as out of network or deny them for dates of service beginning May 1, 2017. A revised date will be published in an upcoming BlueAlert.

Providers can begin the credentialing, enrollment and contracting process by completing the online Provider Enrollment Form. Please contact your local Provider Relations Consultant (PRC) with any questions. If you don't know who your PRC is, please visit our website to locate your BlueCross contact.

Reminder: Electronic Claims Submission Required

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support if you need to discuss any barriers that prevent you from filing electronic claims.

BlueCare Tennessee

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

Reminder: Document Any Refusal to Vaccinate

Each parent/guardian or patient has the right to refuse recommended vaccines. Refusal to get recommended immunizations must be documented in the patient's medical record. Resources for documenting the refusal are available on the American Academy of Pediatrics website.

Additionally, the Centers for Disease Control and Prevention has conversation tools to help talk with parents/guardians and patients about the importance of immunizations and the importance of preventive care.

Reminder: Sick Visit Could be Your Only Chance to Conduct a TennCare Kids Checkup

Thousands of kids from low-income homes in Tennessee miss their annual well-care checkups, and the number who miss increases every year. Any time a child (patient under age 21) with TennCare Kids coverage is in your office is a great time to make sure your patient's checkups are up to date.

While your patient's visit might be for an illness, shots or a prescription refill, statistics show it could be years before you get another chance to conduct a checkup, especially if your patient is a teenager. TennCare Kids Screening Guidelines permit reimbursement for both a "sick" and "well" visit on the same day, so you don't have to schedule another appointment.

For the correct coding and modifier usage for billing both types of care on the same day, please see the TennCare Kids Screening Guidelines section of the BlueCare Tennessee Provider Administration Manual.

Reminder: Prior Authorization Required for DPP-4 and SGLT-2 Inhibitors for Diabetes

Diabetes medications such as DPP-4 and SGLT-2 inhibitors and their combinations require prior authorization (PA).

For questions or prior authorization requests for your BlueCare Tennessee patients, please contact Magellan Health Services Clinic Call Center at 1-866-434-5524 or fax your request to 1-866-434-5523.

Drugs requiring prior authorization for BlueCare Tennessee members are identified by (PA) on the TennCare's Preferred Drug List (PDL).

Reminder: TennCare Registration Required for Secondary Providers on Certain Claims

Beginning with claims on or after June 1, 2017, the following secondary providers submitting professional and/or institutional claims for BlueCare Tennessee and CoverKids members must be registered with the Bureau of TennCare as well as with BlueCare Tennessee for all dates of service on the claim.

Institutional Claims

- Attending Provider
- Operating Provider
- Other Operating Provider
- Rendering Provider
- Service Facility Location

Professional Claims

- Service Facility Location
- Purchased Service Provider

Claims submitted on or after June 1, 2017, with an unregistered secondary provider will be returned to the provider unprocessed.

To learn more about registering with TennCare please visit the TennCare website.

To register with BlueCare Tennessee, please call the Provider Service lines.

BlueCare	1-800-468-9736
TennCareSelect	1-800-276-1978
CoverKids	1-800-924-7141

Medicare Advantage

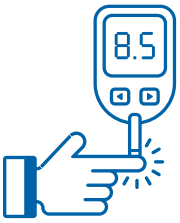
This information applies to BlueAdvantage (PPO)℠ and BlueChoice (HMO)℠ plans. BlueCare Plus (HMO SNP)℠ is excluded unless stated otherwise.

Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. Reimbursement will not be considered for dialysis clinic claims in a given calendar year if a completed CMS-2728-U03 form is not on file with BlueCross. The initial and subsequent claims will be denied, and you will be asked to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002



Reminder: We Can Help Your Patients Manage Their Diabetes

As you know, the key to living with diabetes is properly managing the disease over the long term. That's why BlueCross offers your Medicare Advantage patients tools and rewards to encourage them to follow your plan of care and maintain a healthy lifestyle.

For details about the rewards your patients can receive for completing recommended diabetes screenings, see the comprehensive list of wellness incentives on our Quality Care Rewards webpage.

If you have diabetic patients who have trouble making it to your office, we can help schedule in-home visits so your patients can complete the tests they need. Just call us at 1-800-841-7434 and we can schedule in-home visits with our health partners to help your patients complete each of the following screenings annually:

- blood sugar (HbA1c)
- kidney function
- retinal eye

You will receive all copies of test results. And if you participate in our provider quality program, you will receive credit for these gaps in care getting completed.

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member's health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member's condition. The MA plan follows Medicare policy. According to 42 U.S.C. § 1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

According to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.24(e) and (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

As with Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly; the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

Delay of Breast Cancer Medical Oncology, Mastectomy Episodes of Care

The Breast Cancer Medical Oncology and Mastectomy episodes in Wave 5 will not be included in the Tennessee Health Care Innovation Initiative (THCII) May 2017 preview reports, because the Cancer Registry data has not yet been incorporated. The performance period for these two episodes will begin with calendar year 2019, instead of calendar year 2018.

The Breast Biopsy episode will not be delayed, and will be included in the May 2017 reports. The first performance period for this episode will be in calendar year 2018.

Filing an Encounter Claim for Comprehensive Diabetes Care

An encounter claim may be filed for patients who have a retinal or dilated eye exam by an eye care provider in 2017. For patients who had a negative dilated retinal eye exam in 2016, you can file an encounter claim and refer them to an eye care professional for a comprehensive eye exam in 2017.

The CPT® Category II code for a negative retinal screen in the prior year is 3072F. You can find sample codes for diabetic retinal exams and more information on our website.

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not to discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCareSelect. For TTY help call 771 and ask for 888-418-0008.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online at bcbst.com/providers/newsletters/index.page

CAQH Solutions | PROVIDER

Be sure your **CAQH ProView™** profile is kept up to date at all times. We depend on this vital information.

† Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or press 1. Then, press 1 again and follow the prompts to reach Network Contracts or Credentialing to update your information; and
- Update your provider profile on the CAQH ProView™ website.

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
BlueChoice℠	1-866-781-3489
***Select*Community**	1-800-292-8196
Available 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 6 p.m. (ET)	
BlueAdvantage	1-800-841-7434
BlueAdvantage Group	1-800-818-0962
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	eBusiness_service@bcbst.com
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	