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I. INTRODUCTION

BlueCross BlueShield of Tennessee, Inc. is an independent licensee of the BlueCross BlueShield Association consisting of some 60 BlueCross and/or BlueShield Plans throughout the United States.

BlueCross BlueShield of Tennessee is the state's oldest and largest not-for-profit health plan, serving more than 2.6 million Tennesseans. Founded in 1945, the Chattanooga-based company is focused on financing affordable health care coverage and providing peace of mind for all Tennesseans. BlueCross serves its members by delivering quality health care products, services and information. For more information on BlueCross BlueShield of Tennessee, visit the company's Web site www.bcbst.com.

The following pages contain comprehensive information regarding operating policies and procedures established by BlueCross BlueShield of Tennessee and are incorporated by reference into the Participation Agreements.

This Manual is designed to provide information and guidelines for Facilities, Practitioners and other Providers who participate in one or more of the Provider networks listed below:

- **Blue Network C**
- **Blue Network K**
- **Blue Network P**
- **Blue Network S**
- **BlueCare® (Volunteer State Health Plan, Inc. Network) - See Section XXII**
- **TennCare*Select* (Volunteer State Health Plan, Inc. Network) - See See Section XXII**

A. BlueCross BlueShield of Tennessee Statement of Purpose

➢ BUSINESS

Our Business is financing affordable health care coverage.

➢ PURPOSE

Our Purpose is *Peace of Mind*.

➢ LONG-TERM CORPORATE GOALS

Our Long-Term Corporate Goals are:

- Affordability
- Sustainability
- Outreach

Code of Business Conduct

BlueCross BlueShield of Tennessee has been a part of Tennessee families and businesses since 1945. We have built a bond of trust with the people we serve, as well as the vendors and suppliers with whom we do business.

To strengthen that bond of trust, the BlueCross BlueShield of Tennessee Board of Directors adopted a set of policies and Code of Conduct that applies to all directors, officers, and employees.

Included in our Code of Conduct are two sections entitled “Conflicts of Interest” and “Dealing with Customers and Suppliers”. The primary focus of these sections is to help ensure business decisions are based on the merit of the business factors involved and not on the offering or acceptance of favors. You can review the Code of Conduct in its entirety online at:

http://www.bcbst.com/about/company_profile/CodeofConduct.pdf

Please share this information with all your employees who interact with our company. If you should have any questions, or wish to report a suspected violation, please call the Confidential Compliance Hotline at 1-888-343-4221 or e-mail us at compliancehotline@bcbst.com.

B. Descriptions of Networks

The following grid is intended to serve as a general guide in defining basic characteristics of BlueCross BlueShield of Tennessee networks. **Note:** ***Throughout this manual***, ***references to Primary Care Practitioners and Referrals (Out-of-Network) apply ONLY to BlueCare® and TennCareSelect.*** For more detailed, plan-specific information, please contact your BlueCross BlueShield of Tennessee Provider Relations Representative.

Network	Characteristics
Blue Network C	The Blue Network C Provider Network is open to all Practitioners, hospitals, pharmacies and other health care Providers who meet minimum network participation requirements and are willing to accept BlueCross BlueShield of Tennessee reimbursement levels and therefore includes the broadest array of Providers.
Blue Network P	The Blue Network P Provider Network offers a wide variety of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies.
Blue Network S	Like Blue Network P, the Blue Network S Provider Network is based on a variety of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies, but focuses more on affordability. This is achieved, in most Tennessee markets, with a narrower network of providers than Network P.
Blue Network K	The Blue Network K Provider Network helps employers deliver a lower cost health plan option by offering a limited network of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies. Practitioners will be closely monitored for positive performance and in exchange are not required to comply with certain medical management requirements.
BlueCare®	The BlueCare Network is a Primary Care Practitioner (PCP)-driven Health Maintenance Organization (HMO) network underwritten by Volunteer State Health Plan, Inc., to provide medical care for TennCare Members.
TennCare *Select*	TennCare*Select* is the State of Tennessee's Health Maintenance Organization administered by Volunteer State Health Plan, Inc. TennCare*Select* serves a select population and is the State's safety net network.
Nationwide	Benefits vary, to obtain benefit information, see Section III in this manual, *How to Identify a BlueCross BlueShield of Tennessee Member*.

C. Individual Product and Plan Options

BlueCross BlueShield of Tennessee offers a variety of health benefits plans to meet the needs of individuals who are not covered under an employer-sponsored health care plan.

The summary below is intended to assist you in identifying BlueCross BlueShield of Tennessee individual products and their supporting networks. Although Members' ID cards reflect network/copay information, Providers are encouraged to call the customer service telephone number on the front of the Member ID card to verify benefits, deductible/copay amounts, and prior authorization requirements.

Personal Health Coverage 1 – Group number 95800
Personal Health Coverage (PHC) 1 was introduced in July 2000 and is no longer actively marketed. This PPO product is supported by Blue Network P and offers a variety of benefit designs including:

- 30 different plan designs, based on various combinations of options listed below
  - 5 deductible options ranging from $250 to $5,000
  - 80% coinsurance on all plans, with 100% coinsurance available on the higher deductibles
  - Two office visit copay options
  - Out-of-pocket maximums ranging from $1,250 to $7,000
  - A separate maternity rider and dental coverage option available
  - Two copay PPO plans
  - $10/$25/$35 pharmacy benefit, with a $100 Rx deductible
- Covers well child care and preventive screenings. Other preventive services over age 6 are subject to $300 limit
- 12-month pre-existing condition waiting period, with 12-month look-back period. (If evidence of prior continuous coverage, all or part of 12-month waiting period can be credited based on number of months prior coverage experienced.)
- Can include a condition exclusion rider or dependent exclusion rider
- Behavioral health benefits subject to same deductible and coinsurance percentages as medical, but include 20-day limit on inpatient care and 25-visit limit on outpatient care

PHC1 sample ID card:

Rev 03/04

Personal Health Coverage 2 – Group number 103800
Personal Health Coverage 2 was introduced in March 2002. This PPO product is supported by Blue Network P and offers the same types of plans as Personal Health Coverage 1, but with fewer options available. Options include:

- 14 different plan designs, based on various combinations of options listed below
  - 5 deductible options, ranging from $250 to $5,000
  - 80% coinsurance on all plans, with 100% coinsurance available on the higher deductibles
  - Two office visit copay options
  - Out-of-pocket maximums ranging from $1,250 to $6,000
  - A separate maternity rider and dental coverage option is available
  - Two copay PPO plans
  - $10/$35/$50 pharmacy benefit, no deductible
- Covers well child care and preventive screenings; Other preventive services over age 6 are subject to a $300 limit
- 12-month pre-existing condition waiting period, with 12-month look-back period
- Can include a condition exclusion rider or dependent exclusion rider
- Outpatient behavioral health benefits subject to 50% coinsurance and $1,000 payment maximum; inpatient behavioral health subject to 60% coinsurance and 20-day limit

PHC2 sample ID card

BasicBlue – Group number 106800
BasicBlue was introduced in January 2003. This product is supported by Blue Network K and is designed specifically for affordability.

- No copays
- 20% coinsurance
- Three deductible choices:
  - $500/$5,500 out-of-pocket maximum, per calendar year
  - $1,000/$6,000 out-of-pocket maximum, per calendar year
  - $2,500/$7,500 out-of-pocket maximum, per calendar year
- Includes child well-care and adult preventive screenings (does not include adult well-care benefit with $300 limit)
- No maternity or personal dental coverage option
- 12-month pre-existing condition waiting period, with 12-month look-back period
- Excludes:
  - Pharmacy
  - Behavioral Health
  - Removal of impacted wisdom teeth

BasicBlue sample ID card

BlueValue – Group number 107800
BlueValue was introduced in March 2003. This PPO product is supported by Blue Network S and is designed as a total package for individuals not choosing traditional health care benefits.

- No in-network deductible
- 50% coinsurance
- $10,000 out-of-pocket maximum, per calendar year
- Covered Services include:
  - Pharmacy/$2,000 limit
  - Preventive dental/$400 limit
  - Child well-care
  - Adult preventive screenings
  - Adult preventive care/$300 limit

BlueValue sample ID card

BluePreferred – Group numbers are 80861, 83560 and 89520
BluePreferred is the oldest of the individual products, and has not been actively marketed since July 2000. This PPO product is supported by Blue Network P. The benefits are more limited than the newer Personal Health Coverage plans:

- 3 deductible options - $300, $500, $1,000
- 80% coinsurance
- Maternity and pharmacy included in base benefit, subject to deductible and coinsurance

- No coverage for preventive services
- Limited coverage for therapies
- 24-month on pre-existing condition waiting period, with lifetime look-back period
- Can include a condition exclusion rider or dependent exclusion rider
- Outpatient behavioral health benefits subject to 50% coinsurance and $2,500 payment maximum; inpatient behavioral health limited to $10,000 per year

BluePreferred sample ID card

Short Term Coverage – Group number 82125
Short Term Personal Health Coverage is available for periods of one, two or three months. This PPO product is supported by Blue Network P. There is no medical underwriting for this product; however, pre-existing conditions are not covered.

- 4 deductible options - $250, $500, $1,000, $2,500
- 80% coinsurance
- Pharmacy included in base benefit, subject to deductible and coinsurance
- No coverage for maternity
- No coverage for preventive services
- No coverage for pre-existing conditions
- No coverage for behavioral health

BluePartner – Group number 111800
BluePartner is an individual health plan product meeting regulations established by the recently created Health Savings Account (HSA). BluePartner is a high deductible health plan product for individuals that enables enrollees to enjoy the tax advantages offered by HSAs and features a deductible and coinsurance benefit design with three deductible and coinsurance options for self-only and family coverages.

- Covered Services, other than preventive, are subject to deductible and coinsurance
- Deductibles and coinsurance amounts increase annually on January 1
- All family members' expenses apply to one deductible and out-of-pocket maximum. The entire amount must be met before benefits are paid for any individual family member.
- Preventive services covered at 100 percent subject to $20 office visit copay
- No coverage for behavioral health or maternity
- No payment limits for TMJ and adult well care
- 12-month symptom-based pre-existing waiting period applies

BluePartner sample ID card

SimplyBlue and SimplyBlue Plus – Group number 114800
This product was introduced in August 2005. This product is supported by Blue Network S, and is designed to be a low cost product with options to "buy up" a package of additional benefits.

SimplyBlue

- No copays
- Four deductible choices:
  - $1,000/$6,000 OOP max with 80% plan coinsurance
  - $1,500/$6,500 OOP max with 80% plan coinsurance
  - $2,500/$2,500 OOP max with 100% plan coinsurance
  - $3,500/$3,500 OOP max with 100% plan coinsurance
- Includes child well care and adult preventive screenings (does not include adult wellcare benefit with $300 limit)
- No pharmacy or behavioral health benefit
- Maternity rider available
- 12 month pre-existing condition waiting period

Additional "**Plus**" benefits for SimplyBlue

- Adult well care benefit with $300 annual limit
- $30 OV copays on all preventive services
- $30 OV copays on the first two medical visits (third and subsequent visits subject to deductible and coinsurance)
- Limited generic only pharmacy benefit with $125 per calendar quarter payment limit

SimplyBlue Guaranteed Issue and SimplyBlue Plus Guaranteed Issue – Group number 115800

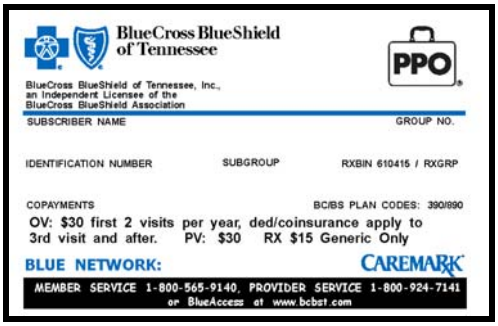
This product is available for individuals who qualify for guaranteed issue coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- No copays
- Three deductible choices:
  - $1,500/$6,500 OOP max with 80% plan coinsurance
  - $2,500/$7,500 OOP max with 80% plan coinsurance
  - $3,500/$8,500 OOP max with 80% plan coinsurance
- Includes child well care and adult preventive screenings (does not include adult wellcare benefit with $300 limit)
- No pharmacy or behavioral health benefit
- Maternity rider not available
- No underwriting or pre-existing condition waiting period

Additional "**Plus**" benefits for Guaranteed Issue

- Adult well care benefit with $300 annual limit (screening colonoscopies not subject to the $300 limit)
- $30 OV copays on all preventive services
- $30 OV copays on the first two medical visits (third and subsequent visits subject to deductible and coinsurance)
- Limited generic only pharmacy benefit with $125 per calendar quarter payment limit

SimplyBlue sample ID cards appear the same except for group numbers



D. Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal act, which includes important protections for people who change jobs, are self-employed or who have pre-existing medical conditions. Its primary intent was to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs within the health care system.

The element of the law labeled Administrative Simplification (HIPAA-AS) is intended to improve the efficiency and effectiveness of the health care system by standardizing the exchange of electronic, administrative and financial data. It is also intended to protect the security and privacy of patient health identifiable information (PHI).

1. Health Information Privacy Policies and Procedures

BlueCross BlueShield of Tennessee Privacy Policies and Procedures implement its obligations to protect the privacy of individually identifiable health information that is created, received or maintained by BlueCross BlueShield of Tennessee. A major component of protecting health information is to adhere to the necessary data safeguards set forth in the Information Security's policies and procedures.

BlueCross BlueShield of Tennessee must promptly change these policies and procedures as necessary to comply with changes in federal and state law. Any changes in the policies and procedures will generate a revision to the Notice of Privacy Practices, which must be distributed within sixty (60) days of the effective date of change. The revised Notice will be available to anyone upon request on the effective date of the change.

BlueCross BlueShield of Tennessee may make changes to these policies and procedures at any time by amending the policies and procedures provided they remain in compliance with federal and state law. BlueCross BlueShield of Tennessee's Privacy Office will review and update (if necessary) these policies annually. If a change is made, BlueCross BlueShield of Tennessee will retain the former policies and procedures for at least six (6) years from their last effective date. The Privacy Office will, at all times, maintain a master list of all policies and procedures.

BlueCross BlueShield of Tennessee's Privacy Office will review and update the protected health information use and disclosure assessment every two (2) years.

BlueCross BlueShield of Tennessee employees are obligated to follow these policies and procedures diligently. Failure to do so can result in disciplinary action, including termination of employment.

BlueCross BlueShield of Tennessee's Privacy Policies can be seen in their entirety on the company Web site at www.bcbst.com/hipaa/general/HIPAA_privacy/default.shtm.
Any questions concerning these policies and procedures should be directed to the BlueCross BlueShield of Tennessee Privacy Office by calling 1-888-455-3824.

2. Protected Health Information-allowable disclosures under HIPAA

Privacy of medical information is important to all covered entities. New federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way BlueCross BlueShield of Tennessee operates, however, it will not prevent us from exchanging the information we need for **treatment**, **payment**, and **health care operations (TPO)**.

BlueCross BlueShield of Tennessee will continue to conduct business as usual in most circumstances. HIPAA regulations allow the disclosure and contractually, BlueCross BlueShield of Tennessee providers (subject to all applicable privacy and confidentiality requirements) are obligated to make medical records of BlueCross BlueShield of Tennessee Members available to each Physician and/or Health Care Professional treating BlueCross BlueShield of Tennessee Members and to BlueCross BlueShield of Tennessee, its agents, or representatives.
Privacy Regulations should not impact patient treatment and quality of care; it is vital for the benefit of our members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. Examples of TPO, include, but are not limited to:

Treatment - rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.

Payment - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a provider for services rendered to a patient.

Health care operations - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and a listing of examples, please review the federal regulations at http://www.hhs.gov/ocr/hipaa/finalreg.html.

If you have any questions or concerns regarding privacy matters, you may call the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail us at privacy_office@bcbst.com.

E. General Information

1. Fraud and Abuse Hotline

A special telephone hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether or not they are a BlueCross BlueShield of Tennessee participating Provider or Member, can report suspected health care fraud by calling 423-763-3150 or 1-800-496-9600, or by visiting the company Web site, www.bcbst.com.

2. Interpretation Services

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received. The Executive Order, signed August 11, 2000, by former President William Clinton, is a guidance tool including specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. It is not permissible to charge BlueCross BlueShield of Tennessee Members, including a BlueCare or TennCare*Select* Member, for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at http://www/usdoj.gov/crt/cor/13166,htm.

Providers can use the “I Speak” Language Identification Flash Card to identify the primary language of BlueCross BlueShield of Tennessee Members, including BlueCare and

TennCare*Select* Members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at http://www.usdoj.gov/crt/Pubs/IspeakCards.pdf.

Additionally, the National Health Law Program and Access Project 2003 is an organization that assists providers having patients with language issues by providing a Language Services Action Kit. The kit can be purchased by e-mailing lepactionkit@accessproject.org.

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers can locate interpreters specializing in meeting needs of LEP clients by calling one of the following numbers below:

- Language Line 1-800-874-9426
- Hablamos Juntos Line 205-824-2360
- Open Communications International 615-321-5858
- Institute of Foreign Language 615-741-7559

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.

The Department of Health and Human Services can also recommend resources for Providers to use when limited English proficiency services are needed.

3. Provider Communications

BlueCross BlueShield of Tennessee produces the *BlueAlert* newsletter on a monthly basis to communicate important policy and benefit-related news to health care Providers. Also included are helpful tips and reminders on how to file claims and conduct other business more efficiently with BlueCross BlueShield of Tennessee. The newsletters are mailed to all participating Providers in Tennessee.

Providers can also find useful information about BlueCross BlueShield of Tennessee on the company Web site, www.bcbst.com; e.g., Referral Directory of Network Providers, Find a Provider, Medical Management Policies, and in a secured area, Member Eligibility, Coverage Verification and Claims Status.

4. Pre-existing Condition

The definition of pre-existing condition differs between **Group** and **Individual** Health Coverage. Additionally, standard waiting periods vary by health plan. Some Individual policies also have benefit exclusion riders that apply to specific conditions and continue past the pre-existing waiting period.

Key differences between Group and Individual pre-existing clauses are:

Group Health Coverage – Employer-funded or sponsored
A pre-existing condition is defined as:

- any physical or mental condition that began prior to the enrollment date* of the member's coverage;
- any physical or mental condition, which was present during a variable look back period immediately before the member's enrollment date, for which medical advice, diagnosis, care or treatment was recommended or should reasonably have been received; and is
- **treatment** driven.

*Could be the effective date of contract, but can be the hire date, if a policy waiting period exists.

Individual Health Coverage – Coverage not sponsored by an employer. Individual products are medically underwritten.

A pre-existing condition is defined as:

- any physical or mental condition, which was present during a variable look back period before the member's coverage became effective, for which symptoms existed, medical advice, diagnosis, care or treatment was recommended or should reasonably have been received; and is
- **symptom** driven.

Examples of Pre-existing Lack of Information Codes:

Code	Description
W57	Information has been requested from another provider to complete pre-existing review. **No action is required.**
W74**	Medical information is needed to complete a pre-existing review. **Correspondence will follow**.
Z57*	We are investigating to determine if this condition is pre-existing. If found to be pre-existing we may seek a refund.

Examples of Pre-existing Denial Codes:

Code	Description
XP1	This service is denied as a pre-existing condition because symptoms existed prior to this Member's effective date.
XP2	This service is denied as a pre-existing condition because treatment was recommended prior to this Member's enrollment date.
XP3	This service is denied as a pre-existing condition because treatment was received prior to this Member's enrollment date.
XP4	This service is denied as a pre-existing condition because treatment was recommended prior to this Member's effective date.
XP5	This service is denied as a pre-existing condition because treatment was received prior to this Member's effective date.
PX	Charges for a pre-existing condition are not eligible for benefits.

*If condition under review is later determined to be pre-existing, the payment may be recovered resulting in Member liability.
**Once a decision is made regarding the condition in question, claims previously denied will be re-processed. Responding promptly and completing all requested information helps ensure claims are handled expeditiously.

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II. BLUECROSS BLUESHIELD OF TENNESSEE QUICK REFERENCE TELEPHONE GUIDE

Contact	Location/Description	Telephone Number	Address/Description
BlueCross BlueShield of Tennessee	Provider Service Line (Toll-free)	1-800-924-7141	General inquiries - voice response line – speak when prompted (available Mon.-Fri., 8 a.m. to 5:15 p.m. ET) Or write to: BlueCross BlueShield of TN ATTN: Correspondence P.O. Box 180150 Chattanooga, TN 37401
e-Commerce	Technical (Phone Local) Enrollment (Phone Local)	423-535-5717 423-535-5174	BlueCross BlueShield of TN ATTN: e-Commerce 801 Pine Street Chattanooga, TN 37402
Provider Relations (Phone Local)	Chattanooga Office	423-535-6307	BlueCross BlueShield of TN ATTN: Provider Relations 801 Pine Street, 1TC Chattanooga, TN 37402
	Jackson Office	731-664-4127	BlueCross BlueShield of TN ATTN: Provider Relations 51 Stonebridge Blvd. Jackson, TN 38305
	Johnson City Office	423-854-6036	BlueCross BlueShield of TN ATTN: Provider Relations 801 Sunset Drive, Bldg C Johnson City, TN 37604
	Knoxville Office	865-588-4644	BlueCross BlueShield of TN ATTN: Provider Relations 6305 Kingston Pike Knoxville, TN 37919
	Memphis Office	901-544-2399	BlueCross BlueShield of TN ATTN: Provider Relations 85 N. Danny Thomas Blvd-2MD Memphis, TN 38103
	Nashville Office	615-386-8630	BlueCross BlueShield of TN ATTN: Provider Relations 3200 West End Ave., Ste 102 Nashville, TN 37203
Fraud & Abuse	Phone (Toll-free)	1-800-496-9600	To report suspected fraudulent activity

Contact	Location/Description	Telephone Number	Address/Description
Credentialing	Toll-free	1-800-357-0395	BlueCross BlueShield of TN Attn: Credentialing Dept. P.O. Box 180176 Chattanooga, TN 37401
Paper Claims Submission	Blue Networks C, P, S, K BlueCross65℠ Federal Employee Program (FEP)		Submit paper claims to: BlueCross BlueShield of TN Attn: Claim Service Center P.O. Box 180150 Chattanooga, TN 37401
Pharmacy Program BlueCross BlueShield of Tennessee	Phone (Toll-free) Fax (Local Memphis) (Local Chattanooga)	1-800-924-7141 901-544-2735 423-535-4566	To submit comments or suggestions regarding BlueCross BlueShield of Tennessee Formulary (BlueCross BlueShield of Tennessee Pharmacy and Therapeutics Committee) To appeal a denial of a Prior Authorization or Quantity Limitation request.
CAREMARK	Phone (Toll-free) Fax (Toll-free)	1-877-916-2271 1-888-836-0730	Prior authorization medication requests (for criteria see Three Tier Formulary book or visit the Pharmacy page on the company Web site, **www.bcbst.com**); or Requests to override pre-established quantities for drugs listed on the Quantity Limitation List (approvals based on the clinical rationale provided by prescriber).
CAREMARK Help Desk	Phone (Toll-free)	1-800-345-5413	Claims processing and technical assistance
CAREMARK Enrollment	Phone (Toll-free)	1-800-314-8457	Pharmacy network contract inquiries
Specialty Pharmacy Vendors			
CAREMARK® SpecialtyRx	Phone (Toll-free) Fax (Toll-free)	1-866-295-2779 1-866-295-2778	To request information or order specialty pharmacy drugs
CuraScript Pharmacy	Phone (Toll-free) Fax (Toll-free)	1-888-773-7376 1-888-773-7386	
Priority Healthcare	Phone (Toll-free) Fax (Toll-free)	1-866-225-5670 1-866-225-5671	

Contact	Location/Description	Telephone Number	Address/Description
Utilization Management (UM)	Phone (Toll-free)	1-800-924-7141 423-535-6475 or 423-535-6994	Selected services require prior authorization. (See Sec. VIII. for a listing of those services.) Prior authorization is required for all inpatient admissions and may be obtained Monday through Friday, 9a.m. to 6p.m. (EST). (See Sec. VIII for information on emergency and after-hours admissions.)
UM Appeals			
Reconsideration	Phone (Toll-free)	1-800-924-7141	
Standard Appeal and Retro Authorization Request	Written Only		BlueCross BlueShield of TN Attn:UM Appeals Supvr, 1G UM Appeals P.O. 180177-7177 Chattanooga, TN 37402
Previously Denied Standard UM Appeal	Written Only		BlueCross BlueShield of TN Attn: Provider Appeals Coordinator Provider Networks & Contracting 801 Pine Street Chattanooga, TN 37402
	Fax (Local)	423-535-7119	For use in checking status of previously submitted appeal requests
Specialty Case Management			
Disease Management and High-Risk Maternity Case Management	Phone (Toll-free) Fax (Chattanooga Local)	1-800-225-8698 423-535-7790 or 423-535-3331 or 1-800-421-2885	To arrange coordination of care for Members with complicated needs, e.g., chronic illnesses and/or catastrophic illnesses or injuries. Available Monday through Friday, 9a.m. to 6p.m. (ET)
Transplant Case Management	Phone (Toll-free) Fax (Chattanooga Local) (Toll-free)	1-888-207-2421 423-535-7790 or 1-800-421-2885	

BlueCard® Benefits & Eligibility All other inquiries	 Phone (Toll-free) Phone (Toll-free)	 1-800-676-2583 1-800-705-0391	 Available Monday through Friday, 8 a.m. to 5:15 p.m. (ET)
BlueAdvantage/ BlueAdvantage*Plus*	See Section XXIV. Commercial Provider Administration Manual		
Provider Audit Inquiries	Phone (Toll-free)	1-888-423-9493	BlueCross BlueShield of TN Attn: Provider Audit P.O. 180150 Chattanooga, TN 37401

We encourage you to logon to BlueAccess and e-Health Services® on the company Web site, www.bcbst.com to access real time information. On this site you can:

- Check medical, behavioral health and dental claims status (excludes prescription drug claims);
- View your remittance advice;
- Submit inpatient prior authorization requests and receive online approvals when specific criteria are met;
- Look up prior authorization status;
- Verify benefits, including eligibility and coverage details;
- and much, much more….

III. HOW TO IDENTIFY A BLUECROSS BLUESHIELD MEMBER

A. Identifying a Member's ID Card

Each BlueCross BlueShield of Tennessee Member is issued an ID card. The ID card contains much of the information you will need to submit claims and coordinate your patient's care.

While BlueCross BlueShield of Tennessee ID cards differ depending on the Member's health care benefits plan, there are some standard elements common to most BlueCross BlueShield of Tennessee ID cards.

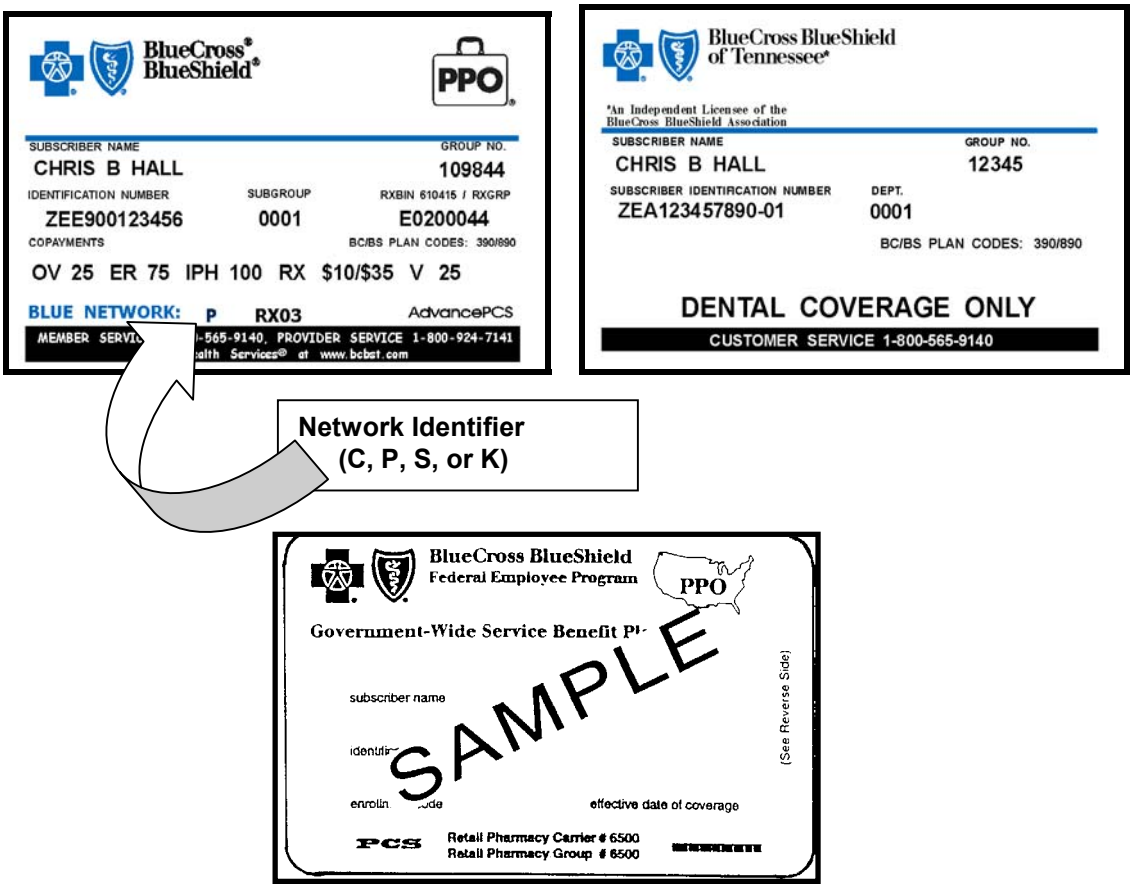
The following information can be found on most BlueCross BlueShield of Tennessee ID Cards:

- Member name;
- Member ID number (including three-letter alpha prefix);
- Group number (if applicable);
- Member fee (co-pay/deductible);
- Prior authorization toll-free number;
- Mailing address for claims & inquiries;
- Behavioral Health Services telephone number; and
- Participating Provider network.

If a Member presents without his or her ID card, Providers should verify health care benefits or eligibility by:

- Calling Provider Service at 1-800-924-7141
- Checking e-Health Services® on the company Web site, www.bcbst.com

BlueCross BlueShield of Tennessee provides standard ID cards to support its commercial health care benefits plans. The sample ID cards shown below are representative of some Member ID cards in use.



Some Member health care benefits plans may have customized ID cards* which differ slightly from those previously shown. The BlueCross BlueShield of Tennessee logo should appear on **all** BlueCross BlueShield of Tennessee ID cards, however, some national accounts may have the BlueCross BlueShield logo without the specific Plan designation, i.e., "of Tennessee".

*The Federal Employees Program (FEP) ID card is a nationally recognized identification card that will aid in admissions to hospitals without having to verify benefits with the Member's employer. Members and Providers may call FEP Customer Service at 1-800-572-1003 or 423-755-5707 for claims filing procedures, requests for additional claim forms and/or benefit information.

All ID cards for federal employees are issued by FEP Operations Center in Washington, DC. Providers may submit claims to the following claims address for Members carrying a BlueCross BlueShield FEP ID card, regardless of the state in which the Member resides.

Mail claims to:

BlueCross BlueShield of Tennessee, Inc.
FEP Claims department
P.O. Box 180150
Chattanooga, TN 37401-7150

Rev 09/04

B. Determining Eligibility

Providers may obtain eligibility or Member health care benefits information by

- calling Provider Service at 1-800-924-7141, or
- accessing BlueCross BlueShield of Tennessee's e-Health Services® on the company Web site, www.bcbst.com.

Note: V*erification of BlueCross BlueShield of Tennessee health coverage is not a guarantee of benefits or coverage (does not guarantee benefits will be paid for the Provider's services).* *The Member's health care benefits plan may have terminated, a self-insured or administrative services only (ASO) group may not pay for services, or benefits may be limited by the terms of the Member's contract or by pre-existing conditions. The Provider's services and course of treatment must also be deemed Medically Necessary and Medically Appropriate. BlueCross BlueShield of Tennessee reserves the right to determine whether, in its judgment, a service is Medically Necessary and Medically Appropriate for purposes of benefit determination. The fact that a Practitioner has prescribed, performed, ordered, recommended or approved a service does not in itself make it Medically Necessary and Medically Appropriate.*

➢ e-Health Services

With e-Health Services, Providers can view information as it appears *right now* in the BlueCross BlueShield of Tennessee computer system. This information is located in a secure area on the company Web site at www.bcbst.com. To access the secured area main menu, first-time users need to register by initiating the following steps:

- Assign a user ID and password;
- Select a token question and complete the personal profile; and
- Assign "permissions" giving you access to all patient data. (**Note**: *This process replaces use of Digital Certificates to obtain secured information*.)

Each Provider number has a "shared secret". If a Provider does not know his/her shared secret, he/she can select "Request Shared Secret" from the secured main menu; follow the prompts and he/she will receive the requested information via mail within a few days. Once this information is received, the Provider can go to the secured area main menu on the company Web site; select "Update Permissions" and click on "Add Providers." Enter the requested information and he/she can access patient data on any Member covered under BlueCross BlueShield of Tennessee commercial lines of business.

If the Provider office staff handles thirty (30) or more different Provider numbers, they can request a single reference number, which will conveniently give access to all patients associated with those provider numbers. A BlueCross BlueShield of Tennessee Provider Relations Representative will contact the Provider once the reference number is assigned.

e-Health Services offers the following Member-specific information:

- Eligibility
- Health care benefits;
- Primary Care Practitioner (PCP) (if applicable);
- Other insurance;
- Dental coverage (if applicable);
- Locate a participating Provider;
- View status of previously submitted:
    - Claims;
    - Prior authorizations; and
    - Referrals

Providers can now submit Inpatient, Outpatient Procedures, and 23-hour Observation prior authorization requests and receive online approval by selecting the option to apply Milliman Care Guideline Criteria and answer a few clinical questions. If the authorization meets specific criteria they will receive online approval and a reference number. Requests will be recorded in the BlueCross BlueShield of Tennessee computer system real time as it is received.

This service* is available 24-hours-a-day, 7-days-a-week for all registered BlueCross BlueShield of Tennessee commercial Providers. Those who have not yet tried e-Health Services, can now register online by visiting the company Web site, www.bcbst.com and then clicking on the "Providers" tab on the right side of the page. Once on the Providers Page, click on the tab to enter the Provider Secure Area and then follow the simple registration instructions. Within 2 business days of registering, Providers will receive a "Shared Secret" for use in gaining access to e-Health Services.

Additionally, Providers can e-mail BlueCross BlueShield of Tennessee via e-Health Services. All correspondence will be answered within two (2) business days. For more information on *e*-Health Services or authorization access, please call BlueCross BlueShield of Tennessee e-Commerce at 423-755-5717.

*At this time, excludes Home Health, Home Infusion Therapy, Durable Medical Equipment and Outpatient Rehabilitation services.

➢ Retroactive Member Termination Recoveries

Effective July 1, 2001, the following guidelines apply to Provider recoveries as a result of retroactive Member terminations:

If BlueCross BlueShield of Tennessee verifies eligibility of an individual who is subsequently determined to have been ineligible at the time services were rendered, BlueCross BlueShield of Tennessee shall recover payments made to BlueCross BlueShield of Tennessee Providers for services rendered to that Member no more than ninety (90) days prior to the date that BlueCross BlueShield of Tennessee was notified the individual Member was ineligible. Such recovery will be based upon actual claim payment date. If the Member Benefit Agreement contains a lesser retroactive Member termination clause (e.g. seven (7) days), such clause shall apply. Notice of recovery will be sent to the Provider no more than thirty (30) days from the date BlueCross BlueShield of Tennessee was first notified of Member ineligibility.

C. Member Fees

Members agree to pay certain cost-sharing fees for a Covered Service, depending upon the health care benefits plan under which he or she is enrolled. These cost-sharing fees are described below:

- **Co-insurance** - a pre-determined percentage of amount allowed;

- **Copayment** - a specified dollar amount that a Member pays each time he or she visits a Provider's office. A Provider can collect a copayment from the Member at the time of the office visit.

- **Deductible** - the amount of money the Member is required to pay in a given time period before BlueCross BlueShield of Tennessee starts to pay benefits. The deductible is usually a set amount or percentage determined by the Member's health care benefits plan.

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IV. GROUP HEALTH CARE BENEFITS

The following is a general outline of Group health care benefits that may be offered subject to limitations and exclusions listed in the Member's health care benefits plan in this, and other sections of this Manual. **This outline should not be relied on as the only benefit options**. Provider office copayments, brand/generic drug copayments and hospital copayments vary. Member health care benefits may be verified by calling Provider Services at 1-800-924-7141, the BlueCross BlueShield of Tennessee Customer Service number listed on the front of the Member's ID card or accessing *e-Health Services*® on the company Web site at www.bcbst.com. (See Section III. *How to Identify a BlueCross BlueShield of Tennessee Member* in this Manual for access information.)

The Member's health care benefits plan will pay the Maximum Allowable Charge for Medically Necessary and Medically Appropriate services and supplies described below provided in accordance with the reimbursement schedules. Charges in excess of the reimbursement rates are not eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with BlueCross BlueShield of Tennessee's Medical Policies and Procedures. (See Sec. X. *Care Management* in this Manual for specifics.)

Covered Services and Limitations are arranged according to eligible Providers and eligible services.

Obtaining services not in accordance with BlueCross BlueShield of Tennessee's Medical Policies and Procedures may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services.

A. Eligible Providers of Service

1. **Practitioners -** All services must be rendered by a Practitioner type listed in the *BlueCross BlueShield of Tennessee Referral Directory of Network Providers*, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or scope of practice.

2. **Network Provider-** A Provider who has contracted with BlueCross BlueShield of Tennessee to provide Covered Services.

3. **Out-of-Network Provider-** Any Provider who is an eligible Provider type but who does not hold a contract with the Member's health care benefits plan to provide Covered Services.

4. **Other Providers of Service -** An individual or facility, other than a Practitioner, duly licensed to provide Covered Services.

5. **Assistant-at-Surgery**- Benefits will be provided for surgery performed by a Practitioner (see Section VI. for Assistant-at-Surgery specifics) who actively assists the operating surgical procedure, provided no intern, resident or other staff Practitioner is available.

B. Eligible Services

Practitioner Office Services

Medically Necessary and Medically Appropriate services in a Practitioner's office.

Covered -

- Services and supplies for the diagnosis and treatment of illness or injury, including those relating to hearing, speech, voice or language other than for a functional nervous disorder;
- Injections and medications administered in a Practitioner's office, except Specialty Pharmacy Medications. (See Section VIII. *Utilization Management Program* and Section XIX. *Pharmacy* in this Manual for coverage information.);
- Allergy care including basic testing, evaluations, allergy extract and injections;
- Casts and dressings;
- Nutritional guidance and education;
- Foot care necessary to prevent the complications of an existing disease state;
- Pre- and postnatal maternity care;
- Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended surgery;
- Rehabilitative therapies; and
- Emergency conditions presenting to the Practitioner's Office.

Exclusions include, but are not limited to –

- Office visits and physical exams for: (1) school; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings; and (7) related immunizations and tests;
- Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain;
- Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace; and
- Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit.

Preventive Services

Medically Necessary and Medically Appropriate services for assessing physical status and detecting abnormalities. The frequency of visits and services is based on BlueCross BlueShield of Tennessee Medical Policy guidelines and the Member's health care benefits plan. Periodic health assessments, including appropriate immunizations, screenings and diagnostics are Covered Services for PPO Members who have extended wellcare benefits.

Covered -

- Well-Child Care for children through age 5 including appropriate immunizations, screenings and diagnostics. Well-child benefits are not provided once the Member reaches age 6;
- Well-Woman Exam every Calendar Year, including any follow-up care. (This visit includes mammogram and cervical cancer screenings); and
- Prostate cancer screenings.

Exclusions include, but are not limited to–

- Preventive services not listed as Covered; and
- Services not recommended by BlueCross BlueShield of Tennessee Medical Policy guidelines.

Well Care Rider (if applicable to Member's Healthcare Plan)

Members age six (6) and over, who are eligible for Coverage under this Rider may receive preventive health services including those listed below, usually limited to a total maximum benefit of $300 during any Calendar Year. All services must be Medically Necessary and Appropriate and recommended by or in conjunction with BlueCross BlueShield of Tennessee 's preventive health care guidelines.

- Periodic health screening;
- Childhood immunizations;
- Blood pressure screening;
- Periodic cholesterol screening;
- Periodic colorectal cancer screening, not subject to the Calendar Year maximum benefit; referenced above. (Note: Colonoscopy and Sigmoidoscopy are invasive diagnostic surgical procedures);
- Influenza immunization;
- Tetanus-diphtheria (TD) boosters;
- Pneumococcal immunization;
- Other recommended adult immunizations and immunizations not completed during childhood;
- Other prescribed X-ray and laboratory screenings associated with preventive care;
- Vision and hearing screenings performed by the Practitioner during the preventive health examination; and
- Immunizations needed for travel to foreign countries.

Office Surgery

Medically Necessary and Medically Appropriate surgeries/procedures performed in a Practitioner's office. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

Covered -

- Excision of skin lesions and incisions;
- Repair of lacerations;
- Removal of foreign bodies from skin, eyes or orifices;
- Sigmoidoscopy, pharyngoscopy or other endoscopies;
- Biopsies;
- Colposcopy;
- Incision and drainage of abscess;
- Cyst aspiration;
- Joint injection and aspiration;
- Toenail excision;
- Casting and splinting;
- Cryosurgery; and
- Vasectomy.

Exclusions include, but are not limited to –

- Dental procedures, except as otherwise indicated in this Manual.
- Procedures which require prior authorization and/or special consent, in accordance with BlueCross BlueShield of Tennessee Medical Policy and procedures, for which authorization was not provided.

Inpatient Hospital Services

Medically Necessary and Medically Appropriate services and supplies in a hospital, which: (1) is a licensed Acute care institution; (2) provides inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease or injury; and (4) has a staff of Practitioners licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

Covered -

- Room and board in a semi-private room (or private room if room and board charges are the same as for semi-private room); general nursing care; medications, injections, diagnostic services and special care units;
- Attending Practitioner's services for professional care;
- Maternity and delivery services, (including Complications of Pregnancy). If the hospital provides newborn services other than routine nursery care, benefits may be Covered for the newborn and mother as separate Members, requiring payment of applicable Member copayments and/or deductibles;
- Observation stays; and
- Blood/plasma is covered unless replaced, donated or at no charge.

Exclusions include, but are not limited to –

- Inpatient stays primarily for therapy (such as physical or occupational therapy);
- Private duty nursing;
- Services that could be provided in a less intensive setting; and
- Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.

Hospital Emergency Care Services

Medically Necessary and Medically Appropriate health care services and supplies furnished in a hospital which are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or hospital protocol.

Benefits for diagnostic services in conjunction with emergency room visit are subject to deductible and coinsurance for Members' health care benefits plans with an ER copay. Members are responsible for both the ER visit copay and deductible and coinsurance for any non-routine diagnostic service performed.

Covered –

- Medically Necessary and Medically Appropriate emergency services, supplies and medications necessary for the diagnosis and stabilization of the Member's emergency condition; and
- Practitioner services.

Exclusions include, but are not limited to -

- Emergency Care does not include treatment of a chronic, non-emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an emergency; and

- Services received for inpatient care or transfer to another facility once the Member's medical condition has stabilized, unless prior authorization is obtained from the Member's health care benefits plan within 24 hours or the next working day.

Ambulance Services

Medically Necessary and Medically Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the patient.

Covered -

- Medically Necessary and Medically Appropriate land or air transportation from the scene of an accident or emergency to the nearest appropriate facility.

Exclusions include, but are not limited to -

- Transportation for the convenience of the Member;
- Transportation that is not essential to reduce the probability of harm to the Member;
- Transfers between facilities that did not receive prior authorization from the Member's health care benefits plan; and
- Services when the Member is not transported to a facility.

Outpatient Facility Services

Medically Necessary and Medically Appropriate diagnostics, therapies and surgery occurring in an outpatient facility, which include: (1) outpatient surgery centers; (2) the outpatient center of a hospital; and (3) outpatient diagnostic centers.

Covered -

- Practitioner services;
- Outpatient diagnostics (such as X-rays and laboratory services);
- Outpatient treatments (such as medications and injections);
- Outpatient surgery and supplies; and
- Observations stays.

Exclusions include, but are not limited to –

- Rehabilitative therapies in excess of the Therapeutic/ Rehabilitative benefit;
- Services that could be provided in a less intensive setting; and
- Outpatient services that require prior authorization but were not authorized by the Member's health care benefits plan. (See Section VIII. *Utilization Management Program* in this Manual for a listing of services requiring prior authorization.)

Behavioral Health Services

Medically Necessary and Medically Appropriate treatment of medical conditions resulting from abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features.

Covered -

- The treatment of medical conditions underlying, or resulting from, behavioral health disorders.

Exclusions include, but are not limited to –

- Behavioral health services are not Covered, except as specified or Covered by the Member's Plan.

Behavioral Health Rider (if applicable to Member's Plan)

Medically Necessary and Medically Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features.

Covered –

- Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders;
- The Member's health care benefits plan may substitute other levels of care for inpatient days as follows:
  - Two (2) residential treatment days for one (1) inpatient day
  - Two (2) partial hospital days for one (1) inpatient day
  - Three (3) intensive outpatient program days for one (1) inpatient day
  - Other case management benefits may be available

Exclusions include, but are not limited to –

- Non-emergency behavioral health acute care, residential care, partial hospitalization, intensive outpatient program stays or treatment in halfway houses or group homes and electroconvulsive treatments that are not prior authorized during the Member's treatment in a facility or program, whether the facility or program is an in-network Provider or an out-of-network Provider. Emergency care services require a notification within 24 hours to receive prior authorization;
- Outpatient visits not prior authorized by the Plan (if outpatient visits require prior authorization) – In most Behavioral Health Riders, outpatient visits do not require prior authorization;
- Pastoral counseling;
- Marriage and family counseling without a behavioral health diagnosis;
- Vocational and educational training and/or services;
- Custodial or domiciliary care;
- Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs;
- Sleep disorders;
- Services related to mental retardation or developmental disabilities;
- Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained;
- Behavioral problems such as anti-social personality disorders, sexual deviation or dysfunction or social maladjustment;
- Any care in lieu of legal involvement or incarceration;
- Pain management;
- Hypnosis or regressive hypnotic techniques;
- Charges for telephone consultations, missed appointments, completion of forms, or other administrative services;
- Methadone and methadone maintenance therapy;
- Buprenorphine and buprenorphine maintenance therapy; and
- Biofeedback.

Family Planning and Reproductive Services

Medically Necessary and Medically Appropriate family planning services and those services to diagnose and treat diseases, which may adversely affect fertility.

Covered -

- Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing;
- Sterilization procedures;
- Medically Necessary and Medically Appropriate termination of a pregnancy;
- Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting and insertion; and
- Services or supplies for the evaluation of infertility.

Exclusions include, but are not limited to –

- Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination, (2) In vitro fertilization, (3) fallopian tube reconstruction, (4) uterine reconstruction, (5) assisted reproductive technology (ART) including, but not limited to GIFT and ZIFT, (6) fertility injections, (7) fertility drugs, (8) services for follow-up care related to infertility treatments;
- Services or supplies for the reversals of sterilizations; and
- Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, (2) the pregnancy is a result of rape or incest, (3) the fetus is not viable, (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

Reconstructive Surgery Services

Medically Necessary and Medically Appropriate surgical procedures intended to restore normal form or function.

Covered -

- Surgery to correct significant defects from congenital causes (except where specifically excluded), accidents or disfigurement from a disease state; and
- Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy) including surgery on the non-diseased breast needed to establish symmetry between the two breasts.

Exclusions include, but are not limited to –

- Services, supplies or prosthetics primarily to improve appearance;
- Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance; and
- Surgeries and related services to change gender.

Skilled Nursing/Rehabilitative Facility Services

Medically Necessary and Medically Appropriate inpatient care provided to Members requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home.

Covered -

- Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units;
- The attending Practitioner's services for professional care; and
- Coverage is limited to a total of sixty (60) days per Calendar Year.

Exclusions include, but are not limited to –

- Custodial, domiciliary or private duty nursing services;
- Skilled Nursing services not received in a Medicare-certified skilled nursing facility;
- Services, which were not authorized by the Member's health care benefits plan; and
- Services for cognitive rehabilitation.

Therapeutic/Rehabilitative Services

Medically Necessary and Medically Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as the result of illness or injury.

Covered -

- Outpatient, home health or office therapeutic and rehabilitative services which are expected to result in significant and measurable improvement in the Member's condition resulting from an acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner;
- Therapies include: (1) physical therapy; (2) speech therapy; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services;
- Speech therapy is covered for restoration of speech but not for development of speech and is limited to disorders of articulation and swallowing, following an acute illness, injury, stroke or congenital anomaly;
- Coverage is limited to a total of thirty (30) treatment visits per therapy per Calendar Year for the following therapies: (1) physical therapy; (2) speech therapy; (3) occupational therapy; and (4) manipulative therapy;
- Coverage for cardiac and pulmonary rehabilitative services is limited to thirty-six (36) visits per Calendar Year;
- The services must be performed in a Practitioner's office, outpatient facility or home health setting. The limit on the number of visits for therapy applies to all visits for that therapy, regardless of the place of service; and
- Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are covered as shown in the inpatient hospital, skilled nursing or rehabilitative facility section, and are not subject to the visit limits.

Therapeutic/Rehabilitative Services (cont'd)

Exclusions include, but are not limited to –

- Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy which is designed to improve the Member's physical status beyond their pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, which the Member's health care benefits plan has determined to not be Medically Necessary. These include, but are not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) neuromuscular reeducation; (5) vision exercise therapy; and (6) cognitive rehabilitation;
- Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities which are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks which can be performed by the Member without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services which can ordinarily be taught to a caregiver or the Member themselves;
- Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider, if applicable to the Member's health care benefits plan; and
- Duplicate therapy, i.e., when the Member receives both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

Organ Transplant Services

Medically Necessary and Medically Appropriate services and supplies provided to the Member, when he/she is the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures which, in BlueCross BlueShield of Tennessee's sole discretion, are not Investigational and which are Medically Necessary and Medically Appropriate.

Prior authorization is required for all Member referrals for any transplant-related care, including evaluation. Transplant services or supplies that have not received prior authorization will not be covered. (See Section VIII. *Utilization Management Program*, in this Manual for prior authorization requirements.)

Covered –

- Medically Necessary and Medically Appropriate services and supplies, otherwise covered under the Member's health care benefits plan;
- Medically Necessary and Medically Appropriate services and supplies for each listed organ transplant are covered only when Transplant Case Management approves a transplant;
- Travel expenses for the Member's evaluation prior to a covered procedure, and to and from the site of a covered procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes the Member's travel expenses and a companion. A companion must be the Member's spouse, family member, guardian or approved companion:

Organ Transplant Services (cont'd)

Covered (cont'd) –

  - Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel for travel more than 30 miles away from the Member's home to and from a facility in the In-Transplant Network.
  - Meals and lodging expenses are covered if the Member or his/her companion travels more than 30 miles each way, and are limited to $150 daily.
  - The aggregate limit for travel expenses is $10,000 per covered procedure and is included in the Member's Lifetime Benefit Maximum.
  - Travel Expenses are covered **only** if the Member goes to an In-Transplant Network Institution;
- Donor Organ Procurement - If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; and (4) transportation of the organ to the site of transplant. Services are covered only to the extent not covered by other health coverage. The search process and securing the organ are also covered under this benefit. Complications of donor organ procurement are not covered. The cost of Donor Organ Procurement is included in the total cost of the Member's Organ Transplant.

Conditions/Limitations include, but are not limited to -

Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. If Transplant Case Management is not notified, the transplant and related procedures will not be covered at all. Highest level of benefits is allowed for transplants performed inside the BlueCross BlueShield of Tennessee In-Transplant Network*.

Not all Network Providers participate in our In-Transplant Network. Network Providers **not in the BlueCross BlueShield of Tennessee In-Transplant Network may bill the Member for any amounts over the Transplant Maximum Allowable Charge (TMAC).*

Exclusions include, but are not limited to –

- If the Member does not receive prior authorization, the transplant and related services, including pre-transplant evaluation, will not be covered;
- Any service specifically excluded under the Member's health care benefits plan, except as otherwise provided in this section;
- Services or supplies not specified as Covered Services under this section;
- If the Member receives prior authorization through Transplant Case Management, but does not obtain services through the In-Transplant Network, he/she will have to pay the Provider any additional charges not Covered by the Member's health care benefits;
- Any attempted Covered procedure that was not performed, except where such failure is beyond the Member's control;
- Non-Covered Services;
- Services which are covered under any private or public research fund, regardless of whether the Member applied for or received amounts from such fund;
- Any non-human, artificial or mechanical organ;
- Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- Donor services including screening and assessment procedures which have not received prior authorization from the Member's health care benefits plan;

Organ Transplant Services (cont'd)

Exclusions include, but are not limited to (cont'd) –

- Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within three (3) months of harvest; and
- Other non-organ transplants (e.g., cornea) are not Covered under this section, but may be covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

Dental Services

Medically Necessary and Medically Appropriate services performed by a doctor of dental surgery (DDS), a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental-related oral surgery except as indicated below.

Covered –

- Dental services and oral surgical care resulting from an accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services must be started within three (3) months and completed within twelve (12) months of the accident;
- General anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient procedure. This section does not provide Coverage for the dental procedure other than those stated, just the related expenses. Prior authorization is required. Coverage of general anesthesia, nursing and related hospital expenses is provided for the following:
    - Complex oral surgical procedures which have a high probability of complications due to the nature of the surgery;
    - Concomitant systemic disease for which the Member is under current medical management and which significantly increases the probability of complications;
    - Mental illness or behavioral condition which precludes dental surgery in the office;
    - Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or
    - Dental treatment or surgery performed on a Member eight (8) years of age or younger, where such procedure cannot be safely provided in a dental office setting;

Exclusions include, but are not limited to –

- Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental X-rays; (6) fillings; (7) tooth extraction (8) periodontal surgery; (9) prophylactic removal teeth; (10) root canals; (11) preventive care (cleanings, X-rays); (12) replacement of teeth (including implants, false teeth, bridges); (13) bone grafts (alveolar surgery); (14) treatment of injuries caused by biting and chewing; (15) treatment of teeth roots; and (16) treatment of gums surrounding the teeth; and
- Treatment for correction of underbite, overbite, and misalignment of the teeth (including, but not limited to, braces for dental indications, orthognathic surgery and occlusal splints.

Temporomandibular Joint Dysfunction (TMJ)

Medically Necessary and Appropriate service to diagnose and treat Temporomandibular Joint Dysfunction (TMJ and TMD)

Covered –

- Diagnosis and management of TMJ or TMD. Non-surgical treatment of TMJ or TMD is limited as indicated in Attachment C: Schedule of Benefits.
- Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.
- Non-surgical TMJ includes: (1) history exam; (2) office visit; (3) X-rays; (4) diagnostic study casts; (5) medications; and (6) appliances to stabilize jaw joint and (7) medications.

Exclusions include, but are not limited to –

- Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental X-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of teeth; (9) root canals; (10) preventive care (cleanings, X-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding teeth; and
- Treatment for correction of underbite, overbite and misalignment of the teeth including braces for dental indications.

Diagnostic Services

Medically Necessary and Medically Appropriate diagnostic radiology services and laboratory tests.

Covered –

- Non-routine diagnostic services ordered by a Practitioner; and
- All other diagnostic services ordered by a Practitioner.

Exclusions include, but are not limited to –

- Diagnostic services which are not Medically Necessary and Appropriate; and
- Diagnostic services not ordered by a Practitioner.

Non-Routine Diagnostic Services Guidelines

The provisions for non-routine diagnostic services listed below apply to all BlueCross BlueShield of Tennessee PPO and Copay PPO Plans:

- **PPO** – Benefits are provided at deductible and coinsurance.
- **Copay PPO** - Copay will apply when services are received from a network Provider. Out-of-network services are reimbursed at deductible and coinsurance.
- Amount of copay varies by Plan ($50.00 - $100.00 per in-network procedure).

Guidelines

- The non-routine copay should be waived if the tests are performed during a Covered admission. The hospital inpatient copay should be taken.

Non-Routine Diagnostic Services Guidelines (cont'd)

Guidelines (cont'd)

- For a Copay PPO Member health care benefits plan, where the Member has copay per Emergency Room visit and a non-routine service is performed in conjunction with the ER visit, the non-routine copay should be waived; only the ER copay should be taken. For a PPO Member health care benefits plan, benefits are provided at deductible and coinsurance.
- When outpatient surgery has a copay per service and a non-routine service is performed in conjunction with the outpatient surgery, both the outpatient surgery and non-routine copay will apply.
- When an office visit has copay per visit and a non-routine procedure is performed in conjunction with the office visit, both the office copay and the non-routine diagnostic copay will apply.
- If other services which have an assigned copay such as therapy services, ambulance services, periodic health assessment and durable medical equipment are performed, the non-routine diagnostic copay should be taken in addition to all other copays for the services mentioned above.
- If the service is provided at a facility, the copay is taken on the facility claim. The facility where the Member presents for care should collect the non-routine diagnostic copay.
- If the Member receives two or more procedures, the non-routine diagnostic copay will apply on each separate procedure.

The following grid is intended to assist Providers in determining when Member copay for non-routine diagnostic services is appropriate:

Member copay for non-routine diagnostic services is appropriate when:

Situation	Rule	Facility Claim	Professional Claim
The Member has inpatient hospital copay. A non-routine diagnostic service is performed during a covered inpatient admission.	Inpatient copay per admission is inclusive. Take only the inpatient hospital copay.	Do not take copay for Non-Routine Diagnostic charges.	Do not take copay for Non-Routine Diagnostic charges.
The Member has ER copay. A non-routine diagnostic service is performed in conjunction with ER visit.	Take the ER copay only for Copay PPO Plans. PPO Plan will pay at deductible and coinsurance.	Do not take copay for Non-routine X-ray and lab services. PPO Provider will bill Member for applicable deductible and coinsurance amounts.	Do not take copay for Non-Routine Diagnostic charges. PPO Provider will bill Member for applicable deductible and coinsurance amounts.
The Member has Outpatient Surgery copay per service. A non-routine diagnostic service in conjunction with the outpatient surgery.	Take both the Outpatient Surgery copay and the non-routine diagnostic procedure copay.	Take the copay.	Do not take copay for Non-Routine Diagnostic charges.
The Member has office visit copay. A non-routine diagnostic procedure is performed in conjunction with the office visit.	Take both the office visit and the non-routine diagnostic copay.	N/A - No facility charge should be billed.	Take copay for Non-Routine Diagnostic charges and office visit copay when performed in Practitioner's office.
Any non-routine service billed as global.	Take copay on "global" fee only.	N/A	N/A
Member has traditional PPO Plan without copay or with office visit copay but deductible and coinsurance for other services.	Applicable deductible and coinsurance apply.	Take the deductible and coinsurance amount.	Take the deductible and coinsurance amount.

Drugs

Medically Necessary and Medically Appropriate pharmaceuticals for the treatment of disease or injury. (See *Provider-Administered Specialty Pharmacy Medications* and *Diabetes Treatment* later this section and also Section XIX. *Pharmacy*, in this Manual for more pharmacy specifics.)

Covered –

- Benefits for the treatment of Phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner; and
- Pharmaceuticals that are prescribed dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or other similar facility.

Exclusions include, but are not limited to –

- Except as specified or covered by a supplemental Rider, the Member's health care benefits plan does not provide coverage for prescription drugs except as indicated above; and
- Those pharmaceuticals, which may be purchased without a prescription.

Prescription Drug Rider (if applicable to Member's Plan)

Covered –

- Prescription drugs prescribed when the Member is not confined in a hospital or other facility. Prescription drugs must be:
  - prescribed on or after Coverage begins;
  - approved for use by the Food and Drug Administration (FDA);
  - dispensed by a licensed pharmacist;
  - listed on the Drug Formulary; and
  - not available for purchase without a prescription.
- Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
- Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.

Limitations include, but are not limited to -

- Drugs for the treatment of onychomycosis (e.g., nail fungus), except for (1) diabetics; or (2) immuno-compromised patients.
- Growth hormones, except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; (2) patients with "Turner" syndrome; and (3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- Prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- Immunizations or immunological agents, including but not limited to: (1) biological sera, (2) blood, (3) blood plasma; or (4) other blood products are not Covered, except for blood products required by hemophiliacs.
- Injectable drugs except when: (1) intended for self-administration; or (2) defined by the Plan.
- Compound Drugs except when filled at a network pharmacy. The network pharmacy must submit the claim through the Plan's pharmacy benefits manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the compound drug.

Prescription Drug Rider (if applicable to Member's Plan) (cont'd)

Limitations include, but are not limited to (cont'd)

- Prescription drugs which are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one drug copayment, provided the quantity does not exceed the FDA approved dosage for four (4) calendar weeks; and
- Prescription drugs prescribed for purposes other than for indications approved by the FDA, or off-label indications recognized through peer-reviewed medical literature.

Exclusions include, but are not limited to –

- Drugs which are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the Member's health care benefits plan;
- Any drugs, medications, prescription devices or vitamins, available over-the-counter that do not require a prescription by federal or state law; except as otherwise Covered in the Member's health care benefits plan;
- Any quantity of prescription drugs which exceed that specified by the Plan's Pharmacy and Therapeutic (P & T) Committee;
- Any prescription drug purchased outside the United States, except those authorized by the Member's health care benefits plan;
- Any prescription dispensed by or through a non-retail Internet pharmacy;
- Contraceptives which require administration or insertion by a Practitioner (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the Member's health care benefits plan;
- Medications intended to terminate a pregnancy (e.g., RU-486);
- Non-medical supplies or substances, including support garments, regardless of their intended use;
- Artificial appliances;
- Allergen extracts;
- Any drugs or medicines dispensed more than one year following the date of the prescription;
- Prescription drugs the Member is entitled to receive without charge in accordance with any Workers' Compensation laws or any municipal, state, or federal program;
- Replacement prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- Drugs dispensed by a Provider other than a Pharmacy;
- Administration or injection of any drugs;
- Prescription drugs used for the treatment of infertility;
- Prescription drugs not on the BlueCross BlueShield of Tennessee Drug Formulary;
- Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- All newly FDA approved drugs prior to review by the Plan's P & T Committee;
- Any prescription drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;

Prescription Drug Rider (if applicable to Member's Plan) (cont'd)

Exclusions include, but are not limited to (cont'd) –

- Compound drugs filled or refilled at an out-of-network pharmacy;
- Drugs used to enhance athletic performance;
- Investigational drugs;
- Provider-administered specialty pharmacy medications, as indicated on the BlueCross BlueShield of Tennessee Specialty Pharmacy Medications list;
- Prescription drugs or refills dispensed:
  - in quantities in excess of specified amounts;
  - without pior authorization when required; or
  - which exceed any applicable annual maximum benefit, or any other maximum benefit amounts stated in the Prescription Drug Rider or Member's health care benefits plan.

Provider-Administered Specialty Pharmacy Medications

Medically Necessary and Medically Appropriate specialty pharmaceuticals for the treatment of disease, administered by a Practitioner or home health agency. Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital require prior authorization from BlueCross BlueShield of Tennessee or benefits will be reduced or denied. (See Section VIII. *Utilization Management Program*, in this Manual for authorization requirements.)

Covered –

- Provider-administered specialty pharmacy medications as identified on the BlueCross BlueShield of Tennessee Specialty Pharmacy Medications listing (includes administration by a qualified provider).

Exclusions include, but are not limited to –

- Self-administered specialty pharmacy medications as identified on the BlueCross BlueShield of Tennessee Specialty Pharmacy Medications listing, except as may be Covered by a supplemental Prescription Drug Rider.

Vision

Medically Necessary and Medically Appropriate diagnosis and treatment of diseases and injuries, which impair vision.

Covered –

- Services and supplies for the diagnosis and treatment of diseases and injuries to the eye; and
- First set of eyeglasses or contact lens to adjust for vision changes when obtained within six (6) months following cataract surgery.

Exclusions include, but are not limited to –

- Services, surgeries and supplies to detect or correct refractive errors of the eyes;
- Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
- Eye exercises and/or therapy; and
- Visual training.

Durable Medical Equipment

Medically Necessary and Medically Appropriate medical equipment or items which, in the absence of illness or injury, are of no medical or other value to the Member. Items that can (1) withstand repeated use in an ambulatory or home setting; (2) that require the prescription of a Practitioner for purchase; (3) are approved by the FDA for the illness or injury for which it is prescribed; and (4) are not for the Member's convenience.

Covered –

- Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment; and
- The replacement of items needed as the result of normal wear and tear, defects or obsolete and aging.

Exclusions include, but are not limited to –

- Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment;
- Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
- Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
- Items to replace those, which were lost, damaged, stolen or prescribed as a result of new technology;
- Items which require or are dependent on alteration of home, workplace or transportation vehicle;
- Motorized scooters, exercise equipment, hot tubs, pools, saunas; and
- "Deluxe" or "enhanced" equipment. In all instances, the most basic equipment needed to provide the medical need will determine the benefit.

Diabetes Treatment

Medically Necessary and Medically Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies and outpatient self-management training and education, including nutritional counseling.

Covered –

- Blood glucose monitors, including monitors designed for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Insulin;
- Injection aids;
- Syringes;
- Lancets;
- Insulin pumps, infusion devices and appurtenances;
- Oral hypoglycemic agents;
- Podiatric appliances for prevention of complications associated with diabetes; and
- Glucagon emergency kits.

Diabetes Treatment (cont'd)

Exclusions include, but are not limited to –

- Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary; and
- Supplies not required by state statute.

Prosthetics/Orthotics

Medically Necessary and Medically Appropriate devices used to correct or replace all or part of a body organ or limb, which may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery.

Covered –

- The initial purchase of surgically implanted prosthetic or orthotic devices;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Splints and braces that are custom made or molded, and are incident to a Practitioner's services or on a Practitioner's order;
- The replacement of Covered items which need replacement due to normal wear and tear, defects or obsolete and aging;
- The initial purchase of artificial limbs, or eyes, or contacts after cataract surgery; and
- The first pair of eyeglasses or contact lenses prescribed as a result of cataract surgery.

Exclusions include, but are not limited to –

- Hearing aids;
- Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants;
- Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
- The replacements of contacts after the initial pair have been provided following cataract surgery; and
- Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace.

Home Health Care Services

Medically Necessary and Medically Appropriate services and supplies authorized by the Plan and provided in a Member's home by an agency that is primarily engaged in providing home health care services.

Covered –

- Part-time, intermittent health services supplies and medications, by or under the supervision of a registered nurse;
- Home Infusion Therapy;
- Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit);
- Medical social services;
- Dietary guidance; and
- Services are limited to sixty (60) visits per Calendar Year.

Exclusions include, but are not limited to –

- Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) maintenance or custodial care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (9) convenience item;
- BlueCross BlueShield of Tennessee's Medical Policy guidelines may limit the number of visits per hour per day; and
- Prior authorization for services must be obtained from BlueCross BlueShield of Tennessee.

Hospice Services

Medically Necessary and Medically Appropriate services and supplies for supportive care where life expectancy is six (6) months or less.

Covered –

- Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

Exclusions include, but are not limited to –

- Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling; and
- Prior authorization for services must be obtained from BlueCross BlueShield of Tennessee.

Supplies

Those Medically Necessary and Medically Appropriate expendable and disposable supplies for the treatment of disease or injury.

Covered –

- Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility or inpatient facility; and
- Supplies for treatment of disease or injury that cannot be obtained without a Practitioner's prescription.

Exclusions include, but are not limited to –

- Supplies that can be obtained without a prescription (except for diabetic supplies). Examples include, but are not limited to: (1) band-aids; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) Q-tips; and (6) eyewash.

C. Exclusions from Coverage

Non-Covered Services include, but are not limited to:

- Services or supplies not listed as a Covered Service under the Member's health care benefits plan;
- Services or supplies that are determined to not be Medically Necessary and Medically Appropriate or have not been authorized by the Member's health care benefits plan;
- Services or supplies that are Investigational in nature including, but not limited to: 1) drugs; 2) biologicals; 3) medications; 4) devices; and 5) treatments;
- When more than one treatment alternative exists, all are Medically Necessary and Medically Appropriate, and either would meet the Member's needs, we reserve the right to provide payment for the least expensive Covered Service alternative;
- Illness or injury resulting from war which occurred before the Member's coverage began and which is covered by (1) veteran's benefit or (2) other coverage for which the Member is legally entitled and which occurred before the Member's coverage began;
- Self-treatment or training;
- Staff consultations required by hospital or other facility rules;
- Services which are free;
- Services or supplies for the treatment of illness or injury related to the Member's participation in a felony, attempted felony, riot or insurrection;
- Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of Workers' Compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group, (2) a partner of the Group or (3) a corporate office of the Group, provided the office filed an election not to accept Workers' Compensation with the appropriate government department;
- Personal, physical fitness, recreational or convenience items and services such as: (1) barber and beauty services; (2) television;(3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) self-help devices which are not primarily medical in nature, even if ordered by a Practitioner;
- Services or supplies received before the effective date of the Member's coverage;

Exclusions from coverage (cont'd)

- Services or supplies related to a hospital confinement, received before the Member's effective date of coverage;
- Services or supplies received after the Member's coverage ceases for any reason. This is true even though the expenses relate to a condition that began while the Member was Covered. The only exception to this is described under *extended benefits* under the Member's health care benefits plan.
- Services or supplies received in a dental or medical department maintained by or on behalf of the Member's employer, mutual benefit association, labor union or similar group;
- Telephone or e-mail consultations, or charges for failure to keep a scheduled appointment or charges to complete a claim form or to provide medical records;
- Services for providing requested medical information or completing forms. BlueCross BlueShield of Tennessee does not charge the Member or his/her legal representative for statutorily required copying charges;
- Court ordered examinations and treatment, unless Medically Necessary and Medically Appropriate;
- Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
- Benefits for pre-existing conditions are excluded until any pre-existing condition waiting periods are met;
- Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum;
- Any service stated in the Member's health care benefits plan as a non-Covered Service or limitation;
- Charges for services performed by the Member or his/her spouse, or the Member's/Member's spouse's parent, sister, brother or child;
- Any charges for handling fees;
- Nicotine replacement therapy and aids to smoking cessation including, but not limited to patches;
- Safety items, or items to affect performance primarily in sports-related activities;
- Services or supplies related to obesity, including surgical or other treatment of morbid obesity;
- Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating Practitioner;
- Services or supplies related to cosmetic services, including surgical or other services, drugs or devices. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) rhinoplasty;
  (7) breast augmentation; and (8) breast reduction;
- Blepharoplasty and Browplasty except for (1) correction of injury to the orbital area resulting from physical trauma or non-cosmetic surgical procedures (e.g., removal of malignancies), (2) treatment of edema and irritation resulting from Graves Disease, or (3) correction of trichiasis, ectropion, or entropion of the eyelids;
- Services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a Member. Services and charges relating to surrogate parenting;
- Sperm preservation;
- Services or supplies for Orthognathic surgery;
- Services or supplies for maintenance care;
- Private duty nursing;

Exclusions from coverage (cont'd)

- Pharmacogenetic testing;
- Treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Removal of impacted teeth, including wisdom teeth;
- Professional services for maternity delivery in a home setting or location other than a licensed hospital or birthing center;
- Services or supplies for methadone maintenance therapy and buprenorphine maintenance therapy; and
- Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.

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V. MEMBER POLICY

A. Introduction

BlueCross BlueShield of Tennessee, Inc. is dedicated to the prevention and treatment of diseases by promoting quality medical services to its Members. Members and participating Providers share a partnership for quality health care. Members have the right to receive covered medical services and have certain responsibilities to aid in receiving them.

B. Member Access-to-Care

To ensure quality and continuity of care for BlueCross BlueShield of Tennessee Members after regular clinic hours, Practitioners will provide 24-hour-a-day, 7-days-a-week service. Practitioners must be able to respond to Member calls or calls from an Emergency Department or Hospital concerning their BlueCross BlueShield of Tennessee patients within the time limits described in the *BlueCross BlueShield of Tennessee Member Access and Availability Standards* for routine or urgent care.

Arrangements for 24-hour access to equally qualified Practitioners participating in the same BlueCross BlueShield of Tennessee network as the Member's Practitioner are the responsibility of all contracted Practitioners who participate in BlueCross BlueShield of Tennessee networks.

Standards for telephone access after regular clinic hours:

1. A telephone number or pager answered by covering Practitioner;
2. A non-automated, "live" answering service that directs Members' calls to an "on-call" covering Practitioner;
3. An automated answering machine that directs the Member to the Practitioner or appropriate covering Practitioner.

Standards for responding to Member telephone calls after regular hours:

1. The Member, or Member's representative, must be able to speak directly with an appropriate Practitioner;
2. It is acceptable for the answering service to take a message and have the Practitioner return the call to the Member;
3. At a minimum, the live answering service should request the following from the Member:
    - Reason for call
    - Name
    - Telephone number
    - Name of Practitioner
4. Practitioners providing on-call coverage after regular office hours must respond directly to Members or Members' representative within the following time frames:
    - **If Urgent**, within 30 minutes of receipt of the message from the answering service/machine; or
    - **If routine**, within 90 minutes of receipt of the message from the answering service machine.

A survey of compliance with BlueCross BlueShield of Tennessee's call coverage policy is performed during office site visits. Noncompliance is addressed through the company's Medical Corrective Action Plan (See Section XII.). BlueCross BlueShield of Tennessee uses these guidelines when credentialing and recredentialing its Practitioners.

Specific ambulatory encounters that BlueCross BlueShield of Tennessee will monitor are:

Appointment Type	Definition	Standard
Routine Adult Physical Examination	Routine exam of a patient who has no acute symptoms which includes Medically Necessary and Medically Appropriate health screenings and immunizations, if a covered benefit.	Annually – within 1 year of last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months
Children Preventive	Counseling, coordination, and treatment of an anticipatory nature to include guidance and risk reduction interventions. (E.g., vaccinations, immunizations) according to the American Academy of Pediatrics periodicity schedule.	According to the American Academy of Pediatrics periodicity schedule
Prenatal Care	Counseling, diagnosis, treatment and coordination of care for pregnancy for all Members to prevent complications, and to decrease the incidence of maternal and prenatal mortality. 1st Trimester 2nd Trimester	 ≤ 6 weeks ≤15 weeks
Urgent Care for Adult and Child	1. Urgent Examination: Medically Necessary and Appropriate services and supplies to diagnose and treat acute symptoms of sufficient severity that cannot wait until the next available appointment. These services may be provided by facility-based Providers. 2. Urgent Specialty: Coordination of care which is diagnostic or confirmatory in nature and needed when an expert opinion is required to determine appropriate care for a patient with an acute condition which is moderate to severe in complexity. If not treated, this condition could lead to harmful outcomes and emergency care.	≤ 48 hours
Emergency Care	Medically Necessary services that are required to evaluate, treat, and stabilize a patient's emergency condition. A condition defined by a "prudent layperson", who possesses an average knowledge of health and medicine, as a medical condition that develops itself by symptoms of sufficient severity, including severe pain. Failure to provide such treatment could place the patient's health in jeopardy, or cause serious medical consequences, impairment to body functions, or serious or permanent dysfunction of any body organ or part. These services may be provided by facility-based providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determinations.	Immediate
Specialty Care for both Adult and Child	Coordination of care, which is diagnostic or confirmatory in nature and needed when an expert is required to perform or determine appropriate follow-up care for a patient. (E.g., cardiology, orthopedics, urology, neurology)	As Practitioner deems appropriate for condition or follow-up
Wait Times	1. Office Wait Time (including lab and X-ray)…… 2. Member Telephone Call (during office hours): • Urgent…….. • Routine…… 3. Member Telephone Call (after office hours): • Urgent…….. Routine…….	≤ 45 minutes ≤ 15 minutes 24 hours ≤ 30 minutes ≤ 90 minutes

References:
Thomas, Clayton L. MD(ED.) 1993 *Tabor's Cyclopedic Medical Dictionary.*
(Edition 17) Philadelphia: F.A. Davis Company. American Medical Association. (1998) *Practitioner s Current Procedural Terminology.*

C. Member Rights and Responsibilities

BlueCross BlueShield of Tennessee educates its Members on their rights and responsibilities. As a participating network Provider, you should know what our Members are being told to expect from you and what you have the right to expect from those Members. To comply with regulatory and accrediting requirements, BlueCross BlueShield of Tennessee periodically reminds Members of their rights and responsibilities. These reminders are intended to make it easier for Members to access quality medical care and to attain services.

Member Rights

Members have the right to:

- be treated with respect and dignity;
- expect that any information they provide to their practitioner will be treated in a confidential manner;
- receive information about policies and services of their health benefit plan network;
- receive information regarding the Practitioners in their health benefit plan network;
- receive Medically Necessary and Appropriate care;
- receive information available regarding their health;
- participate with Practitioners in the decision-making regarding their health care;
- voice appeals/grievances and complaints about their health care, Practitioners, the care provided to them, or their health benefits plan network, with the expectation of an answer within a reasonable time frame. They also have the right to formally appeal this answer if it is not acceptable to them;
- a candid discussion of appropriate Medically Necessary treatment options for their condition, regardless of cost of benefit coverage;
- formulate a living will (advance directive);
- consent or deny employer access to Member-identifiable information; and
- be informed of their associated cost of care.

Member Responsibilities

Members are expected to:

- consult their Practitioner for all medical services to be covered by the health benefits plan;
- provide, to the extent possible, all information concerning their health to those providing their health care;
- follow the instructions and advice of those providing their health care services, or they are expected to immediately question what they do not understand or do not agree with;
- present their membership identification (ID) card each time they seek health care;
- ensure that they are the only person who uses their ID card. (A parent or legal guardian must present the ID card for dependents under the age of 18 each time health care is sought.);
- notify BlueCross BlueShield of Tennessee if there is a change in employment, address or dependents;
- keep health appointments and call the health caregiver's office to cancel if they cannot make the appointment;
- treat their health caregiver with respect and dignity;
- read the Benefits booklet and Evidence of Coverage. Pay any copayment, deductible, coinsurance, or any charges for non-covered and out-of-network services if required as part of the Member's health benefits plan requirements;
- be a part of decision making about their health care; and
- seek understanding of their health benefits plan and their responsibility in obtaining the appropriate level of reimbursement for their care.

D. Member Grievance Process

BlueCross BlueShield of Tennessee has incorporated formal mechanisms to address Member concerns and complaints or grievances. Concerns raised by Members and Providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally. All other written concerns or complaints are considered grievances and will be processed through BlueCross BlueShield of Tennessee's usual grievance procedure described in Sec. VIII and Sec. XIII.

Member concerns and complaints are documented and their resolution is maintained by BlueCross BlueShield of Tennessee. If a Member has an inquiry, concern or complaint regarding any aspect of services received, the Member may contact the designated Customer Service Representative of BlueCross BlueShield of Tennessee to discuss the matter. If a Member feels that the Customer Service Representative has not resolved a problem, it is his/her right to submit a written grievance or suggestion for improvement to the Grievance Committee.

E. Financial Responsibility for the Cost of Services

If a BlueCross BlueShield of Tennessee Network Provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she may be responsible for the cost of the specific service(s). Providers may also utilize this form in the event a Member requests non-emergency, cosmetic or elective services that are specifically excluded under the Member's contract. It is essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to BlueCross BlueShield of Tennessee verifying the Member's agreement to the financial responsibility.

To help assist is this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Services* form for Provider use. This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements. **Providers are strongly encouraged to use this form**. Providers using their own form should assure their form includes the following:

1. The name of the specific service/procedure the Provider will perform;
2. Reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
3. The approximate cost of the service/procedure and associated costs;
4. Statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
5. Statement Member acknowledges he/she understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
6. Statement indicating form is only valid for one (1) service/procedure; and
7. A specific expiration date.

A sample copy of the *Acknowledgement of Financial Responsibility for the Cost of Services* form follows:

BlueCross BlueShield of Tennessee
Acknowledgement of Financial Responsibility
For the Cost of Services
(For use with Blue Networks C, S, P and K)

To: _____;

Re: (Identification of Prescribed Service)

I have been informed that my health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced service(s) may be an Investigational Service, Cosmetic, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the service would be excluded from coverage by my health care benefits plan. My provider has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my provider may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced service(s) is not an Investigational Service, is a Covered Service or the service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced service(s) will be approximately $_____. I understand that, if I elect to receive the service(s) and BlueCross BlueShield of Tennessee determines that the service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I acknowledge that BlueCross BlueShield of Tennessee may not pay for the service(s).

In the event of multiple procedures, this form is valid only for one (1) unit of the prescribed service(s), unless specifically provided for otherwise.

This form will expire and will no longer be valid six (6) months from the date of execution.

Signature of Patient or Responsible Person

_____

Date: _____

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VI. BILLING AND REIMBURSEMENT

A. How to File a Claim

BlueCross BlueShield of Tennessee is prepared to accept claims electronically in the ANSI 837 format or in paper; the preferred method is electronically. An acceptable alternative for the Centers for Medicare and Medicaid Services (CMS) CMS-1500 or CMS-1450 claims is the Optical Character Recognition (OCR) scannable format. Electronic and OCR scannable claims promote effective processing and timely payment. Where neither of the above methods is practical, paper claims will be accepted.

Professional charges should be submitted on the CMS-1500/ANSI-837 Professional Transaction and Institutional charges on the CMS-1450/ANSI-837 Institutional Transaction. Complete claims data should be filed for all services regardless of whether those services are covered. Claims data is vital to report measurements and statistics needed for the Health Plan Employer Data and Information Set (HEDIS) and for Utilization Review Accreditation Commission, also known as URAC, requirements.

BlueCross BlueShield of Tennessee commercial timely filing period is **180 days** from the date of service or, for facilities, within **180 days** from the date of discharge.

If the Provider has documented evidence the Member did not provide BlueCross BlueShield of Tennessee insurance information, the timely filing provision shall begin with receipt of insurance information, subject to the limitations of the Member's benefit agreement.

On paper claims that are returned to the Provider for additional information, **it is important that Providers send back the form that was attached as proof of timely filing**. If BlueCross BlueShield of Tennessee is secondary, the timely filing period is **180 days** from the date of service or, for facilities, within **180 days** from the date of discharge or **60 days** from the primary carrier's notice of payment, whichever is greater.

Proof of timely filing for a returned paper claim is the black and white copy of the claim with error codes listed at the top of the claim that was returned to the provider. Providers should always maintain a copy of the returned claim in case there is a question about timely filing. BlueCross BlueShield of Tennessee will maintain in archives for future reference an image of the original claim submitted.

Proof of timely filing for electronically submitted claims are the following BlueCross BlueShield of Tennessee electronic claims reports:

- EC290R01/R03 – reflects rejected individual claims;
- EC730R01 – reflects accepted and rejected individual claims; and
- EM735R01 – submitter and claim level report generated for ANSI claims.

The new electronic claims Confirmation Report (EC730R01 and/or EM735R01) supplies providers with one comprehensive report of all claims received electronically. This report should be maintained by the Provider for proof of timely filing. Providers submitting claims electronically either directly or through a billing service/clearinghouse can also request an electronic mailbox for viewing claims receipt reports. To learn more about creating an electronic mailbox, call e-Commerce at 423-755-5174, Monday through Friday, 8 a.m. to 5:30 p.m. (EST). Note: Submission dates of claims filed electronically that are **not** accepted by BlueCross BlueShield of Tennessee due to transmission errors are not accepted as proof of timely filing.

1. Filing Electronic Claims

Effective October 16, 2003, BlueCross BlueShield of Tennessee will implement a new electronic claims processing system in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This new system will be used for processing of American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BlueCross BlueShield of Tennessee business edits have been modified to recognize the new ANSI formats. These edits apply to both electronic and scannable paper claims.

Provider Number for Electronic Claims:
Claims submitted electronically must include the Provider's appropriate individual BlueCross BlueShield of Tennessee provider number in the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company Web site at www.wpc-edi.com. Additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission can be accessed at http://www.bcbst.com/providers/docs/ecomm/tech_info.shtm.

Electronic Enrollment and Support
Enrollment of new providers, changes to existing provider or billing information (address, tax ID, Provider number, name), or any changes of software vendor should be communicated to e-Commerce via the *Provider Electronic Profile* form. The Provider Electronic Profile form can be downloaded from the company Web site, www.bcbst.com or obtained upon request. (See contact numbers listed below.)

Mail *Provider Electronic Profile* forms to:

BlueCross BlueShield of Tennessee
e-Commerce, 2TC
801 Pine Street
Chattanooga, TN 37402

Or

For technical support or enrollment information, call, fax, or e-mail:

Technical Support call: 423-535-5717
e-mail: www.ecomm_support@bcbst.com

Enrollment call: 423-535-5174
fax: 423-535-7523
e-mail: www.ecomm_contracts@bcbst.com

Electronic Data Interchange (EDI)
HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCross BlueShield of Tennessee uses the ANSI 837 version. Effective June 16, 2003, we will begin accepting the ANSI 837 version, 4010A1 format.

American National Standards Institute has accredited a group called "X12" that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

ANSI 837 (Versions 4010A1)
The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*.

For detailed specifics on the ANSI 837 format, Providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company Web site at www.wpc-edi.com. Additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission can be accessed at http://www.bcbst.com/providers/docs/ecomm/tech_info.shtm.

*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, Providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company Web site at www.wpc-edi.com. Additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission can be accessed at http://www.bcbst.com/providers/docs/ecomm/tech_info.shtm.

2. Filing Paper Claims

When completing a paper claim, please reference the most recent editions of the manuals or refer to the Data Elements required for submitting CMS-1500 claims included later in this section.

- CMS-1500 Practitioner's Manual
- Tennessee Uniform Procedure Coding Manual
- CMS-1450 Hospital Manual
- ICD-9 Manual

Also refer to the Data Elements required for submitting CMS-1500 claims included later in this section. In order to assure precise control and timely and accurate payment of claims and to reduce the potential of fraud, BlueCross BlueShield of Tennessee will not accept claims faxed, photocopied or altered; claims which do not meet exception criteria listed below will be returned to the Provider:

- Faxed and Photocopied Claims: All faxed and photocopied claims must be approved by BlueCross BlueShield of Tennessee management or faxed at the request of BlueCross BlueShield of Tennessee.

- Altered Claims: All altered claims are returned to the Provider with an attachment stating BlueCross BlueShield of Tennessee does not accept claims that have been altered. **Altered claims are claims with whiteout or which BlueCross BlueShield of Tennessee Operations determines are suspicious.**

3. Tips for Completing CMS-1500, CMS-1450 and Electronic Claims

Listed below are some tips that will help ensure claims are processed rapidly and accurately.

General tips whether submitting OCR or paper:

- Use red standard claim form;
- Type all letters in upper case (capital letters);
- Align all print in appropriate blocks;
- Use a black typewriter ribbon (if typed) or block letters (if handwritten) to reflect a clear impression;
- Enter insured's ID number including the three-letter alpha prefix, exactly as shown on ID card;
- Review each claim to ensure all required fields have been provided;
- Send only original claims and supporting documentation;
- Securely staple any attachments or receipts;
- Do not use Correction Tape or Whiteout when submitting paper claims;

CMS-1500 Specific

- All date information should be shown in the following format (except Block 24A –Date of Service):
  MMblankDDblankCCYY
  MM=month (01-12)
  1 blank
  DD=day (01-31)
  1 blank
  CCYY-year (0000-9999)
  Example: January 1, 2004 = 01_01_2004
  The blank space should fall on the vertical lines provided on the form. **Do Not** exclude leading zeros.
  Block 24A must be a continuous 8-digit number (Correct: January 1, 2004 = 01012004
- Enter BlueCross BlueShield of Tennessee Individual Provider Number immediately to the right of PIN# in Block 33;
- Enter the Individual Provider's Name, billing address and BlueCross BlueShield of Tennessee Provider Number in Block 33;
  (Keep the Provider's signature within signature Block 31);
- Enter Practice address, if different from the billing address, in Block 32;

- List Physician extender name in Block 31 and supervising Physician in Block 33.

- Multi-page Claims:
  - Place the total amount **only on the last page of the claim**. The total on the last page should reflect the sum of the line items for all pages.
  - Use the words "Continued on next page" or "Page X of X" in Block 28 on each page (except on the last page, which reflects the total charge in Block 28).
  - Staple each page of the multi-page claim together. (This will help us identify multi-page claims.)
  - Staple only the pages of the individual claim together as one. **Do not** staple several multi-page claims together as one.

CMS-1450 Specific

- All date information should be shown in the following format (except Form Locator 14 – Birth Date):
  MMDDYY
  MM=month (01-12)
  DD=day (01-31)
  YY=year (00-99)
  Example: January 1, 2004 = 010404
  Form Locator 14 must be a continuous 8-digit number (Correct: January 1, 2004 = 01042004)
- Do not exclude leading zeros in the date fields;
- Multi-page Claims:
  - Place the total amount and 0001 Total Revenue Code **only on the last page of the claim**. The 0001 Total Revenue Code line on the last page of the claim should reflect the sum of the line items for all pages.
  - Use the words "Continued on next page" or "Page X of X" on line 23 on each page (except on the last page, which reflects the total charge on the 0001 Total Revenue Code line).
  - Staple only the pages of the individual claim together as one. **Do not** staple several multi-page claims together as one.

Electronic ANSI 837 Professional and Facility Specific

- All date information should be shown in the following eight-digit format:

  CCYYMMDD
  CCYY=year (0000-9999)
  MM=month (01-12)
  DD=day (01-31)
  Example: January 1, 2004 = 20040101

4. Instructions for Returned Claims and Processed Claims needing Correction

Note: Corrected bills must be submitted within two years of the end of the year the claim was originally submitted. For example, if a claim was filed on 2/15/02, any corrected bill must be submitted by 12/31/04.

Incomplete Claims

Incomplete claims are claims that do not conform to the billing guidelines. These claims have **NOT** been processed and will be returned to the provider. When an incomplete paper claim is returned, providers will receive a black and white reproduction of the claim submitted with the error(s) listed on the form. For CMS-1500 claims, errors will be listed at the top of the form and for CMS-1450 claims, the errors will be listed at the bottom of the form.

Providers should correct the error(s) and resubmit the claim as a new claim on a **new** claim form. **DO NOT WRITE OR STAMP "CORRECTED CLAIM" ON THE NEW CLAIM**. Correcting the error(s) and resubmitting on a **new** claim form will help ensure quicker turnaround.

Incomplete electronic claims are reflected on the Provider's Electronic Receipt Confirmation Report. Providers should correct the error and resubmit the claim electronically.

Note: Since incomplete returned claims have not been processed (providers have not received a Remittance Advice for these claims), the claim will not be denied "duplicate" when resubmitted. Images of all rejected and accepted claims will be maintained in BlueCross BlueShield of Tennessee's archives for future reference.

Corrected Bills

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, codes, units, and/or charges that were not filed on the original claim.

There are two methods that can be used to submit corrected paper claims. The first method listed below is preferred because it allows the automatic scanning of the new claim for quicker turnaround. The alternate method requires marking on the original claim and can result in errors and delay processing of the claim if the handwritten information is not clear or extends beyond the form fields.

Preferred Method for Filing Corrected Paper Claims

- Submit a **new** claim form with the correct data.
- Attach correspondence ***behind*** the claim form indicating what information was originally submitted and what was changed on the new claim form. Example, "Procedure code in Block 24D of first line item was submitted as 99201; corrected to 99202 on new claim".
- Write (using pen with black ink), stamp or type "CORRECTED BILL" in Block 19 on the CMS-1500 claim form. Our Optical Character Recognition (OCR) equipment will not recognize red ink. Do not use a thick marker or crayon that may cover other form fields.
- On the CMS-1450 claim form, if the third digit in the Type of Bill field (form locator 4) ends in a "6", "7" or "8", the claim is considered a corrected bill. Definitions of these codes follow:

If third digit in type of bill is:	it indicates:
6	Adjustment of prior claim
7	Replacement of prior claim
8	Void/cancel of prior claim

Alternate Method for Filing Corrected Paper Claims

- Draw a thin line through the original information and **clearly** list the new information above, below or beside the original information.
- Keep within the boundaries of the form field when adding the correct information. Do not use a thick marker or crayon that may cover other form fields.
- Do not use correction tape or fluid (White Out) – the original information MUST be visible.
- Write (using pen with black ink), stamp or type "CORRECTED BILL" in Block 19 of the CMS-1500 claim form.
- Use the appropriate Type of Bill on the CMS-1450 claim form to identify the claim as a corrected bill. (See code definitions above)

Electronic Claims

If a claim is rejected, it requires correction and resubmission electronically. Effective 11/1/2003, **Corrected Bills** for facility and professional claims can be filed electronically in the ANSI-837, version 4010A1 format. The following guidelines are based on National Implementation Guides found at http://www.wpc-edi.com and BlueCross BlueShield of Tennessee Companion Documents found at www.bcbst.com/providers/docs/ecomm/tech_info.shtm when filing these claims.

ANSI-837P - (Professional)

- In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "6" – CORRECTED (Adjustment of Prior Claim)
  - "7" – REPLACEMENT (Replacement of Prior Claim)
  - "8" – VOID (Void/Cancel of Prior Claim)

- In addition, in the 2300 Loop, the REF02 segment (Original Reference Number (ICN/DCN)) must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic claims receipt confirmation reports.

ANSI-837I - (Institutional)

- In the 2300 Loop, the CLM segment (claim information), the CLM05-3 (claim frequency type code) must indicate the third digit of the type of bill being sent. The third digit of the type of bill is the frequency and can indicate if the bill is an adjustment, a replacement or a void claim as follows:
  - "6" – CORRECTED (Adjustment of Prior Claim)
  - "7" – REPLACEMENT (Replacement of Prior Claim)
  - "8" – VOID (Void/Cancel of Prior Claim)

- In addition, in the 2300 Loop, the REF02 segment (Original Reference Number (ICN/DCN)) must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic claims receipt confirmation reports.

  For Technical Support assistance, contact e-Commerce at (423) 755-5717 or via e-mail at ecomm_techsupport@bcbst.com. Technical support is available Monday through Friday, from 8 a.m. to 5:30 p.m. (EST).

B. General Billing Information

1. Current Dental Terminology (CDT), Current Procedural Terminology (CPT®), HealthCare Common Procedural Coding System (HCPCS) and International Classification of Diseases (ICD) Coding (**Note**: *CPT® is a registered trademark of the American Medical Association and is repeated throughout this manual*.)

Unless specified otherwise in this manual, medical/clinical codes including modifiers should be reported in accordance with the governing coding organization. For example:

- **CDT codes**-should be reported in accordance with the American Dental Association guidelines (e.g., CDT manual).

- **CPT® codes-**should be reported in accordance with the American Medical Association guidelines including the *CPT® Manual*, *CPT® Coding Changes*, *CPT® Assistant*, *CPT® Clinical Examples*, *CPT® Companion* and other coding resources authorized by the American Medical Association.

- **HCPCS codes-**should be reported in accordance with the Department of Health and Human Services guidelines including, but not limited to, the *HCPCS Manual*, *Federal Register*, *Center for Medicare and Medicaid Program Memorandums and Transmittals*, *Medicare Part B Bulletins*, Medicare Region C Durable Medical Equipment Regional Carrier (DMERC) guidelines (e.g., the *DMEPOS Supplier Manual and Revisions*, *DMERC Medicare Advisories*, *Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Product Classification Lists* and *Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Bulletins*).

- **ICD codes-**should be reported in accordance with the Department of Health and Human Services guidelines (e.g., *ICD Manual*).

2. Addition/Deletion CDT Codes

CDT (Current Dental Terminology) codes are used to report diagnostic/preventive/ restorative dental, endodontic, peridontic, prosthodontic, orthodontic, maxillofacial prosthetic, implant, and oral surgery services.

CDT is updated and maintained by the American Dental Association. CDT updates include addition, deletion, and/or revision of codes. Currently, CDT codes are subject to updates on a periodic basis (e.g., 01/01/1990, 01/01/1995, 01/01/2000, 01/01/2003, 01/01/2005).

BlueCross BlueShield of Tennessee will implement updates to CDT codes according to the following schedule:

Effective Date of Change by the American Dental Association	Effective Date of Change by BCBST (Date of Service)		
	Addition	Revision	Deletion
January 1	January 1	January 1	January 1

In the event the American Dental Association modifies the schedule for coding updates, the BlueCross BlueShield of Tennessee schedule will be modified accordingly. CDT codes billed prior to the effective date of the code will be rejected or returned by BlueCross BlueShield of Tennessee as an invalid code for the date of service.

Due to the short American Dental Association publication schedule, it is not possible for BlueCross BlueShield of Tennessee to notify providers of changes to CDT codes. The Provider is responsible for ensuring codes billed are valid for the date of service. CDT codes can be obtained from the American Dental Association.

3. Addition/Deletion CPT® Codes

CPT® (Current Procedural Terminology) codes are used to report physician, radiology, laboratory, evaluation and management, and other medical diagnostic procedures.

CPT® codes are updated and maintained by the American Medical Association. Currently, CPT® codes are subject to updates effective January 1 and July 1 of each year. CPT® updates include the addition, revision and/or deletion of codes.

BlueCross BlueShield of Tennessee will implement updates to CPT® codes according to the following schedule:

Effective Date of Change by the American Medical Association	Effective Date of Change by BCBST (Date of Service)		
	Addition	Revision	Deletion
January 1	January 1	January 1	January 1
July 1	July 1	July 1	July 1

- In the event the American Medical Association modifies the schedule for coding updates, the BlueCross BlueShield of Tennessee schedule will be modified accordingly.
- CPT® codes billed prior to the effective date of the code will be rejected or returned by BlueCross BlueShield of Tennessee as an invalid code for the date of service.
- Due to the short American Medical Association publication schedule, it is not possible for BlueCross BlueShield of Tennessee to notify providers of changes to CPT® codes.
- Provider is responsible for ensuring codes billed are valid for the date of service.

CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT® code updates may also be located on the American Medical Association Web site at www.ama-assn.org.

4. Addition/Deletion HCPCS Codes

HCPCS (HealthCare Common Procedural Coding System) codes are used to report transportation, medical supplies, durable medical equipment, injectable drugs, orthotic, prosthetic, hearing (e.g. hearing aids and accessories) and vision (e.g. frames, lens, contact lens, and accessories) services.

HCPCS codes are updated and maintained by the Department of Health and Human Services. Currently, HCPCS codes are subject to updates effective January 1, April 1, July 1, and October 1of each year. HCPCS updates include addition, deletion, and/or revision of codes.

BlueCross BlueShield of Tennessee will implement updates to HCPCS codes according to the following schedule:

Effective Date of Change by the Department of Health and Human Services	Effective Date of Change by BCBST (Date of Service)		
	Addition	Revision	Deletion
January 1	January 1	January 1	January 1
April 1	April 1	April 1	April 1
July 1	July 1	July 1	July 1
October 1	October 1	October 1	October 1

In the event the Department of Health and Human Services modifies the schedule for coding updates, the BlueCross BlueShield of Tennessee schedule will be modified accordingly. HCPCS codes billed prior to the effective date of the code will be rejected or returned by BlueCross BlueShield of Tennessee as an invalid code for the date of service.

Due to the short Department of Health and Human Services' publication schedule, it is not possible for BlueCross BlueShield of Tennessee to notify providers of changes to HCPCS codes.

The Provider is responsible for ensuring codes billed are valid for the date of service. HCPCS codes, HCPCS code updates, and HCPCS coding resources include, but are not limited to the following:

- Federal Register
- Center for Medicare and Medicaid Program Memorandums and Transmittals
- Medicare Part B Medicare Bulletins Medicare Region C Durable Medical Equipment Regional Carrier (DMERC) guidelines including, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DMERC Medicare Advisories
  - Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Product Classification Lists
- Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Bulletins

5. Addition/Deletion ICD Codes

ICD (International Classification of Diseases) include:

- Volume 1 and 2 ICD codes are used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems
- Volume 3 ICD codes are used to report prevention, diagnosis, treatment, and management

ICD is updated and maintained by the Department of Health and Human Services. ICD codes are subject to updates effective with discharges on or after April 1 and October 1 of each year. ICD updates include addition, deletion, and/or revision of codes.

BlueCross BlueShield of Tennessee will implement updates to ICD codes according to the following schedule:

Effective Date of Change by the Department of Health and Human Services	Effective Date of Change by BCBST (Date of Discharge)		
	Addition	Revision	Deletion
April 1	April 1	April 1	April 1
October 1	October 1	October 1	October 1

In the event the Department of Health and Human Services modifies the schedule for coding updates, the BlueCross BlueShield of Tennessee schedule will be modified accordingly.

ICD codes billed prior to the effective date of the code will be rejected or returned by BlueCross BlueShield of Tennessee as an invalid code for the date of service.

Due to the short Department of Health and Human Services' publication schedule, it is not possible for BlueCross BlueShield of Tennessee to notify providers of changes to ICD codes. The Provider is responsible for ensuring codes billed are valid for the date of service. ICD codes can be obtained from the Department of Health and Human Services.

6. Miscellaneous, Non-Specific and Not Otherwise Classified (NOC) Procedures/Services (Eff 12/13/99 – last revised 9/1/05)

Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) procedures/services should only be used when a more specific CPT® or HCPCS code is not available or appropriate. The maximum allowable for eligible procedures/services reported using an unlisted, miscellaneous, non-specific CDT, CPT® or HCPCS code will be based on "Individual Consideration".

When an unlisted, miscellaneous, non-specific code is reported, the procedure or service should be adequately described in order to determine eligibility and the appropriate maximum allowable. To make this determination, it may be necessary to provide one or more of the following types of supplemental information:

- A description of the procedure or service provided;
- Documentation of the time and effort necessary to perform procedure or service;
- An operative report for surgical procedures;
- An anesthesia flow sheet for anesthesia procedures;
- The name of the drug/immune globulin/immunization/vaccine/toxoid, National Drug Code (NDC), dosage, and number of units provided;
- The name of the manufacturer, name of product, product number, and quantity of durable medical equipment, medical supplies, orthotics and prosthetics; and
- For radiopharmaceuticals and contrast materials:
  - The name of the radiopharmaceutical and or contrast material, NDC, dosage and quantity;

    Or
  - The manufacturer's invoice listing the name of the patient, name of the specific diagnostic radiopharmaceutical or contrast material, dosage and number of units. If multiple patients are listed on the manufacturer's/supplier's invoice, the diagnostic radiopharmaceutical imaging agent or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

If an unlisted, miscellaneous, non-specific CDT, CPT® or HCPCS code is reported without the needed supplemental information, the procedure or service will be non-covered or returned to the Provider.

Effective 2/1/06, regardless of the date of service, BlueCross BlueShield of Tennessee will begin disallowing services billed with an unlisted code when a specific CDT, CPT®, or HCPCS code is more appropriate.

7. Code Bundling

BlueCross BlueShield of Tennessee updated and published its commercial code bundling rules:

- Effective for dates of service April 1, 2004 for professional (CMS-1500/ANSI-837) claim submissions
- Effective for dates of service July 1, 2004 for facility (CMS-1450/ANSI-837) claims

Code bundling edits are performed during the initial claim processing phase, when possible, and are based on nationally recognized code bundling guidelines including:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare and Medicaid (CMS) guidelines
- Guidelines published by medical societies/associations such as the American Academy of Orthopedic Surgeons (AAOS) and American College of Obstetricians and Gynecologists (ACOG)
- Clinical rationale/expertise

BlueCross BlueShield of Tennessee code bundling rules are also based on reimbursement policies such as, but not limited to, the following:

- Bundled Services regardless of the Location of Service
- Bundled Services when the Location of Service is the Practitioner's Office
- Corneal Topography
- Durable Medical Equipment (Purchase and Rentals)
- Home Pulse Oximetry
- Screening Test for Visual Acuity
- Visual Function Screening
- Quarterly Reimbursement Changes

BlueCross BlueShield of Tennessee code bundling rules will be applied during the claim payment process, when feasible; however, some edits can only be applied when all associated claims are processed. In those cases, the edit will be applied during the retrospective audit process when all associated claims are available for review. BlueCross BlueShield of Tennessee's Provider Audit Department will continue to periodically conduct on-site reviews.

Code bundling rules reflect edits where a comprehensive and component code pair exists:

- **Comprehensive (Column 1) code** generally represents the major procedure or service when reported with another code.
- **Component (Column 2) code** generally represents the lesser procedure or service. Reimbursement for a component code is considered included in the reimbursement for the comprehensive code when the service is billed by the same provider, for the same patient on the same date of service and is not made separately from the comprehensive code.

Code bundling can occur on multiple levels depending on the combination of codes reported. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code.

Providers can access the code bundling rules for code pairs via the company Web site at http://www.bcbst.com/providers/docs/code_bundling/default.shtm.

Code pairs reported on the BlueCross BlueShield of Tennessee Web site will be updated on a quarterly basis effective for dates of service January 1, April 1, July 1, and October 1. The updated rules will be posted on the company Web site at least 30 days prior to the effective date.

BlueCross BlueShield of Tennessee reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records) to determine appropriate application of its code bundling rules.

8. Modifiers that Bypass Code Bundling Edits

Modifiers are two-digit indicators (alpha or numeric) that, when appended to a procedure code, indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code.

The following guidelines apply to professional claims filed on a CMS-1500 claim form or by using professional electronic claims format ANSI-837P).

Modifier 59

As consistent with the initiatives of the Office of Inspector General (OIG), BlueCross BlueShield of Tennessee reserves the right to evaluate, audit and/or recoup any and all payments resulting from erroneous reporting of the modifier 59. (OIG Workplan, FY 2005)

Description
Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedure(s)/service(s) that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician.

Guidelines
Modifier 59 will only be recognized as valid to bypass edits when:

- Combination of procedure codes represent procedures that would not normally be performed at the same time (e.g. procedure on head and procedure on feet; craniotomy and setting of compound fracture)
- Different session or patient encounter is documented in patient's medical record
- Surgical procedures performed are not through the same incisional site (Note: doesn't matter if instrumentation changes if incision or presentation is the same)
- Surgical knee procedures involving multiple compartments of the same knee
- Another modifier is not more appropriate (e.g. Modifier 51)

To determine if Modifier 59 is the most appropriate modifier to use, the following questions must be considered:

1. What is the rationale for the existing edit?
2. Is the edit a National Correct Coding Initiative (NCCI) edit with an indicator '0'? If so, there is no appropriate modifier to allow edit bypass.
3. Was the procedure performed in a separate setting, different time, or different encounter?
4. Is there sufficient documentation to support the separateness and distinction of the two procedures?
5. Was the procedure truly separate and/or is it unusual to perform these procedures at the same session?

National Correct Coding Initiative Superscript Designations - NCCI Indicators

- Superscript (Indicator) '0' indicates that the edit would never be eligible for bypassing.
- Superscript (Indicator) '1' indicates that there is a valid reason for the code denial but documented special circumstances could validate the edit bypass when the appropriate modifier is used.

Use of Modifier 59 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement.

Modifier 59 should never be appended to an Evaluation & Management service, as this is inappropriate coding convention.

9. Special Report

A service that is rarely provided, unusual, variable, or new, may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for procedure; and time, effort, and equipment necessary to provide service.

- Complexity of symptoms;
- Final diagnosis;

- Pertinent physical findings (such as size, locations, and number of lesion[s], if appropriate);
- Diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate);
- Concurrent problems;
- Follow-up care.

Providers should send an appropriate "Special Report" documenting the service or procedure designated by the "Unlisted Procedure" code. Undocumented "Unlisted Procedure" code claims will be denied or developed when appropriate. **Unlisted services or procedures must be submitted on a paper copy claim.**

For services billed with an unlisted, miscellaneous, non-specific, or not otherwise classified code, refer to the Unlisted Service or Procedure Guidelines.

10. Coordination of Benefits

BlueCross BlueShield of Tennessee Provider contracts include the provision for Coordination of Benefits (COB), which applies when a Member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary carrier prior to submission to BlueCross BlueShield of Tennessee. Upon claim submission to BlueCross BlueShield of Tennessee, please provide a copy of the Remittance Advice from the primary carrier.

11. Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the Member's health care benefits plan that permits BlueCross BlueShield of Tennessee to pay the Provider when a third party causes the Member's condition. BlueCross BlueShield of Tennessee handles subrogation cases on a "pay and pursue" basis. If a Provider becomes aware that the services rendered result from the actions of a third party, he/she should contact us at the following address and telephone number:

BlueCross BlueShield of Tennessee
Subrogation Department
801 Pine Street
Chattanooga, TN 37402
423-535-5837

If there is a payment from a third party carrier that results in an overpayment, it is the responsibility of the Provider to reimburse BlueCross BlueShield of Tennessee the overpaid amount. If a Provider receives more than he/she should have when benefits are coordinated, the Provider will be expected to repay any overpayment to the appropriate insurer. The Provider will not pursue any third party recoveries, nor accept any payments from other parties after payment by BlueCross BlueShield of Tennessee. This does not apply to copayments, deductible or coinsurance amounts.

12. Balance Billing

Providers agree to accept reimbursement made in accordance with the terms of their Provider Contract with BlueCross BlueShield of Tennessee, plus any applicable Member copayment/deductible, and coinsurance amounts as the maximum amount payable to the Provider for Covered Services rendered to Members.

Providers **may not** seek payment from a BlueCross BlueShield of Tennessee Member when:

- The Provider failed to comply with BlueCross BlueShield of Tennessee medical management policies and procedures or provided a service which does not meet BlueCross BlueShield of

Tennessee standards for medical necessity or does not comply with BlueCross BlueShield of Tennessee medical policy;
- The Provider failed to submit or resubmit claims for payment within the time periods required by BlueCross BlueShield of Tennessee (timely filing guidelines); or
- Services rendered are considered Investigational by BlueCross BlueShield of Tennessee and are therefore non-reimbursable, unless **prior** to rendering such services to the Member, Provider has entered into a **procedure-specific** written agreement with the Member, which advised Member of his/her payment responsibilities.

Providers **may** bill the Member for:
- Non-Covered Services*;
- Any applicable Deductible/Copay Amounts; and
- Any applicable Co-Insurance Amounts.

When seeking payment from a BlueCross BlueShield of Tennessee Member, please refer to the *Patient Owes* column on your Provider Remittance Advice. This column includes *the Non-covered* total, *Deductible/Copay* total, and *Coinsurance* total. It may also reflect the *Other Insurance* total, which is the amount paid by the patient's other insurance carrier.
Before billing the Member, check both the *Deductible/Copay* and the *Other Insurance* columns to make sure that any applicable copayment or other insurance payments haven't already been received.

When billing Members for non-covered services due to benefit limitations, i.e. dollar limits or service limits, network Providers may bill the Member the difference between the limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a Provider write-off.

Example: Dollar Limit
The Member has a $250 limit on wellness services with no copayment. The Member has already used $100 on wellness services. This leaves a remaining benefit of $150.

Billed amount	$450
Allowed amount	$325
Remaining wellness benefit $150	
Member liability	$175 (difference between allowed amount and remaining benefit
Provider write-off	$125 (difference between billed amount and allowed amount)

Example: Service Limit
The Member's coverage allows for one Pap smear per calendar year. The Member has already used this benefit for the year.

Billed amount	$65
Allowed amount	$30
Member liability	$30 (allowed amount)
Provider write-off	$35 (difference between billed amount and allowed amount)

Note: *BlueCross BlueShield of Tennessee Members shall be held harmless for any contractual difference between billed charges and BlueCross BlueShield of Tennessee and Member payment obligations unless noted above.*

13. Final Reimbursement

When considering final reimbursement for services, procedures and items, BlueCross BlueShield of Tennessee considers several factors including:

- Member eligibility on the date of service
- Medical Necessity and Medical Appropriateness
- Applicable Member copayments, coinsurance and deductible

- Member's health care benefits plan exclusions/limitations
- Authorization/Referral requirements
- BlueCross BlueShield of Tennessee Medical Policy†

†Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual on the company Web site at http://www.bcbst.com/providers/docs/mpm.shtm.

14. Policy for Quarterly Reimbursement Changes

This policy will be applicable when referenced in the provider agreement or BlueCross BlueShield Reimbursement Policy. Reimbursement changes applicable to this policy will be made according to the following schedule:

Date Reimbursement Data is Published by Source	Date Change Will Be Applied by BlueCross Blue Shield of Tennessee
January 1 to March 31	July 1
April 1 to June 30	October 1
July 1 to September 30	January 1
October 1 to December 31	April 1

15. Non-Standard Billing Requirement

BlueCross BlueShield of Tennessee makes every effort to structure its commercial provider network contracts and specific billing guidelines to meet the reporting requirements imposed by federal and state agencies. However, due to contract terms in our commercial networks and other business requirements, it sometimes becomes necessary that we require a facility bill in a manner that does not conform to these reporting requirements.

Additionally, BlueCross BlueShield of Tennessee provides services to a diverse member population whose benefits may or may not be provided by federal and state agencies and the billing guidelines required for these services may not always be conducive to the requirements of federal and state agencies.

In circumstances where BlueCross BlueShield of Tennessee's billing requirements are not consistent with federal and state agency reporting, Providers are still required to remain in compliance with all reporting requirements mandated by those agencies. The provider's medical records, census documents and financial reporting should never change as a result of BlueCross BlueShield of Tennessee's billing requirements. BlueCross BlueShield of Tennessee recognizes this may cause a discrepancy between the provider's reporting records and the actual billing documents, however the billing to BlueCross BlueShield of Tennessee is a contractual requirement for claim payment only and should never impact regulated reporting requirements.

The most common example of a non-standard billing requirement is billing for observation services when BlueCross BlueShield of Tennessee has only authorized outpatient observation services and the admitting physician has written an inpatient admission order. In this case, in order to receive payment for observation services, the Provider is required to bill BlueCross BlueShield of Tennessee as follows:

- Change the Type of Bill from inpatient to outpatient (13x)
- Convert the Room and Board revenue code to Observation (76x)

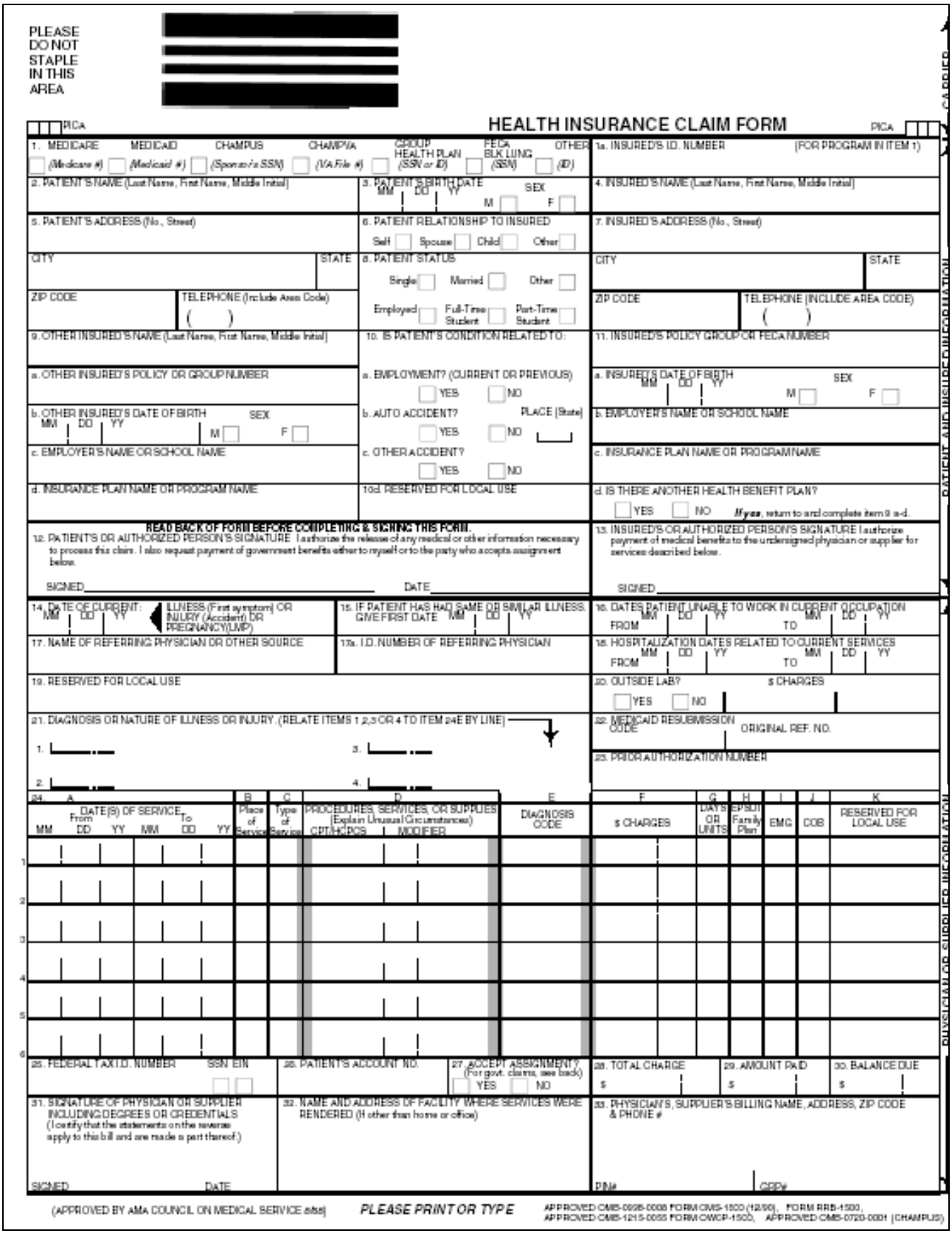
In this example the provider should make no changes to its medical records, continue to report the days as inpatient on their census reports and reflect charges under the Room & Board revenue codes on their financial system. This will keep the provider in compliance with Medicare reporting but will allow payment under contractual terms of their BlueCross BlueShield of Tennessee Provider contract.

C. CMS-1500 Claim Form

All professional services need to be filed on the CMS-1500 claim form. These include:

- Professional Outpatient Services;
- Emergency Room Practitioner Fees-must be filed with Location Code 23 (Emergency Room, Hospital); and
- Clinic Visits (professional fees)

A sample copy of the CMS-1500 claim form follows:



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

1. CMS-1500 Form Field Description:

Block 1	Type of Plan
Block 1a	Insured's ID Number
Block 2	Patient's Name
Block 3	Patient's Date of Birth
Block 4	Insured's Name
Block 5	Patient's Address and Telephone Number
Block 6	Patient's Relationship to Insured
Block 7	Insured's Address
Block 8	Patient Status
Block 9	Other Insured's Name
Block 9a	Other Insured's Policy Number
Block 9b	Other Insured's DOB
Block 9c	Employer's Name or School Name
Block 10a,b,c	Is Patient's Condition Related To
Block 11	Insured's Policy Group or FECA Number
Block 11a	Insured's DOB
Block 11b	Employer's Name or School Name
Block 11c	Insurance Plan Name
Block 11d	Is There Another Health Benefit Plan
Block 12	Patient's or Authorized Person's Signature
Block 13	Insured's or Authorized Person's Signature
Block 14	Date of First Symptom of Illness, Pregnancy or Date of Accident
Block 17	Name of Referring Practitioner or Other Source
Block 17a	ID Number of Referring Practitioner
Block 19	Identifies as "CORRECTED BILL"
Block 21	Diagnosis or Nature of Illness or Injury
Block 22	List the Medicaid Resubmission Code (If Any)
Block 23	Prior Authorization Number (If Applicable)
Block 24a	Dates of Service
Block 24b	Place of Service
Block 24c	Type of Service
Block 24d	CPT® or HCPCS code, modifiers
Block 24e	Diagnosis Codes
Block 24f	Charges
Block 24g	Days or Units
Block 24h	EPSDT/Family Plan
Block 24I	EMG
Block 24k	Individual Practitioner UPIN Number (not used for commercial business)
Block 25	Federal Tax ID Number
Block 26	Patient's Account Number
Block 27	Does the Provider Accept Medicare Assignment
Block 28	Total Charges
Block 29	Amount Paid
Block 30	Balance Due
Block 31	Signature of Practitioner or supplier (or an authorized representative for the supplier) including degrees or credentials
Block 32	The Practitioner's practice address, if different from that shown in Block 33.
Block 33	Appropriate individual or billing name, address, telephone number (how check and remittance advice should be endorsed) and BlueCross BlueShield of Tennessee designated provider number.

2. Data Elements Required for Submitting CMS-1500 Claims

To avoid delays in receiving payments and to avoid unnecessary claim denials, it is imperative that all required information is provided. The following lists data required when filing a CMS-1500 Claim Form. If these are not complete, the claim is subject to be returned/denied. Note: (+) indicates if format or data is not valid, the claim will be rejected and returned to the Provider for correction and resubmission

• +Insured's I.D. number (including three-letter alpha prefix)	Block 1A
• +Patient's Name	Block 2
• +Patient's Date of Birth	Block 3
• Insured's Name	Block 4
• Patient's Address	Block 5
• Patient's Relationship to Insured	Block 6
• Another Health Plan	Block 11d
• +Patient's Signature	Block 12
• Insured's Signature	Block 13
• +Date of Accident	Block 14
• Referring Practitioner	Block 17
• ID Number of Referring Practitioner	Block 17a
• +Diagnosis	Block 21
• +Dates of Service	Block 24a
• +Place of Service	Block 24b
• +Type of Service	Block 24c
• +Procedure Codes/Modifiers	Block 24d
• +Diagnosis Code	Block 24e
• +Charges	Block 24f
• +Days/Units	Block 24g
• +Federal Tax ID Number	Block 25
• Patient's Account Number	Block 26
• +Total Charges	Block 28
• Name of Physician/Supplier	Block 31
• +Provider Identification Number	Block 33

Note: *Additional requirements for each type of claim submitted are covered in Sec. VI.E.*

D. CMS-1500 Provider's Manual

The inclusion of the CMS-1500 Provider's Manual in the BlueCross BlueShield of Tennessee Provider Administration Manual is intended to provide information on how to complete claim forms in compliance with CMS regulations and accepted by most health insurance carriers including BlueCross BlueShield of Tennessee and all programs that it administers.

Included is a description of how each block of the form should be completed, what type of data should be entered, and the proper format for entering the data. Since detailed discussions or explanations of all the codes, rules and options go beyond the scope of this document, please refer any questions to the payor organization with which you are dealing.

Information and codes contained herein are accurate at the time of publication. Payor-issued mailings (newsletter, bulletins, etc.), workshop sessions and Provider Relations Representative visits are all sources of information for keeping this manual current.

To avoid delays in receiving payments and to avoid unnecessary claim denials, it is important that all of the required information is provided in the specified formats.

The print specification sections are among the most important parts of this manual. The CMS-1500 form makes it possible for payors to continue adding the use of Optical Character Recognition equipment to their claims entry operations, making faster and more accurate claim payments possible. However, incomplete data, or data not properly aligned in the proper block will be rejected by OCR equipment, creating delays in processing.

1. General Instructions

The form designated CMS-1500 is approved by CMS, TRICARE/CHAMPUS, AMA's Council on Medical Services, and BlueCross BlueShield of Tennessee.

A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:

- Only one line item of service per claim line (Block 24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
- "Super bills," statements, computer printout pages, or other sheets listing dates, service, and/or charges **cannot** be attached to the CMS-1500 claim form.
- The form is designated for double spacing with the exception of Bocks 31, 32 and 33, which may be single-spaced.
- Laser Jet or Inkjet printers produce the best output; however, if Dot Matrix printers must be used, print must be dark enough to be machine read.
- Do not use italics and script on the form.
- Do not use old or worn print bands, ribbons, or cartridges when completing the form – print must be dark enough to be scanned.
- Use upper case (CAPITAL) letters for all alpha characters.

- Do not use dollar signs ($), decimals (.), or commas (,) in any dollar amount blocks.
- Enter information on the same horizontal plane.
- Enter all information within the boundaries of the designated block.
- Enter insured's ID number including three-letter alpha prefix.
- Extraneous data (handwritten or stamped) may not be printed on the form except to mark as "Corrected Bill".
- Pin feed edges should be evenly removed prior to submission.
- If handwritten, use pen ONLY, do not use pencil.

2. Form Alignment

The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block 1 and Block 1A are 6 boxes labeled "PICA". These boxes should be considered Line 1, Columns 1,2 and 3, and Line 1, Columns 77,78 and 79. Form alignment can be verified by printing "X's" in these boxes.

3. Entering All Dates

- All date information should be shown in the following format (except Block 24A – date of service):

  MMblankDDblankCCYY
  MM=month (01-12)
  1 blank space
  DD=day (01-31)
  1 blank space
  CCYY=year (0000-9999)
- The blank space should fall on the vertical lines provided on the form.
- Do NOT exclude leading zeros in the date fields.

Block 24A must be a continuous 8-digit number (Correct: January 1, 2003 = 01012003)

4. Physical Claim Form Specifications

While CMS-1500 claim forms can be ordered from the Government Printing Office, some Providers may elect to deal with independent form vendors. All CMS-1500 claim forms MUST conform to the following print specifications; submitting non-standard forms that do not conform to these specifications can result in delayed processing and payment of the claim:

PAPER
- OCR bon - JCP25
- 20 pound
- 217 mm x 281mm (+ or - 2mm)
- Cut square, corners 90 degrees (+ or -.025)

INK

- Standard is Sinclair and Valentine J6983
- Same ink front and back of form
- Multipart forms must have same ink on all copies

MARGIN

- Top to typewriter alignment bar is 34mm
- Right to left margin is 9mm

ASKEWITY

- No greater than .15mm in 100mm
  X and Y OFFSET for MARGINS must not vary by more than + or - 0.010 inches from page to page (x= horizontal distance form left margin to print, y= vertical distance from top to print).

  NO MODIFICATIONS may be made to the CMS-1500 without the authorization of the Centers for Medicare and Medicaid Services.

5. Form Content and Description

Below is a description of each block on the form with print specifications for completing each area.

BLOCK 1 - TYPE COVERAGE

1. MEDICARE	MEDICAID	CHAMPUS	CHAMP/VA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)

Description: Place an "X" in the box that describes the type of health care coverage program being billed.

Print Specs: Line 3, Columns 1,7,15, 24, 31, 39 or 45
Print "X".

BLOCK 1A - INSURED'S I.D. NUMBER

1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
AAA123456789	

Description: Enter the insured's identification number (**including the 3-letter alpha prefix**) for the company/agency being billed from the enrollment materials available to the insured. Correctly and completely record the number in your file, including all alphabetic (alpha) and numeric characters.

Print Specs: Line 3, Columns 51-78.
Print alpha - numeric,
Left justify,
Do not zero fill, or use imbedded spaces.

BLOCK 2 - PATIENT'S NAME

2. PATIENT'S (Last Name, First Name, Middle Initial)
MCCORMACK JAMES C

Description: Place the full name of the patient receiving service (**LAST, FIRST, MIDDLE INITIAL**) in this block. List only one patient per claim form.

Print Specs: Line 5, Columns 2-28.
Print alphanumeric,
Left justify,
ALL CAPITAL LETTERS,
No special characters, no titles and no imbedded spaces except to separate last and first names and middle initial.

Example: Tim L. O'Neal, Jr. = ONEAL TIM L

BLOCK 3 - PATIENT'S BIRTHDATE AND SEX

3. PATIENT'S BIRTH DATE MM	DD	CCYY	SEX
01	03	2003	M ☐ F ☐

Description Two pieces of information are entered in this block: the date the patient was born and the patient's sex.

Enter 8 positions (MMDDCCYY) indicating the date on which the patient was born.

Examples: January 3, 2003 = 01_03_2003
November 25, 1998 = 11251998

To indicate SEX, place an "X" in the appropriate box to denote if the patient is male (M) or female (F).

Print Specs: Line 5, Columns 31, 32 and 34,35 and 37, 38, 39, 40 and 42 or 47.
Columns 31,32 = MM
Columns 34,35 = DD
Columns 37,38, 39, 40 = CCYY
Print "X" in 42 or 47.

BLOCK 4 - INSURED'S NAME

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MCCORMACK MARY O

Description: For patients with coverage through private insurance (Blue Cross, etc.) or Medicaid (TennCare), FEP, TRICARE/CHAMPUS, etc., the patient's name may be different from the "insured". As the payor also needs the insured's name, place the full name of the "insured", "subscriber," or "contract holder" in this block (see Block 2). If the subscriber's name on the identification card is the same as the patient's name, you may use the word SAME or SELF.

Print Specs: Line 5, Columns 51-78.
Print alphanumeric,
Left justify,
ALL CAPITAL LETTERS,

No special characters, no titles and no imbedded spaces except to separate last and first names, and middle initial. (Must be filed as Last Name first, then First Name followed by Middle Initial, if applicable.)

BLOCK 5 - PATIENT'S ADDRESS

5. PATIENT'S ADDRESS (No., Street)	
123 MAIN STREET APT 12	
CITY	
YOURTOWN	TN
ZIPCODE / TELEPHONE (Include Area Code)	
37400 (615) 755 5600	

Description: Enter patient's permanent mailing address and telephone number:
Line 7 = street address, including apt #
Line 9 = city and state
Line 11 = ZIP code and telephone #

(If it is necessary to contact the person for additional information in order to process the claim, current and correct information will speed the resolution of claims payment.)

Print Specs: Line 7, Columns 2-28:
Line 9, Columns 2-24:
Line 11, Columns 2-10 and 15-28.
Print alphanumeric,
Left justify,
Special character "-" (dash) may be used, No imbedded spaces except to separate street number/name, and to separate city/state.

BLOCK 6 - PATIENT'S RELATIONSHIP TO INSURED

6. PATIENT RELATIONSHIP TO INSURED			
Self ☐	Spouse ☐	Child ☐	Other ☐

Description: Place an "X" in the block that describes the family relationship between the patient (Block 2) and the insured (Block 4).

Print Specs: Line 7, Columns 33, 38, 42, or 47.
Print "X".

BLOCK 7 - INSURED'S ADDRESS

7. INSURED'S ADDRESS (No., Street) SAME	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)

Description: Enter insured's (Block 4) permanent address and telephone number.

If the patient and the insured are the same, enter "SAME."
Line 7 = street address, including apt #
Line 9 = city and state
Line 11 = ZIP code and telephone #

Print Specs: Line 7, Columns 51-72;
Line 9, Columns 51-72 and 75-76;
Line 11, Columns 51-59 and 65 -77.
Left justify,
ALL CAPITAL LETTERS,
No special characters, except "-" (dash) may be used,
No imbedded blanks except to separate street number/name, and city/state.

BLOCK 8 - PATIENT STATUS

8. PATIENT STATUS			
Single ☐	☐ Married		Other ☐
Employed ☐	Full - Time Student ☐	Part - Time Student ☐	

Description: Two pieces of information are entered in this block: the patient's marital status and the patient's employment status. For MARITAL STATUS, place an "X" in the box that describes the patient's

marital status (married, single, or other). For EMPLOYMENT STATUS, place an "X" in the box that describes the patient's employment status (employed, full-time student, or part-time student).

***Note**: **More than one** box can be checked if the patient is both employed and attending school, or **No** boxes checked if the patient is neither employed nor a student.*

Print Specs: Line 9, Column 35, 41, or 47;
Line 11, Column 35 and/or 41 or 47.
Print "X" on Line 9,
Optional print "X" on line 11.

Blocks 9A-9D - COORDINATION OF BENEFITS

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
MCCORMACK JAMES C
. OTHER INSURED'S POLICY OR GROUP NUMBER
23456789A
b. OTHER INSURED'S DATE OF BIRTH MM DD CCYY SEX M ☐ F ☐
01 03 2003
c. EMPLOYER'S NAME OR SCHOOL NAME
RETIRED
d. INSURANCE PLAN NAME OR PROGRAM NAME
MEDICARE

Coordination of benefits is a very important cost containment feature for payors. Providing complete and accurate information about a patient's health care coverages will help your office receive prompt and accurate claim payments. Blocks 9A-9D pertain to the coverage not shown in Block 1A. For the company receiving the original claim (the company whose identification data is included in Block 1A), this information pertains to the "other" coverage.

BLOCK 9 - OTHER INSURED'S NAME

Description: Record the name of the insured/subscriber/policy holder if the patient has more than the one coverage represented by the enrollment data in blocks 1A, 4, 7, etc.

If the "insured" under the additional coverage is the same as the person listed in Block 4, enter "SAME".

Print Specs: Line 13, Columns 2-28.
Left justify,
ALL CAPITAL LETTERS,
No imbedded spaces except to separate last and first names, and middle initial.

(See previous example under Blocks 9A-9D - COORDINATION OF BENEFITS)

BLOCK 9A - OTHER INSURED'S POLICY OR GROUP NUMBER

Description: In group health plans, a group number without any additional identifying information is of limited use to most payors. Enter the policy, ID, certificate, or contract number of the other coverage.

Payor organizations may use different wording to signify the policy or group number (e.g. "insured's identification number," "contract number" or "certificate number"). (Do not repeat the same number listed in Block 1A.)

Print Specs: Line 15, Columns 2-28.
Print alphanumeric,
Left justify.

(See previous example under Blocks 9A-9D - COORDINATION OF BENEFITS)

BLOCK 9B - OTHER INSURED'S DATE OF BIRTH

Description: Two-data-element field includes date of birth and sex of the person you have identified in Block 9.

Print Specs: Line 17, Columns 2,3, 5, 6, 8, 9, 10, 11 and 18 or 24
DATE OF BIRTH = enter
MMDDCCYY in 8 positions, 8 numeric with spaces
(January 5, 1904 = 01_05_1904).
SEX = print "X" in either the male (M) or female (F) box,
column 18 or 24.

BLOCK 9C - EMPLOYER NAME OR SCHOOL NAME

Description: List the employer name or school name of the coverage holder listed in block #9.

Print Specs: Line 19, Columns 2-28.
Print alphanumeric,
Left justify.

Note*: If the person listed in Block 9 has both an employer and attends school, list the employer.*

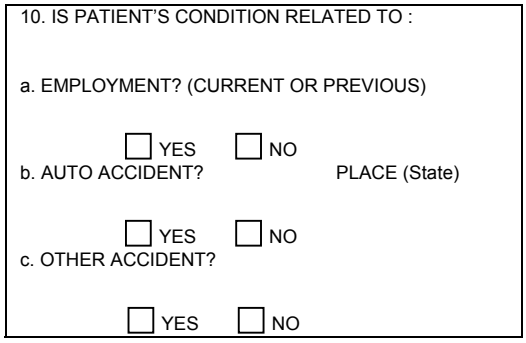
BLOCK 9D - INSURANCE PLAN NAME OR PROGRAM NAME

Description: Record the name of the organization providing coverage for the person shown in Block 9: Blue Cross, FEP (for crossover claims), Medicaid, Aetna, TennCare MCO, etc.

Note*: Medicare carriers require you to attach an additional page to the claim form providing the complete mailing address for the company/organization listed in Block 9D. Enter "ATTACHMENT" in Block 10D to indicate this required page is provided.*

Print Specs: Line 21, Columns 2-28.
Print alphanumeric,
Left justify.

BLOCK 10 - IS PATIENT'S CONDITION RELATED TO



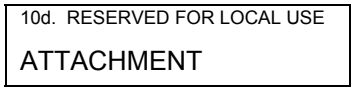
Description:
a. Employment (current or previous)
b. Auto accident (state where accident occurred)
c. Other accident

Because most payors provide special benefit handling for certain conditions, it is necessary to report general information about the condition in this block. The term "special benefit handling" can mean either increased or limited benefits. Insurance plans have different procedures for handling special benefit conditions.

Print an "X" in each box that describes the condition. If you answered "yes" to the auto accident question, add the two-character U.S. Postal Service assigned code for the state in which the accident occurred.

Print Specs: (10A) Line 15, Column 35 or 41, Print "X".
(10B) Line 17, Column 35 or 41, Print "X".
If "X" in 35, print postal state code in 46 and 47.
(10C) Line 19, Column 35 or 41.

BLOCK 10D - RESERVED FOR LOCAL USE



Description: The Medicare carrier in Tennessee requires an additional attached page with the complete mailing address of the "other carrier" identified in Block 9-9D. When an attached page is required, print the word "ATTACHMENT" in this block.

Print Specs: Line 21, Column 31-48.
Print "ATTACHMENT".
Left justify.

BLOCK 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

11. INSURED'S POLICY GROUP OR FECA NUMBER
88888
a. INSURED'S DATE OF BIRTH MM DD CCYY SEX 01 03 2003 M ☐ F ☐
b. EMPLOYER'S NAME OR SCHOOL NAME
SMITH MANUFACTURING CO
c. INSURANCE PLAN OR PROGRAM NAME
RETIRED
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

(This block refers to the person referenced in Block 4)

Description: Enter the benefit identification numbers on membership cards or policy brochures issued to the insured person indicated in Block 4.

Print Specs: Line 13, Columns 51-78.
Print alphanumeric
Left justify,
Do not zero fill.

BLOCK 11A - INSURED'S DATE OF BIRTH AND SEX

Description: This two data-element field pertains to the person referenced in Block 4.

Print specs: Line 15, Columns 54, 55, 57, 58, 60, 61, 62, 63 and 68 or 75.
DATE OF BIRTH = enter MM_DD_CCYY in 8 positions, 8 numeric with spaces (February 9, 2003 = 02_09_2003).
SEX = print "X" in either the male (M) or female (F) box, position 68 or 75.

(See previous example under *BLOCK 11 - INSURED'S POLICY, GROUP OR FECA NUMBER)*

BLOCK 11B — EMPLOYER'S NAME OR SCHOOL NAME

Description: Enter the employer's name or the name of the school attended by the insured listed in Block 14. If the person is both employed and attending school, enter the employer's name.

Print Specs: Line 17, Column 51-78.
Left justify,
ALL CAPITAL LETTERS.

(See previous example under *BLOCK 11 - INSURED'S POLICY, GROUP OR FECA NUMBER)*

BLOCK 11C — INSURANCE PLAN NAME OR PROGRAM NAME

Description: Name of insurance company (Provident, Aetna, etc.) or program (Medicare, Medicaid [TennCare], TRICARE/CHAMPUS, Preferred Care, etc.) that provides health care benefits for the person listed in Block 4. When referring to a Blue Cross and /or Blue Shield Plan, include the state or geographical area as part of the name (e.g. BlueCross BlueShield of Tennessee, BlueCross of Idaho-include 3-letter alpha prefix and/or state of coverage or plan code). Providers who send many claims to the same insurance company may choose to indicate program names rather than the name of the insurance company.

Print Specs: Line 19, Columns 51-78.
Left justify,
ALL CAPITAL LETTERS.

(See previous example under *BLOCK 11 - INSURED'S POLICY, GROUP OR FECA NUMBER)*

BLOCK 11D — IS THERE ANOTHER HEALTH BENEFIT PLAN?

Description: Enter if the patient (Block 2) is or may be entitled to benefits under any other health care coverage program other than the coverage identified in Block 1A.

A definitive answer is required.
A "yes" answer requires completion of Blocks 9, 9A, 9B, 9C, and 9D.

Print specs: Line 21, Column 52, or 57, Print "X".
"X" in Line 21, Column 52 requires entries:
Line 13, Columns 2-28.
Line 15, Columns 2-28.
Line 17, Columns 2, 3, 5, 6, 8, 9,10, 11 and 18 or 24.
Line 19, Columns 2-28.
Line 21, Columns 2-28.

BLOCK 12 — INFORMATION RELEASE/GOVERNMENT ASSIGNMENT

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

ON FILE 01_03_2003
SIGNED _____ DATE _____

Description: Signature or mark of the patient or the patient's representative granting permission for the Provider to release medical information required to process the claim.

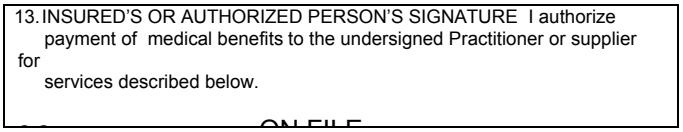
The signature also authorizes payment of government benefits directly to the Provider.

- Patient must sign and date the form in the indicated spaces, or

- Patient's representative must sign, indicate relationship to patient, and date the form in the spaces provided, or
- The Practitioner's office must obtain a release/assignment on a separate document, which will be held in the patient's file. In which case, enter "ON FILE" in this block.

Print Specs: Line 25, Columns 7-30.
Left justify,
ALL CAPITAL LETTERS,
Print "ON FILE" if release/assignment is being kept in patient's file

BLOCK 13 — BENEFIT ASSIGNMENT (non-government programs)


13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned Practitioner or supplier for services described below.

ON FILE

Description: For non-government programs, an assignment of benefits separate from the information release (Block 12) is required if benefits are to be sent to the Provider.

- The patient must sign in this block if payment to the Provider is desired, or
- The patient's/insured's signature on a separate document must be maintained in the patient's file (enter "ON FILE"), or
- Some Provider agreements specifically address how payments are to be handled, in which case leave this block blank. However, it is still advisable to obtain an assignment of benefits from the patient or patient's representative if payment is to go to your office.

Note: DO NOT make any notations in Block 13 if payment is to go to the patient.

Print Specs: Line 25, Columns 56-78.
Left justify,
ALL CAPITAL LETTERS,
Print "ON FILE" if signature is kept in the patient's file.

BLOCK 14 — DATE OF CURRENT ILLNESS


14. DATE OF CURRENT:
MM DD CCYY
01 03 2003

ILLNESS (First symptom) OR
INJURY (Accident) OR
PREGNANCY (LMP)

Description: If Block 10 indicates that the condition is related to an accident or the diagnosis codes in Blocks 21 or 24E are accident diagnosis codes (800-949), the accident date must be entered into Block 14. Enter the date of onset for the primary condition being treated by showing the date MM_DD_CCYY. If the accident date is unknown, enter the first date of treatment.

- First symptom (illness), or
- Accident (trauma), or
- Last menstrual period (pregnancy), or
- Date of first Dialysis treatment, or date of kidney transplant.

Print Specs: Line 27, Columns 2, 3, 5, 6, and 8, 9, 10, 11
positions = 8 numeric and 2 spaces.
(January 1, 2003 01_01_2003)

BLOCK 15 — IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD CCYY

At this time, no major payors have announced plans to use data provided in this block. It may be left blank.

BLOCK 16 — DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
	MM	DD	CCYY		MM	DD	CCYY
FROM	01	03	2003	TO	02	22	2003

Description: If condition being treated will result in any time being lost from patient's work (school), enter the inclusive dates for that period of disability. Missing dates will be interpreted to mean no disability exists.

Print Specs: Line 27, Columns 54, 55, 57, 58, 60, 61, 62, 63, 68, 69, 71, 72, 74, 75, 76, and 77

BLOCK 17 — NAME OF REFERRING PRACTITIONER OR OTHER SOURCE
BLOCK 17A — ID NUMBER OF REFERRING PRACTITIONER

17. NAME OF REFERRING PRACTITIONER OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PRACTITIONER
OREAR WILLIAM	1234567

Description: Provide the name and if applicable, the referring Practitioner's seven-digit BlueCross BlueShield of Tennessee individual provider number. If provider number is not 7-digits, fill in with leading zeros; e.g., 0002345. The number must be valid at the time of entry. For electronic billing, the referring Practitioner ID must be a valid BlueCross BlueShield of Tennessee provider number.

Print Specs: Line 29, Columns 2-27 and 29-48.
Columns 2-27 — enter name, left justify, ALL CAPITAL LETTERS
Columns 29-48 — enter UPIN, left justify, six positions, alphanumeric.

Note: *See CMS Guidelines for NPI requirements for Medicare-covered services.*

BLOCK 18 — HOSPITALIZATION DATES

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
	MM	DD	CCYY		MM	DD	CCYY
FROM	01	03	2003	TO	01	17	2003

Description: Inclusive dates of an inpatient confinement should be shown if any of the reported services are a result of, or subsequent to, that period of hospitalization.

Print Specs: Line 29, Columns 54, 55, 57, 58, 60, 61, 62, 63, 68, 69, 71, 72, 74, 75, 76, and 77.

Note: *BlueCross BlueShield of Tennessee will return submitted claims if dates are not provided.*

BLOCK 19 — RESERVED FOR LOCAL USE/DATE LAST SEEN

19. RESERVED FOR LOCAL USE
CORRECTED BILL

Description: Use this block when submitting corrected bills. Write, stamp or type “CORRECTED BILL” in Block 19. It is important to keep the text within the boundaries of the field. Extending the type beyond the block may result in errors and delay processing of the claim.

Print Specs: Line 31, Columns 2-48 (8 positions with spaces are required by CMS)

BLOCK 20 — OUTSIDE LAB

20. OUTSIDE LAB?		$ CHARGES
☐ YES	☐ NO	

Description: This is a two-data-element block, reporting if, and how much, is being billed for laboratory work performed outside the Provider's office. Block 20 is used in conjunction with Block 32 when any laboratory work is performed outside a Practitioner's office. If a "yes" answer is provided, the purchase price of those services, and the name and address of the facility where the services were rendered (Block 32) must be completed.

Print Specs: Line 31, Columns 52, 57, and 62-69.
If column 52 is used, then a value grater than 0 is required in columns 62-69.
Print "X" in column 52 or 57, and numeric amount in columns 62-69.

BLOCK 21 — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)	
1. 005.80	3. ___.__
2. 536.80	4. ___.__
	E

Description: Diagnosis/condition of patient based on ICD-9-CM code. Enter up to 4 codes in priority order (primary condition, secondary condition, etc.) Code identifiers from Block 24E (1, 2, 3, or 4) should point back to diagnosis codes corresponding in Block 21. At least one (1) diagnosis code must be entered in Block 21. For electronic billing, all diagnosis codes should appear in the EAO Record. Diagnosis codes 1-4 are located in Fields 30-33, Positions 179-198. All diagnosis pointers go in the FAO Record. Pointers 1-4 are located in Fields 14-17, Positions 78-81.

Decimal position is indicated on the form.
Skip space in code location for decimal indication.
Zero fill from the left to correct decimal position.

Enter codes in the following sequence to indicate "priority order": upper left, lower left, upper right, and lower right.

Print Specs: Line 33, Columns 3, 4, 5, 7, 8.
Line 35, Columns 3, 4, 5, 7, 8.
Line 33, Columns 31, 32, 33, 35, 36.
Line 35, Columns 31, 32, 33, 35, 36.
Zero fill from the left, alphanumeric.

BLOCK 22 — MEDICAID RESUBMISSION

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.

At this time payers have not announced plans to use data provided in this block. It may be left blank.

BLOCK 23 — PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER
009876

Description: Enter the Professional Review Organization (PRO) prior authorization number for appropriate surgical procedures and for an assistant in cataract surgery for Medicare claims.

Prior authorization numbers can be entered in this area for plans that require them.
Note*: Enter authorization number for appropriate procedures.*

Print Specs: Line 35, Columns 50-78.
Print alphanumeric,
Left justify.

BLOCK 24

Up to 6 services (line items) may be reported on any one document. If more than 6 services (line items) need to be reported, additional forms must be completed.

Data interpretation, benefit pricing, and fee determinations will be made by payors based on nationally recognized coding structures and reporting rules. Avoid non-standard codes as they might delay or reduce your reimbursement.

BLOCK 24A — DATE(S) OF SERVICE

Must be entered in ALL 8-digit characters with NO Spaces (MMDDCCYY)

	24. A DATE(S) OF SERVICE From MMDDCCYY	To MMDDCCYY
1.	02152003	02172003
2.		
3.		
4.		
5.		
6.		

Description: Enter date (MMDDCCYY) for each procedure, service, and supply being reported. Show both the "from" and the "to" dates.

If "from" and "to" dates are shown for a series of identical services, the number of these services must be placed in Block 24G.

Print Specs: Lines 39, 41, 43, 45, 47, 49,
Columns 1 – 8 and 10 – 17 must use CMS specs.
Total of 16 positions are required; (2 X 8 continuous numeric characters).

January 1, 2003 = 01012003

BLOCK 24B — PLACE OF SERVICE

PLACE OF SERVICE CODE LISTING	
CODE	DESCRIPTION
01-02	Unassigned
03	school
04	homeless shelter
05	Indian health service; free-standing facility
06	Indian health service; provider-based facility
07	tribal 638; free-standing facility
08	tribal 638; provider-based facility
09-10	unassigned
11	office
12	home
13	assisted living facility
14	group home*
15	mobile unit
16-19	unassigned
20	urgent care facility
21	inpatient hospital (non-psychiatric)
22	outpatient hospital
23	emergency room, hospital
24	ambulatory surgical center
25	birthing center
26	military treatment facility
27-30	unassigned
31	skilled nursing facility
32	nursing facility
33	custodial care facility
34	hospice
35-40	unassigned
41	ambulance, land
42	ambulance, air or water
43-48	unassigned
49	independent clinic
50	federally qualified health center
51	inpatient, psychiatric facility
52	psychiatric facility, partial hospitalization
53	community mental health center
54	intermediate care facility, mentally retarded
55	residential substance abuse facility
56	psychiatric residential treatment center
57	non-residential substance abuse treatment facility
58-59	unassigned
60	mass immunization center
61	comprehensive inpatient rehabilitation facility
62	comprehensive outpatient rehabilitation facility
63-64	unassigned
65	end stage renal disease treatment facility
66-70	unassigned
71	public health clinic
72	rural health clinic
73-80	unassigned
81	independent laboratory
82-98	unassigned
99	other place of service

B
Place of Service
21
23

Description: Enter the code of the location where the service was performed from the above list. For laboratory tests (except for hospital inpatients), code the location for the “drawn” service rather than the actual test performance location. Valid codes are those numeric values between 00-99, which have been assigned by CMS.

Print Specs: Lines 39, 41, 43, 45, 47, 49, Columns 19 and 20. Print 2 numeric characters.

BLOCK 24C — TYPE OF SERVICE

TYPE OF SERVICE DESCRIPTION	
CODE	**DESCRIPTION**
01	Medical
02	Surgery
03	Consultation
04	Diagnostic Radiology
05	Diagnostic Laboratory
06	Radiation Therapy
07	Anesthesia
08	Assistant Surgeon
09	Other Medical
1A	Professional Radiology
1B	Professional Laboratory
1C	Second Opinion
1D	Chiropractor
1E	Donor Surgery
1F	Dental
1G	Global Radiology
1H	Global Laboratory

C
Type of Service
01
04

Description: Although most payors have not assigned this field, BlueCross BlueShield of Tennessee uses the types of service codes listed above.

Print Specs: Lines 39, 41, 43, 45, 47 and 49,
Columns 22 and 23.
Print alphanumeric.

BLOCK 24D — PROCEDURES, SERVICES, OR SUPPLIES

D	
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
CPT/HCPCS	MODIFIER
99221	
99231	

Description: Enter the CDT, CPT® or HCPCS Code that most accurately describes the service provided.

Enter applicable CPT® or HCPCS modifiers to further describe the service provided. Refer to the Specific CMS-1500 Claim Form Billing Guidelines for special guidelines for CDT, CPT® or HCPCS and modifier coding.

Modifiers: A modifier is a 2-digit combination of numeric, alpha and/or numeric that may be added to a procedure code. Modifiers may be used to indicate that:

- A service or procedure is either a professional or technical component.
- A service or procedure was performed by more than one Practitioner and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A service or procedure was provided more than once.

Print Specs: Lines 39, 41, 43, 45, 47, 49,
Columns 26-30 (procedure code) and 32 – 39 modifiers.

BLOCK 24E — DIAGNOSIS CODE

E
DIAGNOSIS CODE
1 - 2
3

Description: Enter reference numbers linking the ICD-9-CM codes listed in block to the dates of service and CPT® or HCPCS codes listed in Blocks 24A and 24D. Enter only one (1) single-digit reference number per line item; e.g., 1, 2, 3, or4. **Do not enter 01, 02, 03, or 04**. When multiple services are performed, enter the primary reference number for each service. In a situation where two (2) or more diagnoses are required for a procedure code, you must reference only one (1) of the diagnoses in Block 21.

Print Specs: Lines 39, 41, 43, 45, 47, 49,
Columns 42-47.
Minimum 3 alphanumeric characters including leading zeros.
Do not print decimal.

BLOCK 24F — CHARGES

F	
$ CHARGES	
65	00
135	00

Description: Enter charges for the services being billed. Omit dollar sign ($), decimal (.) and comma (,) in money fields. The dotted line provided on the form is to be used for the indication of the decimal and is to separate the dollars and cents. No space is needed to represent the decimal. ALWAYS print 2-position cents fields.

Print Specs: Lines 39, 42, 43, 45, 47, 49,
Columns 50-56
Columns 50-54=dollars
Columns 55-56 = cents
Always print 2 digits in cents columns.

BLOCK 24G — DAYS OR UNITS

G
DAYS OR UNITS
1
3
170

Description: Enter the number of units, days or services being billed on the appropriate line. (For anesthesia, submitted paper, enter the anesthesia time in minutes in this block. For anesthesia submitted electronically, enter the anesthesia time in accordance with electronic billing guidelines.)

Print Specs: Lines 39, 41, 43, 45, 47, 49,
Columns 59-61.
Numeric characters

BLOCK 24H — EPSDT

H
EPSDT FAMILY PLAN

Description: Enter “Y” for “Yes” and “N” for “No” to indicate that early and periodic screening, diagnosis and treatment (EPSDT) services were provided. EPSDT applies only to children who are under age 21 and receive medical benefits through public assistance.

BLOCK 24I — EMG

I
EMG
X

Description: Enter "X" if service was performed in a hospital emergency room. The indicator used should agree with the Place of Service code entered in Block 24B.

Print specs: Lines 39, 41, 43, 45, 47, 49,
Columns 65.
Print "X".

BLOCK 24J — COB

J
COB

No major payor has indicated a use for this block.

BLOCK 24K — LOCAL USE/PERFORMING PROVIDER

K
RESERVED FOR LOCAL USE
T54321

Description: Completion of this field is optional; previously, the rendering Practitioner's UPIN was entered here. BlueCross BlueShield of Tennessee will also accept the rendering Practitioner's Medicaid number in this field. Enter the Medicare assigned UPIN (Unique Provider Identification Number) of the person providing the service if different from the Practitioner/Supplier identified in Block 33. This number will be used to distinguish the different members of a group practice. For electronic billing, the rendering Practitioner's UPIN or Medicaid number is located in the FB1 Record, Field 17, Positions 202-216. Providers without Medicare UPINs, such as social workers or therapists, enter the appropriate abbreviation for the license designation held by the individual performing the service (PH.D, M.S., L.C.S.W., etc.). For interns and residents, refer to Block 17A. (Use the Medicare assigned UPIN in this block when filing claims for BlueCross BlueShield of Tennessee TennCare patients)

Print Specs: Lines 39, 41, 43, 45, 47, 49,
Columns 71-78.
Alphanumeric

BLOCK 25 — FEDERAL TAX I.D. NUMBER

25. FEDERAL TAX I.D. NUMBER	SSN	EIN
612123456	☐	☐

Description: Enter the Federal Tax I.D. Number or Social Security Number of the Provider identified in Block 33. Designate whether number listed is SSN or EIN by placing and "X" in the appropriate box.

Print Specs: Line 51, Columns 2-15 and 17 or 19.
Left justify.
Print alphanumeric in columns 2-15.
Print "X" in columns 17 or 19.

BLOCK 26 — PATIENT'S ACCOUNT NUMBER

26. PATIENT'S ACCOUNT NO
M123456

Description: Enter the patient's account number (medical record number used in your office to identify the patient's account). In most cases, payors will list that number on your remittance.

Print Specs: Line 51, Columns 23-35.
Print alphanumeric, no spaces,
Left justify.

BLOCK 27 — ACCEPT ASSIGNMENT

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
☐ YES ☐ NO

Private and Federal Programs

Description: Place an "X" in the box indicating whether you are accepting assignment.

Print Specs: Line 51, Column 38 or 43.
Print "X".

BLOCK 28 — TOTAL CHARGE

28. TOTAL CHARGE
$ 200 ¦ 00

Description: Enter the total of all charges for services listed in Block 24.
The total amount should be the sum of the individual amounts shown in Block 24F. DO NOT use dollar signs ($) or decimals (.) since both are reflected on the printed document.

Print Specs: Line 51, Columns 51-59.
Numeric characters.
Columns 51-56 = dollars
Columns 58-59=cents
Always print 2 positions in the cents field.

BLOCK 29 — AMOUNT PAID

29. AMOUNT PAID
$ ¦ 00

Description: Enter the amount that has been paid on the charges listed in Block 24.
Print Specs: Line 51, Columns 62-69.
Numeric characters.
Columns 62-66 = dollars.
Columns 68-69=cents.

BLOCK 30 — BALANCE DUE

30. BALANCE DUE
$ 200 ¦ 00

Description: Show the amount still owed on the charges listed in Block 24. This number should be the difference between the amounts in Blocks 28 and 29.

Print Specs: Line 51, Columns 72-79.
Numeric characters.
Columns 72-76 = dollars.
Columns 78-79 = cents.

BLOCK 31 — SIGNATURE OF PRACTITIONER OR SUPPLIER (OR AN AUTHORIZED REPRESENTATIVE FOR THE SUPPLIER)

31. SIGNATURE OF PRACTITIONER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

Description: The form should be signed by the Practitioner or Supplier (or an authorized representative for the supplier). (See Special CMS-1500 Billing Guidelines Section.)

Enter the current date when signing the form.

Print Specs: Unless an agreement exists between the Provider and payor, this block must be manually completed.
Line 55, Columns 1-21.

BLOCK 32 — NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
GENERAL HOSPITAL 123 EAST STREET THIS TOWN TN 37000

Description: Enter the name and address (no commas, dashes, periods, etc.) of the person or organization performing the services if performed anywhere other than the patient's home or the Practitioner's office. The Practitioner's practice address should be listed in this block if it is different from the address shown in Block 33. When billing for a purchased diagnostic test, list the name and Medicare-assigned carrier UPIN if more than one vendor was involved.

Print Specs: Lines 53-56, Columns 23-48.
Print alphanumeric,
Left justify.

BLOCK 33 — PRACTITIONER'S, SUPERVISING PRACTITIONER'S AND SUPPLIER'S BILLING NAME, ADDRESS

33. PHYSICAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	(615) 755-5600
WILLIAM S SMITH MD 124 EAST STREET THIS TOWN TN 37000	
PIN# 0123456	GRP#

Description: Enter the proper individual or billing name, address and telephone number of the business entity who provided the claimed services, to whom reimbursement is due, and to whom taxable income is assigned. (See Special CMS-1500 Billing Guidelines this section.)

Enter the correct **BlueCross BlueShield of Tennessee professional provider number** in the PIN# field. Enter the correct BlueCross BlueShield of Tennessee provider number in the group # field for a laboratory, health department, dialysis clinic, ambulance, durable medical equipment supplier, home health agency, or home infusion therapy. Provider numbers should be 7-digits, with leading zeros to satisfy seven digits if necessary; e.g., 0001234 (See Special CMS-1500 Billing Guidelines this section.)

Print Specs: Lines 53-56, Columns 50-78.
Print alphanumeric,
Left justify
Address: Lines 53-55.
Provider Number:
Individual - Line 56, Columns 52-62.
Group – Line 56, columns 52 – 62 (Only if a lab, health department, etc.)

E. Specific CMS-1500 Claim Form Billing and Reimbursement Guidelines

Final reimbursement determinations are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and medical policy.

1. Anesthesia Billing and Reimbursement Guidelines – **(Revised - Effective 7/1/2001, Regardless of the Date of Service)**

Anesthesia services provided by an anesthesiologist or CRNA can be categorized as follows:

- **Administration of anesthesia**
- **Qualifying circumstances for anesthesia such as:**
  - Anesthesia for patient of extreme age, under one year or over seventy
  - Anesthesia complicated by utilization of total body hypothermia
  - Anesthesia complicated by utilization of controlled hypotension
  - Anesthesia complicated by emergency conditions
- **Unusual forms of monitoring such as:**
  - Intra-arterial
  - Central venous
  - Swan-Ganz
  - Transesophageal echocardiography (TEE)

- **Postoperative pain management-placement of epidural**
- **Postoperative pain management-daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration**

Anesthesia services provided by an anesthesiologist or CRNA should be billed according to the following guidelines:

- Anesthesia services provided by an anesthesiologist or CRNA should be billed on a CMS-1500/ANSI 837P.
- Anesthesia services provided on different dates of service should be billed on separate claim forms.

Administration of Anesthesia

Paper Claim Form - Block 24C (Type of Service)
Electronic Media Claim - Record FA0 Field No. 8.0 (Type of Service Code)
Administration of anesthesia must be billed with Type of Service code 07 (Anesthesia).
Paper Claim Form - Block 24D (CPT®/HCPCS)
Electronic Media Claim - Record FA0 Field No. 9.0 (HCPCS Procedure Code)
Administration of anesthesia must be billed using the most appropriate CPT® code 00100-01995 or 01999 in effect for the date of service.

The anesthesia administration code includes the following:

* Pre-operative visits and/or evaluations
* Routine post-operative visits to the recovery room
* The administration of fluids and/or blood products incident to the anesthesia care
* Interpretation of non-invasive monitoring (EKG, EEG, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).

Note: *Services for the administration of anesthesia will be rejected or returned if billed using a CPT© code in the range10040-69979.*

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest Basic Value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the highest Basic Value. This applies to vaginal deliveries and Cesarean Sections followed immediately by a hysterectomy.

Billing more than one anesthesia administration code for a single anesthetic administration may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24D (First Modifier)
Electronic Media Claim - Record FA0 Field No. 10.0 (HCPCS Modifier 1)
Anesthesia services must be billed using the most appropriate anesthesia modifier. Acceptable anesthesia modifiers are as follows:

Modifier	Description
AA	Anesthesia service performed personally by anesthesiologist
AD	Medical supervision by a physician: more than 4 concurrent procedures
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
QX	CRNA service: with medical direction by a physician
QY	Anesthesiologist medically directs one CRNA
QZ	CRNA service: without medical direction by a Practitioner

Anesthesia administration services billed without an acceptable anesthesia modifier will be rejected or returned.

It is not appropriate to bill modifier 47 (Anesthesia by Surgeon) with CPT® codes 00100-01999.

Paper Claim Form - Block 24D (Second Modifier)
Electronic Media Claim - Record FA0 Field No. 11.0 (HCPCS Modifier 2)
A physical status modifier may be billed in the second modifier field. Acceptable physical status modifiers are as follows:

Modifier	Description
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

Paper Claim Form - Block 24G (Days or Units)
Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time **must** be reported in minutes. **One minute equals one number of service (unit).**

Anesthesia time **must not** be converted to units. Conversion to units will result in an incorrect payment.

Electronic Media Claim - Record FA0 Field No. 18.0 (Units of Service)
Administration of anesthesia should be billed with one unit.

Do not bill anesthesia minutes in this field.

Electronic Media Claim - Record FA0 Field No. 19.0 (Anesthesia Minutes)
Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Note: ***Anesthesia time must be reported in minutes. Anesthesia time must not be converted to units. Conversion to units will result in an incorrect payment.***

If anesthesia time exceeds 0999 minutes, it is recommended a paper claim be submitted with the supplemental information such as the anesthesia flow sheet to ensure correct reimbursement.

➢ Qualifying Circumstances

Paper Claim Form - Block 24C (Type of Service)
Electronic Media Claim - Record FA0 Field No. 8.0 (Type of Service Code)
Qualifying circumstances for anesthesia should be billed with the most appropriate Type of Service.

Note**:** ***Type of Service 07 (Anesthesia) is not appropriate for billing qualifying circumstances.*** *Qualifying circumstances billed with Type of Service 07 may result in delay in reimbursement, rejection of charge(s) or return of claim.*

Paper Claim Form - Block 24 D (CPT® /HCPCS)
Electronic Media Claim - Record FA0 Field No. 9.0 (HCPCS Procedure Code)
Qualifying circumstances for anesthesia may be billed with the following CPT® codes as applicable:

Code	Description
99100	Anesthesia for patient of extreme age, under one year and over seventy
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency condition

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

Paper Claim Form - Block 24D (First Modifier)
Electronic Media Claim - Record FA0 Field No. 10.0 (HCPCS Modifier 1)
Do not bill qualifying circumstances with an anesthesia modifier (e.g. AA, AD, QK, QX, QY, or QZ) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24D (Second Modifier)

Electronic Media Claim - Record FA0 Field No. 11.0 (HCPCS Modifier 2)
Do not bill qualifying circumstances with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

Paper Claim Form - Block 24G (Days or Units)
Electronic Media Claim - Record FA0 Field No. 18.0 (Units of Service)
Qualifying circumstances should be billed with one number of service.

Do not bill anesthesia minutes in this field.

➢ Unusual Forms of Monitoring

Paper Claim Form - Block 24C (Type of Service)
Electronic Media Claim - Record FA0 Field No. 8.0 (Type of Service Code)
Unusual forms of monitoring should be billed with the most appropriate Type of Service.

Type of Service 07 (Anesthesia) is not appropriate for billing unusual forms of monitoring.

Unusual forms of monitoring billed with Type of Service 07 may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24 D (CPT® /HCPCS)
Electronic Media Claim - Record FA0 Field No. 9.0 (HCPCS Procedure Code)
Unusual forms of monitoring may be billed using the most appropriate CPT® or HCPCS code.

Paper Claim Form - Block 24D (First Modifier)
Electronic Media Claim - Record FA0 Field No. 10.0 (HCPCS Modifier 1)
Do not bill unusual forms of monitoring with an AA, AD, QK, QX, QY, or QZ modifier as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24D (Second Modifier)
Electronic Media Claim - Record FA0 Field No. 11.0 (HCPCS Modifier 2)
Do not bill unusual forms of monitoring with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

Paper Claim Form - Block 24G (Days or Units)
Electronic Media Claim - Record FA0 Field No. 18.0 (Units of Service)
Unusual forms of monitoring should be billed using the appropriate number(s) of service.

Do not bill anesthesia minutes in this field.

➢ Postoperative Pain Management-Placement of Epidural

If operative procedure was performed or ends under general anesthesia and epidural is placed for postoperative pain management purposes, placement of the epidural may be billed as follows:

Paper Claim Form - Block 24C (Type of Service)
Electronic Media Claim - Record FA0 Field No. 8.0 (Type of Service Code)
Postoperative pain management-placement of epidural should be billed with the most appropriate Type of Service.

Type of Service 07 (Anesthesia) is not appropriate for billing postoperative pain management-placement of epidural.

Postoperative pain management-placement of epidural billed with Type of Service 07 may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24 D (CPT® /HCPCS)
Electronic Media Claim - Record FA0 Field No. 9.0 (HCPCS Procedure Code)
Postoperative pain management-placement of epidural should be billed using the most appropriate CPT® code.

For 2004 dates of service, the most appropriate CPT® code are 62318 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast for either localization or epidurography, of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solution; epidural or subarachnoid; cervical or thoracic) or 62319 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast for either localization or epidurography, of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solution; epidural or subarachnoid; lumbar sacral).

For dates of service other than 2004, refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

Paper Claim Form - Block 24D (First Modifier)
Electronic Media Claim - Record FA0 Field No. 10.0 (HCPCS Modifier 1)
Do not bill post operative pain management-placement of epidural with an AA, AD, QK, QX, QY, or QZ modifier as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24D (Second Modifier)
Electronic Media Claim - Record FA0 Field No. 11.0 (HCPCS Modifier 2)
Do not bill postoperative pain management-placement of epidural with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

Paper Claim Form - Block 24G (Days or Units)
Electronic Media Claim - Record FA0 Field No. 18.0 (Units of Service)
Postoperative pain management-placement of epidural should be billed using the appropriate number(s) of service.

Do not bill anesthesia minutes in this field.

➢ Postoperative pain management-daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration

Postoperative pain management-daily hospital management should only be billed for postoperative days. Postoperative pain management-daily hospital management should not be billed on the same day as the operative procedure.

Billing of postoperative pain management-daily hospital management billed on the same day as the operative procedure may result in delay in reimbursement, rejection of charge or return of claim.

Postoperative pain management-daily hospital management should be billed as follows:

Paper Claim Form - Block 24C (Type of Service)
Electronic Media Claim - Record FA0 Field No. 8.0 (Type of Service Code)
Postoperative pain management-daily hospital management should be billed with the most appropriate Type of Service.

Type of Service 07 (Anesthesia) is not appropriate for billing postoperative pain management-daily hospital management.

Postoperative pain management-daily hospital management billed with Type of Service 07 may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24 D (CPT® /HCPCS)
Electronic Media Claim - Record FA0 Field No. 9.0 (HCPCS Procedure Code)
Postoperative pain management-daily hospital management should be billed using the most appropriate CPT® code.

For 2004 dates of service, the most appropriate CPT® code is 01996 (Daily hospital management of continuous epidural or continuous subarachoid drug administration).

For dates of service other than 2004, refer to the CPT® book in effect for the date of service for the most appropriate code.

Paper Claim Form - Block 24D (First Modifier)
Electronic Media Claim - Record FA0 Field No. 10.0 (HCPCS Modifier 1)
Do not bill postoperative pain management-daily hospital management with an AA, AD, QK, QX, QY, or QZ modifier as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24D (Second Modifier)
Electronic Media Claim - Record FA0 Field No. 11.0 (HCPCS Modifier 2)
Do not bill postoperative pain management-daily hospital management with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

Paper Claim Form - Block 24G (Days or Units)
Electronic Media Claim - Record FA0 Field No. 18.0 (Units of Service)
Postoperative pain management-daily hospital management should be billed using one number of service for each day of post operative pain management.

Do not bill anesthesia minutes in this field.

Anesthesia Reimbursement Guidelines (Effective July 1, 2001)

Reimbursement for eligible anesthesia services provided by an anesthesiologist or CRNA are categorized as follows:

➢ Administration of anesthesia

- **Qualifying circumstances for anesthesia such as:**
  - Anesthesia for patient of extreme age, under one year or over seventy
  - Anesthesia complicated by utilization of total body hypothermia
  - Anesthesia complicated by utilization of controlled hypotension
  - Anesthesia complicated by emergency conditions
- **Unusual forms of monitoring such as:**
  - Intra-arterial
  - Central venous
  - Swan-Ganz
  - Transesophageal echocardiography (TEE)
- **Postoperative pain management-placement of epidural**
- **Postoperative pain management-daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration**

➢ Administration of Anesthesia

Maximum allowables for administration of anesthesia performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) are based on the lesser of covered charges or the following formula:

Maximum Allowable = (Basic Value + Time Unit + Physical Status Unit Value) x
Conversion Factor x Percentage

Basic Values
Basic Values are based on the American Society of Anesthesiologist (ASA) Relative Value Guide in effect for the date of service.

Updates to the Basic Values will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

Updates to the Basic Values may result in increases and decreases in maximum allowable.

Time
Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision. In cases where there is a break in anesthesia (e.g. due to technique used, delay of surgeon, relief, multiple start and stop times, etc.), time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time in minutes will be converted to time units by BlueCross BlueShield of Tennessee as indicated below:

- Fractional time units will be rounded up to the next whole unit (i.e. 1.1 units will be rounded to 2 units, 1.4 units will be rounded to 2 units, 1.5 units will be rounded to 2 units, 1.6 units will be rounded to 2 units, 1.9 units will be rounded to 2 units) **Anesthesia time does not apply to CPT® codes 01995 and 01996.**

Physical Status Unit Values
Additional base units for physical status will be allowed as follows:

Modifier	Description	Unit Value
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Time Units, Conversion Factors and Percentages
Conversion Factors and Percentages are as follows:

Modifier	Description	Time Unit	Conversion Factor	Percentage
AA	Anesthesia service performed personally by anesthesiologist	15	Refer to contract	100%
AD	Medical supervision by a physician: more than 4 concurrent procedures	15		100%
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals	15		50%
QX	CRNA service: with medical direction by a physician	15		50%
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	15		50%
QZ	CRNA service: without medical direction by a physician	15		100%

Medical Supervision of Anesthesia Services
Reimbursement for medical supervision of anesthesia services, e.g. anesthesia modifier AD, will be limited to three (3) Basic Values, one (1) unit of time, and 100% of the conversion factor for the anesthesiologist.

➢ Qualifying Circumstances for Anesthesia

Maximum allowable for qualifying circumstances for anesthesia performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) are based on the lesser of covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

The following are the Unit Values for qualifying circumstances for anesthesia:

Code	Description	Unit Value	Conversion Factor
99100	Anesthesia for patient of extreme age, under one year and over seventy	1	Refer to contract
99116	Anesthesia complicated by utilization of total body hypothermia	5	
99135	Anesthesia complicated by utilization of controlled hypotension	5	
99140	Anesthesia complicated by emergency condition	2	

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

➢ Unusual Forms of Monitoring

Maximum allowable for unusual forms of monitoring such as intra-arterial, central venous, Swan-Ganz, and transesophageal echocardiography (TEE) provided in conjunction with anesthesia administration will be based on the lesser of covered charges or the Professional Maximum Allowable Fee Schedule.

➢ Postoperative Pain Management-Placement of Epidural

Maximum allowable for placement of epidural for postoperative pain management services performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) are based on the lesser of covered charges or the Professional Maximum Allowable Fee Schedule.

➢ Postoperative Pain Management-Daily Hospital Management of Epidural (Continuous) or Subarachnoid (Continuous) Drug Administration

The maximum allowable for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) is based on the lesser of covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

The following is the Unit Value for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration:

Code	Description	Unit Value	Conversion Factor
01996	Daily Management of epidural or subarachnoid drug administration	3	Refer to contract

Reimbursement is limited to no more than three postoperative days of daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration.

2. Assistant-at-Surgery – (last modified 1/1/06)

BlueCross BlueShield of Tennessee adopted the Centers for Medicare and Medicaid Services (CMS) as the primary source for medical appropriateness for assistant-at-surgery services for Blue Networks C, P, S, and K.

CMS denotes whether a procedure is eligible for assistant-at-surgery services by assigning an indicator to each procedure code. These indicators are noted in the Reimbursement Rule Indicators and RBRVS Relative Value Units (RVUs) chart available on the company Web site at http://www.bcbst.com/providers/docs/ReimbursementRuleRBRVS_RVU.pdf. BlueCross BlueShield of Tennessee will update this document quarterly in accordance with its policy on Quarterly Reimbursement Changes.

A companion document describing the values on the Reimbursement Rule Indicators and RBRVS Relative Value Units (RVUs) document can be referenced on the company Web site at http://www.bcbst.com/providers/docs/ReimbursementRuleRBRVS_RVU_CompanionDocument.pdf.

The following guidelines apply:

Assistant-at-Surgery Services Provided by a Physician

Assistant-at-surgery services provided by a Physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon) or 82 (Assistant Surgeon when qualified resident surgeon not available) to the procedure code.

The 80, 81 or 82 modifier should **not** be used to report assistant-at-surgery services provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist

BlueCross BlueShield of Tennessee will reimburse eligible assistant-at-surgery services provided by a Physician based on the lesser of covered charges or 16% of the maximum allowable fee schedule amount for all BlueCross BlueShield of Tennessee networks.

Assistant-at-Surgery Services Provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist

Assistant-at-surgery services provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist should be reported by appending the Level II HCPCS modifier AS (Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant-at-surgery).

Assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist is considered ancillary support. Reimbursement for assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist is included in the reimbursement to the licensed Practitioner for services provided in the Physician's office or in the reimbursement to the facility for services provided in an inpatient or outpatient setting. The maximum allowable for assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist will be $0.00. Participating and non-participating Providers will not be permitted to bill the Member for the difference between the charge and the BlueCross BlueShield of Tennessee maximum allowable for the AS modifier as the Nurse Practitioner or Clinical Nurse Specialist should be compensated directly by the supervising Physician or facility.

Eligible assistant-at-surgery services provided by a Physician Assistant credentialed as an assistant-at-surgery will be based on the lesser of charges or 13.6% (i.e. 85% of 16%) of the maximum allowable fee schedule amount.

Note: Physician Assistants must bill assistant-at-surgery services using the unique provider number assigned for this purpose. Some Physician Assistants may be contracted for both assistant-at-surgery and for other practitioner services. In these cases, the Physician Assistant will be issued two provider numbers – one (1) for assistant-at-surgery services and one (1) for other practitioner services. Claims should be filed using the appropriate provider number for the service provided. ***Assistant-at-surgery charges will only be reimbursed if filed with the appropriate assistant-at-surgery provider number.***

3. OB/GYN Services

Bill in accordance with CPT® and American College of Obstetricians and Gynecologists (ACOG) coding guidelines in effect for Date of Service. Providers can write to the ACOG at 409 12th Street, SW, Washington, D.C., 20024-2188 to obtain a copy of ACOG's CPT® *Coding in Obstetrics & Gynecology* guidebook.

4. Global, Professional and Technical Components for Radiology, Laboratory and Other Diagnostic Procedures – (last modified 9/1/05)

Per the BlueCross BlueShield of Tennessee Reimbursement Policy for Professional and Technical Components for Radiology, Laboratory, and Other Diagnostic Procedures, reimbursement will be limited to procedures where a 26-professional component or TC-technical component modifier is appropriate per the Medicare Physician Fee Schedule Data Base, Federal Register or National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals in effect for the date of service. These documents can be located at www.cms.gov.

Reimbursement will be based on the lesser of covered charges or the maximum allowable fee schedule allowance for the procedure.

Note: If the Provider performs:

- **only** the technical component for a radiology, laboratory, or other diagnostic procedure, the provider should append modifier TC to the CPT® or HCPCS code if the code is eligible to be billed with modifier TC per the BlueCross BlueShield of Tennessee's Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures.

- **only** the professional component for a radiology, laboratory, or other diagnostic procedure, the provider should append modifier 26 to the CPT® or HCPCS code if the code is eligible to be billed with modifier 26 per the BlueCross BlueShield of Tennessee's Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures.

- **both** the technical and professional components for radiology, laboratory, or other diagnostic procedures, it is appropriate to bill the service as a global procedure (i.e. without a 26 or TC modifier appended to the CPT® or HCPCS code).

5. Billing Guidelines and Reimbursement Policy for Radiopharmaceuticals and High Dose Contrast Material – (last modified 9/1/05)

Effective date of service Jan. 1,2005, BlueCross BlueShield of Tennessee has established maximum allowables for the following codes based on the Reimbursement Guidelines for Radiopharmaceuticals and Contrast Materials:

A4642, A4644, A4645, A4646, A9500, A9502, A9503, A9504, A9505, A9507, A9508, A9510, A9511, A9512, A9513, A9515, A9516, A9522, A9523, A9600, A9605, Q3002, Q3003, Q3004, Q3005, Q3007, Q3008, Q3009, Q3010, Q3011, Q3012, and Q9945-Q9951.

The maximum allowable for eligible radiopharmceuticals and contrast materials is based on a percentage of Average Wholesale Price (AWP) as defined and published by Medicare Part B (Tennessee).

BlueCross BlueShield of Tennessee shall update maximum allowables for radiopharmceuticals and contrast materials published by Medicare Part B (Tennessee) in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

Maximum allowables for radiopharmaceuticals and contrast materials not published by Medicare Part B (Tennessee) will be calculated based on a percentage of AWP according to one of the following methods:

Method 1

A. The AWP based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed.

Or

Method 2

A. For a single-source radiopharmaceutical or contrast material, the AWP equals the AWP of the single product.

B. For a multi-source radiopharmaceutical or contrast material, the AWP is equal to the lesser of the median AWP of all of the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product AWP.

BlueCross BlueShield of Tennessee reserves the right to select the method used to calculate AWP and the source for AWP for radiopharmaceuticals and contrast materials not published by Medicare Part B (Tennessee). Examples of sources for AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

For codes where it is not feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g. when the radiopharmaceutical or contrast material does not have a NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. In order to determine a reasonable allowable, BlueCross BlueShield of Tennessee reserves the right to request one of the following:

- The name of the radiopharmaceutical or contrast material, NDC, dosage, and quantity

Or

- The manufacturer/supplier's invoice. When a manufacturer/supplier's invoice is requested, the name of the patient, name of the specific diagnostic radiopharmaceutical or contrast material, dosage, and number of units must be provided. If multiple patients are listed on the manufacturer/supplier's invoice, the diagnostic radiopharmaceutical imaging agent or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

Radiopharmaceuticals and contrast materials provided in a facility setting are not billable to or reimbursable by BlueCross BlueShield of Tennessee on a CMS-1500/ANSI-837P. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility.

"XI" Modifier for Radiopharmaceuticals and Contrast Materials
As the result of the reimbursement changes for radiopharmaceuticals and contrast materials, the "XI" modifier will be officially deactivated effective date of service 1/1/2005.

Refer to Exhibit A for network percentages of AWP.

Exhibit A

Percentage of Average Wholesale Price (AWP) by Network

Network	Percentage of AWP
C	100%
K	100%
P	100%
BlueCross BlueShield of Tennessee Medicare-Based Fee Schedule	95%

6. Specialty Pharmacy Medications

Claim Form
Specialty pharmacy medications covered under the Member's medical plan must be billed on a CMS-1500/ANSI-837P. Self-administered specialty pharmacy medications must be billed through the Member's pharmacy benefits manager.

Block 24b - Place of Service
The place of service (POS) should represent where the service is provided.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each medication provided.

Block 24d - Codes and Modifiers
Medications must be billed using the most appropriate HCPCS code in effect for the date of service.

In the event there is not a specific HCPCS code for the medication, the most appropriate unlisted code (e.g., J3490, J7599, J9999) in effect for the date of service may be used.

Unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes must be billed with the name of the drug, National Drug Code (NDC), dosage per the Practitioner's order and quantity.

Block 24g – Days or Units

To report units for medications, the units must be billed in accordance with the HCPCS definition in effect for the date of service and the Practitioner's order.

General Billing Guidelines

- BlueCross BlueShield of Tennessee reserves the right to request the name of the drug, National Drug Code (NDC), dosage per the Practitioner's order and quantity.
- Updates to the maximum allowables for existing codes will be made in accordance with the BlueCross BlueShield of Tennessee Reimbursement Policy for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.
- Due to frequent changes in AWP, BlueCross BlueShield of Tennessee reserves the right to update the maximum allowable amount without prior notification.
- Updates to the maximum allowables may result in increases and decreases in fees.
- Reimbursement for medications is limited to that amount actually prescribed and administered to the Member.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage for the Member with the least amount of medication wastage.
- Refer to Section XIX. Pharmacy in this Manual for self-administered specialty pharmacy medications as defined by BlueCross BlueShield of Tennessee covered under the Member's medical benefits plan.

7. Home Infusion Therapy- **Blue Network K (eff. 7/1/02)** **Blue Networks C, S, and P (eff. 2/1/03)**

Infusion therapy provided in a Member's private residence must be billed as follows:

Claim Form
Home infusion therapy must be billed on a CMS-1500/ANSI-837P.
Block 24b - Place of Service
The place of service (POS) should represent where the service is provided.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each per diem or medication provided.

To facilitate claims administration, a separate line item must be billed for each date of service.

Block 24d - Codes and Modifiers
Home infusion therapy per diems must be billed using the following HCPCS codes:

Code	Type of Service	Description
S5498	Catheter Care Maintenance - single lumen	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing services coded separately), per diem
S5501	Catheter Care Maintenance - more than one lumen	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing services coded separately), per diem
S5502	Catheter Care Maintenance - interim (implanted access device)	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing services coded separately), per diem
S9326	Pain Management Continuous Infusion	Home infusion therapy, continuous pain management infusion; administrative services, professional pharmacy services, care coordination all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9327	Pain Management Intermittent Infusion	Home infusion therapy, intermittent pain management infusion; administrative services, professional pharmacy services, care coordination all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9328	Pain Management Implanted Pump Infusion	Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9330	Chemotherapy Continuous Infusion	Home infusion therapy, continuous chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9331	Chemotherapy Intermittent Infusion	Home infusion therapy, intermittent chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9347	Epoprostenol Infusion Therapy	Home infusion therapy, uninterrupted, long-term, controlled rate intravenous therapy (e.g. Epoprostenol); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9349	Tocolytic Infusion Therapy	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Block 24d - Codes and Modifiers (Cont'd)

Home infusion therapy per diems must be billed using the following HCPCS codes:

Code	Type of Service	Description
S9374	Hydration Therapy 1 liter	Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9375	Hydration Therapy 2 liter	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9376	Hydration Therapy 3 liter	Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9379	TPN/Lipids	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9500	Anti-Infective Therapies Q 24 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9501	Anti-Infective Therapies Q 12 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9502	Anti-Infective Therapies Q 8 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9503	Anti-Infective Therapies Q 6 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9504	Anti-Infective Therapies Q 4 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9379	Miscellaneous Infusion Therapy	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

When multiple therapies are provided concurrently on the same date:

- the primary therapy must be billed using the applicable HCPCS code for the per diem without a modifier;
- the secondary therapy must be billed using the applicable HCPCS code for the per diem with the "SH" modifier in the modifier 1 field to indicate the second concurrently administered infusion therapy; and
- The third or concurrent therapy must be billed using the applicable HCPCS code for the per diem with the "SJ" modifier in the modifier 1 field to indicate the third or more concurrently administered infusion therapy.

Medications, total parenteral nutrition solutions, and hydration solutions must be billed using the most appropriate HCPCS code in effect for the date of service.

In the event there is not a specific HCPCS code for the medication, total parenteral nutrition solutions, or hydration solutions the most appropriate unlisted code (e.g. J3490, J7599, J9999) in effect for the date of service may be used.

Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

Medications, total parenteral nutrition solutions, and hydration solutions billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the drug, National Drug Code (NDC), dosage per the Practitioner's order, and quantity.

Block 24g - Days or Units

To report units for per diems, one unit must be billed for each day.

To report units for medications, total parenteral nutrition solutions, and hydration solutions, the units must be billed in accordance with the HCPCS code definition in effect for the date of service and the physician's order.

General Billing Guidelines

- Infusion therapy provided in a location other than a Member's private residence is **not** billable or reimbursable as home infusion therapy.
- The maximum allowable for the home infusion therapy per diems constitutes full reimbursement for:
  - Pharmacy professional and cognitive services
  - Overhead and operational services
  - Infusion therapy related supplies
  - Comprehensive 24-hours-per-day, 7-days-per-week delivery and pick-up services
  - Clinical coordination
  - Inventories and accounts receivable
  - Costs associated with substantial insurance requirements
  - Costs associated with accreditation requirements
  - Costs associated with administrative requirements
- The per diem will only be billable on days when medications (drugs), total parenteral nutrition solutions, or hydration solutions are actually administered.
- The per diem and related medications must be billed on the same claim form.
- Multiple therapies are defined as more than one type of service (i.e. antibiotics and TPN, or continuous chemotherapy infusion and hydration) provided concurrently on the same date. The individual therapy types include total parenteral nutrition, chemotherapy, hydration, anti-infective, pain management, epoprostenol, tocolytic, catheter care and miscellaneous.
- Catheter care - The per diem for catheter care should only be used when the catheter care services are provided as a stand-alone therapy and should not be billed on days when the services are covered under per diem of another therapy.
- Multiple drugs administered in a single class of service (i.e. three antibiotics) will be reimbursed as a single per diem based on the highest administration frequency plus all applicable pharmacy charges.
- Hydration therapy involves the infusion of intravenous solutions in 1-liter increments. Intravenous solutions used for dilution or vehicles for the administration of other drug therapies do not constitute hydration therapy and will not be reimbursed as a per diem.
- Hydration per diem applies only when intravenous fluids are administered independently and solely for hydration of the patient. Administration of hydration in conjunction with other intravenous fluids will be reimbursed based on pharmacy amount only.

- Field-based nursing services, PICC and Midline insertion procedures and associated supplies are considered home health agency/private duty nursing services and are not billable by the home infusion therapy Provider.
- Surgically implanted central vascular access devices are considered facility and/or professional services and not billable by the home infusion therapy Provider.

Codes Without A Published Fee on the Maximum Allowable Detail Report

- BlueCross BlueShield of Tennessee reserves the right to request the name of the drug, National Drug Code (NDC), dosage per the Practitioner's order, and quantity.

8. Durable Medical Equipment (DME)

Claim Form
Durable medical equipment must be billed on a CMS-1500/ANSI-837P.
Block 24b - Place of Service
The place of service (POS) should represent where the item is being used, not where it is dispensed.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each procedure, service or supply.

The following items require the use of span dates (i.e. a span of time between the from and to dates of service). Failure to use span dates will result in incorrect payment for the following items:

- Supply kits
- Continuous passive motion device (HCPCS code E0935)
- Enteral Formulae
- Food Thickener (HCPCS code B4100)
- Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the CMS-1500/ ANSI-837P for each partial month of billing. In this case, the HCPCS code should be billed with the RR modifier in the first modifier field and the KR modifier in the second modifier field.

DO NOT SPAN DATES FOR ITEMS OTHER THAN THOSE LISTED.

Block 24d - Codes and Modifiers
Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service.

The following are the most common HCPCS modifiers that may be reported with HCPCS durable medical equipment codes:

Modifier	Description
KR	Rental item, billing for partial month
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
NU	New equipment
RP	Replacement and repair - RP may be used to indicate replacement of DME, orthotic and prosthetic devices which have been in use for sometime. The claim shows the code for the part, followed by the 'RP modifier and the charge for the part.
RR	Rental (use the 'RR' modifier when DME is to be rented)
UE	Used durable medical equipment
BO	Orally administered nutrition, not by feeding tube

Codes and modifiers must be billed in accordance with the following:

- Medicare Region C Durable Medical Equipment Regional Carrier (DMERC) guidelines which include, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DMERC Medicare Advisories
  - Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Product Classification Lists
  - Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Bulletins

These documents may be located on the Palmetto Government Benefits Administrators Web site at www.pgba.com.

Block 24g - Days or Units

For monthly rentals (excluding code E0935), one unit should be billed for each month the item is rented as the maximum allowable for the rental is for a whole month.

For partial month rentals (excluding code E0935), one unit should be billed for each month the item is rented. BlueCross BlueShield of Tennessee reserves the right to prorate the maximum allowable to reflect the partial month rental.

For rentals for code E0935, one unit should be billed for each day the item is rented as the maximum allowable is for one day.

General Billing Guidelines

- The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item. These services including mileage are not separately billable.

- Warranties-Supplier must honor all product warranties, express and implied, under applicable state law. Maintenance and/or service charges for durable medical equipment covered under a manufacturer or supplier's warranty are not billable unless such charges are excluded from the warranty.

- DME Repairs, Adjustments, and Replacements-If the item is rented, the repair, adjustment or replacement of the equipment and its components are included in the maximum allowable for the rental for the equipment and are not separately billable.

  Reimbursement for reasonable and necessary parts and labor to member owned equipment which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code with the appropriate new or used purchase modifier in the modifier 1 field and "RP" modifier in the modifier 2 field. Labor should be billed using the most appropriate HCPCS code (e.g. E1340) with the "RP" modifier in the modifier 1 field.

  Repairs to Member owned durable medical equipment are billable when necessary to make the item functional. If the expense for repairs exceeds the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess.

  Billable parts and labor must be billed on the same claim form.

- Mileage is not separately reimbursed or billable.

- Routine maintenance of equipment owned by Member-Reimbursement for routine maintenance and servicing for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty, is only allowed after equipment is considered owned by the Member for 6 months. Reimbursement for routine maintenance and servicing for reasonable and necessary parts and labor will be based on the maximum allowable for one month's rental for the durable medical equipment. Routine maintenance and servicing for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty, must be billed using the most appropriate code for the equipment with a "MS" modifier.

- Supplies and accessories related to **RENTED** DME must be billed in accordance with DMERC guidelines and billed on the same claim form as the rented DME.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g. E1399) should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

  Durable medical equipment billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided. *Effective July 1, 2002, BlueCross BlueShield of Tennessee no longer requires a manufacturer's/supplier's invoice when billing for compression stockings. Compression stockings (L8100-L8230 and A4490-A4510) are reimbursed on established maximum allowable reimbursement rates.*

- Codes without a published Medicare fee - *BlueCross BlueShield of Tennessee reserves the right to request the name of the manufacturer, product name, product number, and quantity provided.*

- Leased DME should be billed in accordance with guidelines for rented DME. Reimbursement for leased DME will be based on the reimbursement provisions for rented DME.

Reimbursement Guidelines for Durable Medical Equipment (DME) Purchase and Rentals

This policy applies to durable medical equipment purchases and rentals billed on a CMS-1500/ANSI-837P for:

Network	Dates of Service, and after:
➢ Blue Network K	71/2002
➢ Blue Networks C, P, S	2/1/2003

The maximum allowable for durable medical equipment classified as Capped Rental, Inexpensive/Routinely Purchased, TENS, and enteral nutrition infusion pumps (i.e. purchases and rentals) will be the lesser of covered charges or the contracted network percentage of the Medicare Region C DMEPOS Fee Schedule for Tennessee.

Durable medical equipment will be considered purchased after the equipment has been rented for a period of 10 months.

The published Medicare fees for durable medical equipment classified as Capped Rentals are based on a 15-month rental period where the Medicare allowable for the first 3 months is at 100% and the Medicare allowable for the remaining 12 months is at 75%. Since BlueCross BlueShield of Tennessee considers durable medical equipment purchased after the equipment has been rented for a period of 10 months, the published Medicare fees for durable medical equipment classified as Capped Rentals will be adjusted as follows:

Published Medicare Fee for Capped Rental x 3 months x 100%
\+ Published Medicare Fee for Capped Rental x 12 months x 75%
= Medicare Purchase Fee

BlueCross BlueShield of Tennessee Purchase Allowable = Medicare Purchase Fee x Contracted Network %

BlueCross BlueShield of Tennessee Rental Allowable = BlueCross BlueShield of Tennessee Purchase Allowable/10 months

If the member changes to different but similar equipment (e.g. from a non-heated humidifier to a heated humidifier) when the equipment is medically needed (i.e. the member's medical needs have

substantially changed and the new equipment is necessary), a new 10-month rental period begins with the new equipment. Otherwise, BlueCross BlueShield of Tennessee will reimburse the least expensive piece of equipment (continuing to count against the current 10-month period). If the 10-month rental period has already expired, then no additional rental payments can be made.

Reimbursement for supplies used in conjunction with durable medical equipment rentals will be determined by the Medicare Region C Durable Medical Equipment Regional Carrier (DMERC) guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.

Reimbursement for routine maintenance and servicing for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty is only allowed after equipment is considered owned by the Member for 6 months. Reimbursement for routine maintenance and servicing for reasonable and necessary parts and labor will be based on the maximum allowable for one month's rental for the durable medical equipment.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item.

All maximum allowables for rentals are monthly rates unless specified otherwise on the Maximum Allowable Detail Report.

BlueCross BlueShield of Tennessee reserves the right to pro-rate the maximum allowable for partial month rentals.

Providers are contractually obligated to provide services at the agreed upon rates, regardless of patient acuity or nursing skill level.

Aerosol Therapy

- Equipment used in conjunction with aerosol therapy must be billed by a durable medical equipment Provider.
- Supplies used in conjunction with aerosol therapy must be billed by a durable medical equipment Provider or medical supplier.
- Inhalation medication used in conjunction with aerosol therapy must be billed through Member's pharmacy program.

Enteral Therapy

- Equipment used with enteral therapy must be billed by a durable medical equipment provider.
- Supply kits, pumps and formulae used with enteral therapy must be billed by a durable medical equipment provider or medical supplier. These items must be billed with the most appropriate HCPCS code and modifier, if applicable. DME used for enteral feedings should be billed as follows:
    - **Supply Kits** – The appropriate “B” HCPCS code should be billed with span dates using one unit for each day a kit is used. These are disposable supply items and no modifier is required to indicate a purchase. A span date indicates the time period services were provided; i.e., 01012004 to 01152004. Because of the use of span dates, a separate line item is not required for each day.

- **Pump** (if used) – Pumps are considered as monthly rentals. The "from" and "to" dates on the claim should indicate the month, day and year for the rental; i.e., 01012004 to 01012004. One unit should be used for each month the pump is rented.

- **Formulae** – Span dates should be used to indicate the period formulae was provided. Per 2004 HCPCS coding guidelines, formulae is billed with one unit for 100 calories. If formulae has not been assigned a specific HCPCS code by Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC), bill formulae using B9998 with one unit for each 100 calories. BlueCross BlueShield of Tennessee requires the complete brand name and NDC for formulae billed with this miscellaneous code to determine appropriate reimbursement. SADMERC coding bulletins can be accessed on the Palmetto Government Benefits Administration Web site.

- **Food Thickener** - Span dates should be used to indicate the period thickener was provided. Per 2004 HCPCS coding guidelines, food thickener is billed with one unit for each ounce of product. All brands of commercially manufactured food thickener, used as an additive, should be billed with the specific HCPCS code assigned by Healthcare Common Procedure Coding System or Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). Bill pre-thickened foods, juices and other liquids using B9998 with one unit for each bottle, box, or container. BlueCross BlueShield of Tennessee requires the complete brand name, volume of container supplied, manufacturer's name, and product number for pre-thickened foods billed with this miscellaneous code to determine appropriate reimbursement.

Note: Claims for orally administered nutrition must include the appropriate HCPCS code and BO modifier or they will be considered an enteral tube feeding.

9. Prosthetics and Orthotics

Blue Network K (eff. 7/1/02)
Blue Networks C, S, and P (eff. 2/1/03)

Claim Form
Prosthetics and orthotics must be billed on a CMS-1500/ANSI-837P.

Block 24b - Place of Service
The place of service (POS) should represent where the item is being used, not where it is dispensed.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each procedure, service or supply.

Block 24d - Codes and Modifiers
Prosthetics and orthotics must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service.

Codes and modifiers must be billed in accordance with the following:

- Medicare Region C Durable Medical Equipment Regional Carrier (DMERC) guidelines which includes, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DMERC Medicare Advisories
  - Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Product Classification Lists
  - Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Bulletins

These documents may be located on the Palmetto Government Benefits Administrators Web site at www.pgba.com.

General Billing Guidelines

- Warranties-Supplier must honor all product warranties, express and implied, under applicable state law. Maintenance and/or service charges for prosthetics and orthotics covered under a manufacturer or supplier's warranty are not billable unless such charges are excluded from the warranty.

- Mileage is not separately reimbursed or billable.
- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g. L0999, L1499, L2999, L3649, L3999, L5999, L7499, L8039, L8239, L8499, L8699, L9900) should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

  Prosthetics or orthotics billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.

- Codes without a published Medicare fee - BlueCross BlueShield of Tennessee reserves the right to request the name of the manufacturer, product name, product number, and quantity provided.

Prosthetics

- Repairs, Adjustments, and Replacements
  - An adjustment is any modification to the prosthesis due to change in the patient's condition or to improve the function of the prosthesis.
  - A repair is a restoration of the prosthesis to correct problems to due to wear or damage.
  - A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

- The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable:

  - Evaluation of the residual limb and gait
  - Fitting of the prosthesis
  - Cost of base component parts and labor contained in HCPCS base codes
  - Repairs due to normal wear or tear within 90 days of delivery
  - Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities

- Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis is not separately billable.

- Repairs to a prosthesis are billable when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payment can be made for the amount of the excess. Maintenance, which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist, is billable as a repair.

- Reimbursement for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code and the "RP" modifier in the modifier 1 field. Labor should be billed using the most appropriate HCPCS code (e.g. L7500, L7520) with the "RP" modifier in the modifier 1 field.

  Billable parts and labor must be billed on the same claim form.

Orthotics

- Evaluation of the patient, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis and are not separately billable. There is no separate payment for these services.

- Repairs to an orthotic due to wear or to accidental damage are billable when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for the repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the amount in excess.

- Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the Member's condition, irreparable wear, or irreparable accidental damage is billable if the device is still Medically Necessary. The reason for the replacement must be documented in the supplier's record.
- The allowance for the labor involved in replacing an orthotic component that is coded with a specific L code is included in the allowance for that component and is not separately billable.

- The allowance for the labor involved in replacing an orthotic component that is coded with the miscellaneous code L4210 is separately billable in addition to the allowance for that component. Billable orthotic components and labor must be billed on the same claim form.

10. Reimbursement Guidelines for Immune Globulins, Vaccines and Toxoids (last modified 4/27/05)

BlueCross BlueShield of Tennessee shall reimburse providers for eligible immune globulins, vaccines and toxoids based on a percentage of Average Wholesale Price (AWP) according to one of the following methods:

A. The AWP based on the National Drug Code (NDC) for the specific drug billed.

Or

A. For a single-source drug, the AWP equals the AWP of the single product.

B. For a multi-source drug, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or the lowest brand name product AWP.

BlueCross BlueShield of Tennessee reserves the right to select the method used to calculate AWP and the source for AWP for immune globulins, vaccines and toxoids.

To determine eligibility and reimbursement for a immune globulin, vaccine or toxoid, BlueCross BlueShield of Tennessee reserves the right to request the name of the drug, National Drug Code (NDC), dosage and number of units for items billed with an unlisted, miscellaneous, not otherwise classified CPT® or HCPCS code.

The percentage of AWP that will be reimbursed for immune globulins, vaccines and toxoids will be 100% with the exception of Provider agreements under the BlueCross BlueShield of Tennessee Medicare Based Professional Maximum Allowable Fee Schedule. For Provider agreements under the BlueCross BlueShield of Tennessee Medicare Based Professional Maximum Allowable Fee Schedule, the percentage of AWP will be reimbursed at 95%.

11. Reimbursement Guidelines for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs – (last modified 7/1/04)

The maximum allowable for eligible infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs for professional and home infusion therapy providers is based on a percentage of Average Wholesale Price (AWP) and one of the following sources:

Source A
AWP as defined and published by Medicare Part B – Tennessee and Medicare Region C DMERC.

BlueCross BlueShield of Tennessee shall update maximum allowables for infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs published by Medicare Part B – Tennessee and Medicare Region C DMERC in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

Maximum allowables for infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B – Tennessee or Medicare Region C DMERC will be calculated based on a percentage of AWP according to one of the following methods:

Method 1

A. The AWP based on the National Drug Code (NDC) for the specific drug billed.

Method 2

A. For a single-source drug, the AWP equals the AWP of the single product.

C. For a multi-source drug, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or the lowest brand name product AWP.

In the event Medicare Part B – Tennessee and Medicare Region C DMERC publishes a fee for a code and the fees are not consistent between these two sources, BlueCross BlueShield of Tennessee reserves the right to select a source for AWP and the method used to calculate AWP.

BlueCross BlueShield of Tennessee reserves the right to select the method used to calculate AWP and the source for AWP for infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B – Tennessee or Medicare Region C DMERC. Examples of sources for AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the drug manufacturer.

To determine eligibility and reimbursement for an injectable drug, BlueCross BlueShield of Tennessee reserves the right to request the name of the drug, National Drug Code (NDC), dosage and number of units for items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code or for HCPCS codes not published by Medicare Part B – Tennessee or Medicare Region C DMERC.

Source B

The AWP based on the National Drug Code (NDC) for the specific drug billed per First Data/Medispan.

This source is reserved for networks that do not use HCPCS codes for infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs provided by home infusion Providers.

This policy applies to HCPCS Level II codes for all infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs billed on a CMS-1500/ANSI-837P.

To determine the percentage that will be allowed for infusion therapy, immunosuppressive, nebulizer, chemotherapy and other injectable drugs, refer to your network Provider Agreement or contact your Provider Relations Representative.

12. Reimbursement Guidelines for Non-Injectable Medications when the Location of Service is the Practitioner's Office **(last modified 4/27/05)**

Reimbursement by BlueCross BlueShield of Tennessee for prescription medications other than injectables when the location of service is the Practitioner's office will not be allowed. Exceptions to this policy include, but are not limited to the prescription drugs addressed under Reimbursement Policy for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

The maximum allowable fee schedule amount for non-injectable medications when the location of service is the Practitioner's office is $0.00 unless otherwise specified in the Member's medical benefit plan.

This policy applies to services billed on a CMS-1500/ANSI-837P.

13. Reimbursement Guidelines for Self-Administered Prescription Medications Dispensed and Submitted by a Licensed Pharmacist (last modified 4/27/05)

Whenever a Licensed Pharmacist submits a claim for reimbursement for self-administered medications to BlueCross BlueShield of Tennessee, the claim must either be submitted electronically or on a paper claim form through the appropriate Pharmacy Network. This will ensure that possible duplication of payment can be avoided, that only costs for those prescription medications that are included on the appropriate contract formularies are reimbursed, that those medications that require prior authorization are appropriately reviewed, and that all pertinent pharmacy discounts and copays apply. If a pharmacy claim is submitted paper to BlueCross BlueShield of Tennessee, that claim will be routed to the appropriate pharmacy network for processing.

Self-administered prescription drugs submitted by a licensed pharmacist on a CMS-1500/ANSI-837P or CMS-1450/ANSI-837I will not be priced by BlueCross BlueShield of Tennessee as a medical benefit unless otherwise specified by the Member's medical benefit plan.

14. Reimbursement Guidelines for Any Prescription Medications Dispensed by a Provider other than a Licensed Pharmacist when the Location of Service is Not the Practitioner's Office (last modified 4/27/05)

Reimbursement by BlueCross BlueShield of Tennessee for any prescription medication that has been dispensed by a provider other than a licensed pharmacist when the location of service is not the practitioner's office will not be allowed. This will ensure that only those professionals who are properly trained will administer these services at the contracted rates as stipulated in the member's prescription drug benefit plan.

The maximum allowable fee schedule amount for prescription medications dispensed by a provider other than a licensed pharmacist when the location of service is not the practitioner's office is $0.00.

This policy applies to prescription medications dispensed by a provider other than a licensed pharmacist when the location of service is not 11 when billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee business.

15. Reimbursement Guidelines for Medications Not Requiring a Prescription from a Licensed Practitioner Regardless of the Location of Service (last modified 4/27/05)

Reimbursement by BlueCross BlueShield of Tennessee for medications that do not require a prescription from a licensed physician regardless of the location of service will be considered non-covered.

The maximum allowable for medications that do not require a prescription from a licensed physician as defined by this policy will be $0.00.

This policy applies to medications that do not require a prescription from a licensed physician (e.g. over the counter drugs) regardless of the location of service billed on a CMS-1500/ANSI-837P or CMS-1450/ANSI-837I for all BlueCross BlueShield of Tennessee business.

16. Reimbursement Guidelines for Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, the service may be reported by appending CPT® modifier 22 to the procedure code.

Documentation supporting the unusual procedural service such as descriptive statements identifying the unusual circumstances, operative report, pathology report, progress notes, and/or office notes must be submitted by the provider in order to determine if the service is eligible for additional reimbursement.

Services billed with CPT® modifier 22 without the required supplemental documentation will not be considered for additional reimbursement.

If the documentation supports additional reimbursement for the unusual procedural service, reimbursement for eligible services will be based on the lesser of covered charges or up to 130% of the base maximum fee schedule allowable.

This policy applies to unusual procedural services billed with CPT® modifier 22 on a CMS-1500/ANSI-837P.

17. Reimbursement Guidelines for Administration of Regional or General Anesthesia Provided by a Surgeon

Administration of regional or general anesthesia provided by a surgeon may be reported by appending modifier 47 (Anesthesia by Surgeon) to the appropriate procedure code in accordance with CPT® guidelines.

Reimbursement for administration of regional or general anesthesia provided by a surgeon is included in the reimbursement for the surgical or other procedure and is not separately reimbursed.

Reimbursement for the surgical or other procedure is based on the lesser of covered charges or the professional maximum allowable fee schedule.

Modifier 47 has no effect on the maximum allowable.

18. Reimbursement Guidelines for Multiple Procedures

This policy applies to multiple procedures billed for the same patient on the same date of service by the same provider on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business for dates of service 7/1/2004, and after.

The maximum allowable for eligible multiple procedures billed for the same patient on the same date of service by the same provider will be based on the multiple procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be located at www.cms.gov.

Codes published by Medicare National Physician Relative Value Fee Schedule with a multiple procedure indicator “3” will be administered by BlueCross BlueShield of Tennessee based on the guidelines for multiple procedure indicator “2”.

Updates resulting from changes to the multiple procedure indicators published by Medicare will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

Refer to Exhibit for a summary of percentages of the base allowable that will be applied for each multiple procedure indicator and procedure code rank.

The determination of the primary procedure when multiple procedures are billed for the same patient on the same date of service by the same provider will be based on the procedure with the highest allowed amount according to the appropriate base fee schedule. All base allowables will be evaluated for each line billed. The procedure with the highest dollar amount according to the fee schedule will be considered as the primary procedure.

Exhibit A – Reimbursement Guidelines for Multiple Procedures

MPFSRVF Indicator	Procedure Rank	Percentage	Explanation
0	1st	100%	No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.
0	2nd +	100%	
2	1st	100%	Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.
2	2nd	50%	
2	3rd	50%	
2	4th	50%	
2	5th	50%	
2	6th +	IC	
3	1st	100%	Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.
3	2nd	50%	
3	3rd	50%	
3	4th	50%	
3	5th	50%	
3	6th +	IC	
9	1st	100%	Concept does not apply.
9	2nd+	100%	Concept does not apply.

19. Reimbursement Guidelines for Bilateral Procedures

The maximum allowable for eligible bilateral procedures billed for the same patient on the same date of service by the same Provider will be based on the bilateral procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be located at www.cms.gov.

Updates resulting from changes to the bilateral procedure indicators published by Medicare will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

This policy applies to bilateral procedures billed for the same patient on the same date of service by the same provider on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business for dates of service 7/1/2004, and after.

Refer to Exhibit A for a summary of the percentages of the base allowable that will be applied for each bilateral procedure indicator.

Exhibit A – Reimbursement Guidelines for Bilateral Procedures (last modified 7/1/04)

MPFSRVF Indicator	Percentage	Comments
0	100%	150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1	150%	150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.
2	100%	150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3	200%	The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
9	100%	Concept does not apply.

20. Reimbursement Guidelines for Procedures Performed by Two Surgeons

BlueCross BlueShield of Tennessee adopted Medicare as the primary source for medical appropriateness for procedures performed by two surgeons for Blue Networks C, P, S, and K.

BlueCross BlueShield of Tennessee follows Medicare's guidelines by assigning an indicator to each procedure code to denote whether the procedure is medically appropriate for co-surgery services. These indicators are noted in the Reimbursement Rule Indicators and RBRVS Relative Value Units (RVUs) chart available on the company Web site at http://www.bcbst.com/providers/docs/ReimbursementRuleRBRVS_RVU.pdf. BlueCross BlueShield of Tennessee will update this document quarterly in accordance with its policy on Quarterly Reimbursement Changes.

A companion document describing the values on the Reimbursement Rule Indicators and RBRVS Relative Value Units (RVUs) document can be referenced on the company Web site at http://www.bcbst.com/providers/ReimbursementRuleRBRVS_RVU_CompanionDocument.pdf.

Reimbursement for eligible procedures performed by two surgeons based on the lesser of covered charges or 62.5% of the base maximum allowable fee schedule amount for the procedure for each surgeon (or a total of 125% of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the provider in accordance with standard coding and billing guidelines.

21. Reimbursement Guidelines for Bundled Services Regardless of the Location of Service

Under Resource Based Relative Value Scale (RBRVS) methodology, Medicare considers reimbursement for certain codes bundled regardless of the location of service. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code "B". These documents can be located at www.cms.gov.

Unless specified otherwise in this policy, BlueCross BlueShield of Tennessee considers codes published by Medicare with a Status Code "B" as bundled regardless of the location of service. The maximum allowable for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code "B" will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

Exception:

Code	Effective Date	Exception
99050 99052 99054	1/1/98	Reimbursement is considered bundled with the service to which it is incident when the service is provided in all locations of service with the exception of the Practitioner's office (place of service 11). When the location of service is the Practitioner's office, code will be eligible for reimbursement in an effort to encourage Practitioners to extend office hours and discourage the use of the emergency room by a Member when medically appropriate.
99078 99371 99372	1/1/98	Reimbursement is considered bundled with the service to which it is incident with the exception of when the service is approved through an eligible BlueCross BlueShield of Tennessee initiative.
99100 99116 99135 99140	1/1/98	Reimbursement is considered bundled with the service to which it is incident with the exception of when the service is performed by an anesthesiologist or CRNA related to anesthesia administration.

22. Reimbursement Guidelines for Bundled Services when the Location of Service is the Practitioner's Office

Under Resource Based Relative Value Scale (RBRVS) methodology, Medicare considers reimbursement for certain codes bundled when the location of service is the Practitioner's office. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code "P". These documents can be located at www.cms.gov.

Unless specified otherwise in the policy, BlueCross BlueShield of Tennessee considers codes published by Medicare with a Status Code "P" as bundled when the location of service is the Practitioner's office. The maximum allowable for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code "P" will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

This policy applies to services billed on a CMS-1500/ANSI-837P.

Exception:
When the location of service is the Practitioner's office (place of service 11), HCPCS code V2520 is eligible for reimbursement.

23. Reimbursement Guidelines for Screening Test for Visual Acquity **(eff. 1/1/00 – last modified 4/27/05)**

According to Current Procedural Terminology (CPT®), a "screening test of visual acuity must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an evaluation and management service of the eye, it is a diagnostic examination and not a screening test."

The American Medical Association created code 99173 (Screening test of visual acuity, quantitative, bilateral) at the request of the American Academy of Ophthalmology in association with the American Academy of Pediatrics to enable pediatricians to bill for performing a visual screening test to ascertain whether future referral for visual care is needed. The code was also developed to electronically track visual screenings for pediatric patients to support proposed Utilization Review Accreditation Commission (URAC) Health Plan Employers Data and Information Set (HEDIS) efforts.

According to the American Academy of Pediatrics, a screening test of visual acuity is typically provided in conjunction with a preventive medicine service, which includes external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination. Since a screening test of visual acuity would not be provided as an independent/stand alone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99173 will be considered bundled with the service to which it is incident such as the preventive medicine service.

The maximum allowable for visual acuity will be $0.00 even when billed alone.

Sources

American Academy of Ophthalmology: "EyeNet – Savvy Coder." Accessed September 19, 2000.
Available: http://www.eyenet.org/eyenet_mag/01_00/coder.html

American Academy of Pediatrics. "Eye Examination and Vision Screening in Infants, Children, and Young Adults". Accessed September 14, 2000.
Available: http://www.aap.org/policy/01461.html

American Medical Association, Current Procedural Terminology: CPT® 2000. (Chicago: American Medical Association, 1999), p 452.

Rev 03/06

24. Reimbursement Guidelines for Visual Function Screening (eff. 1/1/01 – last modified 4/27/05)

According to Current Procedural Terminology (CPT®), code 99172 may be used to report visual function screening which includes automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision. Code 99172 may also include all or some screening of the determination(s) for contrast sensitivity vision under glare. This service must employ graduated visual acuity stimuli that allow a quantitative determination of visual acuity (e.g. Snellen chart).

Code 99172 is intended for use by Practitioners who provide occupational health services, usually involving the specialties of occupational medicine, internal medicine, family practice and emergency Practitioners.

Code 99172 was created to facilitate reporting of federally mandated visual function screening services for certain workers in an occupational field where optimal vision is crucial and safety standards for vision exist (e.g. firefighter, heavy equipment controller, nuclear power plant operators).

Since a visual function screening would not be provided as an independent/stand alone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99172 will be considered bundled with the service to which it is incident.

The maximum allowable screening test for visual acuity will be $0.00 even when billed alone.

Sources

American Medical Association, Current Procedural Terminology: CPT® 2001. (Chicago: American Medical Association, 2000), p 353.

American Medical Association, CPT® Changes 2001. (Chicago: American Medical Association, 2000), p 209.

25. Reimbursement Guidelines for Codes Classified as Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable

Codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable may require submission of the manufacturer name, product name, product number, and quantity.

The maximum allowable for these services will be based on the lesser of covered charges or the following percentages of the manufacturer's published list price as defined by BlueCross BlueShield of Tennessee:

100%	Medical Supplies
100%	Durable Medical Equipment
100%	Orthotics
100%	Prosthetics

Sources used by BlueCross BlueShield of Tennessee to determine the manufacturer's published list price include, but are not limited to:

- A nationally recognized database BlueCross BlueShield of Tennessee subscribes to that is updated periodically with information and pricing for more than 1,000,000 medical products from over 2,500 manufacturers; and
- Information provided to BlueCross BlueShield of Tennessee by manufacturer (e.g. product catalogs, product price listings, telephone/written inquiries to manufacturer).

In the event BlueCross BlueShield of Tennessee is unable to determine the manufacturer's published list price using one of the aforementioned sources, BlueCross BlueShield of Tennessee reserves the right to request submission of a manufacturer/supplier's invoice indicating the product acquisition cost after all discounts and rebates. The maximum allowable for these items will be the lesser of covered charges or 120% of the acquisition cost after all discounts and rebates per the manufacturer/supplier's invoice.

This policy applies to:

- durable medical equipment, medical supplies, orthotics, and prosthetics billed on the CMS-1500/ANSI-837P; and

- medical supplies on the BlueCross BlueShield of Tennessee Home Health Non-routine Supply List billed by a home health agency on the CMS-1450/ANSI-837I.

Reimbursement for codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable is subject to the Medicare Region C Durable Medical Equipment Regional Carrier (DMERC), BlueCross BlueShield of Tennessee reimbursement guidelines and BlueCross BlueShield of Tennessee billing guidelines.

26. Reimbursement Guidelines for Home Pulse Oximetry

Spot Home Pulse Oximetry

A spot home pulse oximetry check is a single measurement of oxygen saturation that may provide adjunctive information for the clinician. It is no different than any other routine vital sign (e.g. blood pressure) obtained as part of a general patient assessment.

Reimbursement for home pulse oximetry is included in the reimbursement for the rental of oxygen equipment or home health service when used as a spot oxygen saturation check.

When used as a spot oxygen saturation check, home pulse oximetry should not be billed separately from the rental of oxygen equipment or the home health visit.

Continuous Home Pulse Oximetry

Reimbursement for Medically Appropriate continuous home pulse oximetry will be limited to the rental of the pulse oximetry equipment. Medically appropriate home pulse oximetry equipment will be considered purchased when the rental payments have reached the network cap limitation.

This policy applies to home pulse oximetry services billed with HCPCS code E0445 on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee business.

27. Guidelines for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology – (eff. 7/1/04)

This policy only applies when specifically referenced in the Provider's Agreement.

Resource Based Relative Value Scale (RBRVS) is a reimbursement methodology, which values services according to the relative costs required to provide them.

RBRVS reimbursement methodology applies to most surgery, radiology, non-clinical laboratory, evaluation and management services, and diagnostic/therapeutic procedures.

RBRVS reimbursement methodology does not apply to anesthesia administration, clinical laboratory, immune globulins, vaccines, toxoids, injectable drugs, radiopharmaceuticals, medical supplies, durable medical equipment, orthotics, prosthetics, visions products (e.g. frames, lens, contact lens), or hearing products (i.e., hearing aids).

RBRVS is comprised of the following components used to determine the base maximum allowable for a service:

- **Relative Value Units (RVUs)**

  RVUs are expressed in numeric units that represent the units of measure of cost for Physician services. Services that are more complex, more time consuming will have higher unit values than services that are less complex, less time consuming. There are 3 types of RVUs including:

  - Physician Work RVUs – reflects the cost of the Physician's time and skill related to each service provided.

  - Practice Expense RVUs (facility and non-facility) – represents the Physician's direct and indirect costs related to each service provided.

    Direct expenses include non-physician labor, medical equipment and medical supplies.

    Indirect expenses include the cost of general office supplies, rent, utilities and other office overhead that cannot be directly tied to a specific procedure.

  When a procedure is performed in a facility setting, the expenses related to non-physician labor, medical equipment, and medical supplies are incurred and billed by the facility. As a result, the physician's cost related to a procedure performed in a facility is less than the Physician's cost related to a procedure performed in a non-facility.

  The facility practice expense RVUs apply when the location of service is inpatient hospital (place of service 21), outpatient hospital (place of service 22), emergency room-hospital (place of service 23), ambulatory surgery center (place of service 24), or skilled nursing facility (place of service 31).

  The non-facility practice RVUs apply to all other locations of service.

  - Malpractice RVUs – the relative value units assigned to the malpractice insurance component for a procedure.

    The source for the physician work, practice expense (facility and non-facility) and malpractice RVUs is the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals published by Medicare. These documents can be located at www.cms.gov.

    Updates to the RVUs are made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

- **Geographic Practice Cost Indices (GPCIs)**

  GPCIs are used to adjust the relative value units to reflect cost differences among geographic areas.

  There are 3 types of GPCIs including:
  - Physician Work GPCI
  - Practice Expense GPCI
  - Malpractice GPCI

  The source for the GPCIs is the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals published by Medicare. These documents can be located at www.cms.gov.

  BlueCross BlueShield of Tennessee uses the GPCIs assigned to Tennessee regardless of the geographic location in which the services are provided.

  Updates to the GPCIs are made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

- **Conversion Factor**

  The conversion factor represents the dollar value of each relative value unit.

  When the conversion factor is multiplied by the geographically adjusted relative value units it will yield the maximum allowable for the specific service.

  Network conversion factors are determined by the Provider contract.

  The following are formulas used to calculate the base professional maximum allowable for procedures applicable under RBRVS reimbursement methodology:

  Non-facility Professional Maximum Allowable

  ((Physician Work RVU x Physician Work GPCI) + (Non-Facility Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)) x Conversion Factor

  Facility Professional Maximum Allowable

  ((Physician Work RVU x Physician Work GPCI) + (Facility Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)) x Conversion Factor

  Note: *The sum of the Physician Work, Practice Expense, and Malpractice components of the RBRVS formula will be rounded to the nearest thousandth (i.e., to the 3rd decimal place, x.xxx) before the conversion factor is applied.*

  Example 1
  Maximum Allowable = [(1.27 x 1.000) + (2.20 x .900) + (.08 x .612)] x Conversion Factor
  Maximum Allowable = 3.29896 x Conversion Factor
  Maximum Allowable = 3.299 x Conversion Factor

  In this example 3.29896 is rounded to 3.299 before the conversion factor is applied.

  Example 2

  Maximum Allowable = [(1.19 x 1.000) + (4.73 x .900) + (.29 x .612)] x Conversion Factor
  Maximum Allowable = 5.62448 x Conversion Factor
  Maximum Allowable = 5.624 x Conversion Factor

  In this example 5.62448 is rounded to 5.624 before the conversion factor is applied.

Example 3
Maximum Allowable = [(2.30 x 1.000) + (.55 x .900) + (.21 x .612)] x Conversion Factor
Maximum Allowable = 2.92352 x Conversion Factor
Maximum Allowable = 2.924 x Conversion Factor

In this example 2.92352 is rounded to 2.924 before the conversion factor is applied.

The following are other major components that may have an impact on the base maximum allowable under RBRVS reimbursement methodology:

- Reimbursement Policy for Bilateral Procedures
- Reimbursement Policy for Bundled Services Regardless of the Location of Service
- Reimbursement Policy for Bundled Services When the Location of Service is the Practitioner's Office
- Reimbursement Policy for Global Periods
- Reimbursement Policy for Multiple Procedures
- Reimbursement Policy for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only

28. Reimbursement Guidelines for Global Periods

The concept of the "Global Period" includes the routine preoperative history and physical including the hospital admission, the operative procedure, and all care related to the surgical procedure. The Centers for Medicare and Medicaid Services (CMS) has established global periods for certain surgical procedure codes. These assigned periods can be **0** days, **10** days, or **90** days.

Global periods are determined based on the guidelines published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be located at www.cms.gov.

If Medicare has not assigned a global period for certain procedures, BlueCross BlueShield of Tennessee reserves the right to assign a global period based on a similar service.

Updates resulting from changes to the global periods published by Medicare will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business for dates of service 7/1/2004, and after.

29. Reimbursement Guidelines for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only Services – (eff. 7/1/04)

This policy applies to the following services billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business for dates of service 7/1/2004, and after:

- Preoperative Management Only Services billed with CPT® modifier 56;
- Surgical Care Only Services billed with CPT® modifier 54; and
- Postoperative Management Only Services billed with CPT® modifier 55.

Preoperative Management Only Services
When one Physician performs the preoperative care and evaluation and another Practitioner performs the surgical procedure, the preoperative component should be reported with CPT® modifier 56 appended to the appropriate procedure code.

Surgical Care Only Services
When one Physician performs a surgical procedure and another Physician provides preoperative and/or postoperative management, the surgical services should be reported with CPT® modifier 54 appended to the appropriate procedure code.

Postoperative Management Only Services
When one Physician performs the postoperative management and another Physician performs the surgical procedure, the postoperative component should be reported with CPT® modifier 55 appended to the appropriate procedure code.

Eligible preoperative management only, surgical care only, and postoperative management only services will be reimbursed based on the lesser of covered charges or a percentage of the base maximum allowable for the procedure code as published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be located at www.cms.gov.

Updates resulting from changes to the percentages published by Medicare will be made in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Changes.

30. Reimbursement Guidelines for Procedures Performed on Infants Less than 4kg – (eff. 1/1/03)

Procedures on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work. According to the Current Procedural Terminology, CPT® 2003 Manual, this modifier may only be appended to procedures/services listed in the 20000 through 69999 code series.

According to presentations made by representatives of the American Pediatric Surgical Association (APSA), there are many definite exclusions of CPT® codes within the Surgical series of CPT® codes.

The APSA noted the following exclusions, whereas Modifier 63 should **not** be appended to any CPT® codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/laboratory, or Medicine sections and any of the following codes listed within the Surgical section of the CPT® 2003 Manual:

CPT® Procedure codes excluded from Modifier 63 use				
33401	33694	33961	43831	49496
33403	33730	30540	44055	49600
33470	33732	30545	44126	49605
33472	33735	31520	44127	49610
33502	33736	36415	44128	49611
33503	33750	36420	46070	53025
33505	33755	36450	46075	54000
33506	33762	36460	46015	54120
33610	33778	36510	47700	54160
33611	33786	36660	47701	63700
33619	33918	39503	49215	63702
33647	33919	43313	49491	63704
33670	33922	44314	49492	63706
33690	33960	43520	49495	65820

Services billed with Modifier 63 without the required supplemental documentation will not be considered for additional reimbursement.

If the documentation supports additional reimbursement for the indication of procedure performed on an infant less than 4 kg representing physician work and complexity over and above the services included in the standard base code, then reimbursement for eligible services will be based on the lesser of charges or up to 130% of the base maximum fee schedule allowable.

This policy applies to those appropriate CPT® codes with a Modifier 63 billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business.

31. Reimbursement Guidelines for Corneal Topography – (eff. 1/1/01 – last modified 4/27/05))

BlueCross BlueShield of Tennessee reimbursement for codes used to report services of corneal topography is considered to be an inclusive component of the general opthalmalogical services evaluation and management codes.

In the August, *1998* CPT® *Assistant*, the following is stated "*from a* CPT® *coding perspective, corneal topography is included in the general ophthalmological service codes and is not separately reported*." In addition, a letter dated 11/30/2000 from the American Medical Association CPT® *Information Services to BlueCross BlueShield of Tennessee* again reiterated the determination that corneal topography was an inclusive component of the ophthalmological services and should not be billed separately.

The maximum allowable for corneal topography will be $0.00 even when billed alone.

32. Reimbursement Guidelines for Category II CPT® Codes – (eff. 1/1/04 – last modified 4/27/05)

The goal of Category II CPT® Codes is to aid performance measurement by easing quality-of-care data collection. These codes generally describe either common components of Evaluation & Management services or test results that are part of a laboratory procedure. Each code is linked to a particular "performance measure set" and the codes have no corresponding Relative Value Units.

According to the American Medical Association, "the use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for Category I codes."

Because the true definition of these Category II CPT® codes is for tracking purposes, the maximum allowable will be $0.00 even when billed alone.

33. Reimbursement Guidelines for STAT Services –(eff. 1/1/02)

STAT services reported to denote procedures processed as done immediately, as soon as possible, and/or processed with priority.

Reimbursement by BlueCross BlueShield of Tennessee for STAT services will be considered bundled with the service to which it is incident (e.g. specific laboratory, pathology etc. codes) regardless of the location of service.

The maximum allowable fee schedule amount for STAT services is $0.00 even when billed alone.

34. Reimbursement Guidelines for Online Evaluation and Management Services – (eff. 4/1/04 – last modified 4/27/05)

The American Medical Association established the Category III CPT® code 0074T to report an online evaluation & management service, per encounter, provided by a Practitioner, using the Internet or similar electronic communications network, in response to a patient's request; established patient.

According to the American Medical Association, an online medical evaluation is a type of Evaluation & Management service provided by a Practitioner or qualified health care professional, to a patient using Internet resources, in response to the patient's online inquiry. Reportable services involve the Practitioner's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hardcopy) of the encounter. This service should not be reported for patient contacts (e.g. Telephone calls) considered to be pre-service or post-service work for other E & M or non E&M services. A reportable service would encompass the sum of communication (e.g. Related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s).

Category III CPT® codes are a set of temporary codes for emerging technology, service or procedures. These codes allow for data collection purposes to substantiate widespread usage or in the FDA approval process. These codes will not be referred to the CPT® Editorial Panel for valuation because no relative value units (RVUs) will be assigned.

The maximum allowable fee schedule amount for online evaluation and management services will be $0.00 even when billed alone with the exception of when the service is approved through an eligible BlueCross BlueShield of Tennessee initiative.

This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business.

Online source from the American Medical Association located at:
http://www.ama-assn.org/ama/pub/article/3885-4897.html

35. Reimbursement Guidelines for Hearing Services/Equipment – (eff. 8/1/04)

BlueCross BlueShield of Tennessee reimbursement and billing guidelines for hearing-related services and equipment are as follows:

- Hearing examinations, screenings, assessments and conformity evaluations will be reimbursed based on the lesser of covered charges or the network maximum allowable fee schedule. These services should be billed using the most appropriate CPT® or HCPCS code.
- Hearing aids, hearing aid batteries, hearing aid accessories, assisted listening devices, and dispensing fees will be reimbursed based on covered charges. These items should be billed using the most appropriate "V" HCPCS code and number of units as defined by HCPCS.
- Reimbursement for the dispensing fee includes reimbursement for fabrication and fitting of the ear mold, fitting tubing to ear mold, hearing aid orientation and instruction, shipping/handling, and sales tax.

A manufacturer's invoice is not required on claims for these items.

This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business.

It is important to note that member benefits for hearing-related services and equipment can vary. Final reimbursement determinations are based on member eligibility on the date of service, Medical Necessity, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BlueCross BlueShield of Tennessee Medical Policy.

36. Billing Guidelines and Documentation Requirements for CPT® Code 99211 (Eff. 7/7/05)

The American Medical Association established the Evaluation and Management CPT® code 99211 to report an office or other outpatient visit for the evaluation & management of an established patient that may not require the presence of a Physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

According to the American Medical Association, medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history. The medical record facilitates the ability of the Physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time.

There should be documentation in the medical record such as the patient/clinician face-to-face encounter exchanging significant and necessary information. There should be some type of limited physical assessment or patient review. The encounter must be for a problem stated by the patient and not involve solely the performance of tests or services ordered at prior encounters where evaluation and management services were provided. There should be documentation in the medical record of management of the patient's care via medical decision-making and the medical record should provide evidence that evaluation and management services (consistent with the above) were provided. Basic Guidelines for billing CPT® code 99211:

- The patient must be an established patient
- The patient/clinician encounter must be face-to-face
- Some degree of an evaluation and management service must be provided
- Pertinent documentation in the medical record of the encounter is required and documented
- Patient must state a present problem

This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business.

F. Special CMS-1500 Billing Guidelines – Blocks 31 and 33

CMS-1500 forms submitted by Providers in Tennessee and contiguous counties must have the Provider's BlueCross BlueShield of Tennessee designated provider number in Block 33 PIN# and tax ID# or Group # field based on the following criteria. If not, the CMS-1500 claim forms will be returned to the Provider for correct submission.

1. Physician

Practitioners should use their individual provider number assigned by BlueCross BlueShield of Tennessee. Some Practitioners may have multiple provider numbers. Practitioners should use the appropriate Provider number based on a unique tax, pay to, or physical location.

- Block 31 Signature of Practitioner or Supplier including degrees and credentials
- Block 33 Individual or billing name, address and telephone. It can differ from the Practitioner or Supplier name in Block 31, e.g., check and remittance endorsed in the group's name. PIN# field – Practitioner's Individual Provider number as assigned by BlueCross BlueShield of Tennessee. Provider number should be seven digits with leading zeros to satisfy seven digits if necessary; e.g., 0001234. **This number should represent the Practitioner's signature in Block 31 unless billing via Delegated Services Policy.**

2. Health Care Professional

All contract-eligible Health Care Professionals should follow the Practitioner previously noted guidelines.

3. Medical Service Provider

Durable Medical Equipment (DME) suppliers, Home Infusion Therapy services, and laboratories should bill on the CMS-1500/ANSI-837P for all BlueCross BlueShield of Tennessee commercial business using the following billing requirements:

Specific Billing Requirements:

Block 31	Signature of Supplier (or an authorized representative of the same) including degrees or credentials.
Block 33	Supplier's billing name, address, and telephone number. Indicate the BlueCross BlueShield of Tennessee designated provider number in the Group # Field. Provider number should be seven digits with leading zeros to satisfy seven digits if necessary; e.g., 0001234.

Note: *Home Health Agencies and Hospice Providers should bill charges on the CMS-1450/ANSI-837I.*

Any questions concerning the use of the appropriate provider number should be addressed to BlueCross BlueShield of Tennessee's Provider Management Department at 1-800-899-2640.

G. Staff Supervision Requirements for Delegated Services (eff. 2/9/98)

This policy defines BlueCross BlueShield of Tennessee (BCBST) requirements for supervision by eligible Physicians and Chiropractors of their associates and assistants. Supervision by itself does not create eligibility for the services of associates and assistants. Such Practitioners must be supervised as specified in the categories below for a service to be eligible for reimbursement. The policy also describes requirements for billing delegated services. To the extent that state or federal law or regulation exceeds these internal requirements, these laws or regulations will control.

Licensed Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Chiropractic (DCs), Doctors of Podiatric Medicine (DPMs), Licensed Professional Counselors (LPC), and Licensed Certified Social Workers (LCSW) are examples of autonomous Providers. Their services do not require the supervision of another profession. These Practitioners should bill their services under their own provider number or the provider number of their facility. (Refer to clarification of term "autonomous" under ***Clarification of terms used within this policy***.)

Provider Categories/Billing and Supervision Requirements:

- **Licensed Providers Requiring Supervision by Retrospective Review**

  Supervision by Retrospective Review is defined as supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual's medical record (e.g., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (e.g., facility, office) during the time that a delegated service is performed.

  Licensed Providers requiring supervision by Retrospective Review include Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Licensed Resident Physician, Nurse Practitioner, and Physician Assistant.

  Supervising Physicians or Chiropractors are required to perform a review of the services they delegate to this category of Practitioner. Practitioners in this category are required to bill under the billing number of their supervising Practitioner except when rendering services independently, and

are eligible to bill directly under their own BlueCross BlueShield of Tennessee provider billing number. The actual provider of service must also be listed on the billing form. This does not apply to licensed residents when performing services that are a part of their residency program.

Supervising Physicians and Chiropractors must:

- Annually review and document the licensure or certification of any office staff or employee to whom they delegate medical services.
- Review the patient records and certify by signed notation that evaluations and treatment plans are appropriate, as prescribed by law.
- Only delegate services that are within the scope of the delegated Practitioner's license.

Specific Billing Requirements:

Block 31 Practitioner rendering the service
Block 33 Supervising Practitioner name, billing address and telephone number. Indicate BlueCross BlueShield of Tennessee designated provider number for supervising Practitioner in the PIN# Field. Provider number should be seven digits with leading zeros to satisfy seven digits if necessary; i.e., 0001234.

➢ Licensed Physicians Requiring Minimal Supervision

Minimal Supervision requires that the supervising/treating Physician evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

Licensed Physicians requiring Minimal Supervision include Certified Athletic Trainer, Certified Audiologist, Certified Occupational Therapist, Chiropractic Radiology Technician, Licensed Physical Therapist, Licensed Practical Nurse, Licensed Psychological Examiner, Medical Laboratory Technologist, Orthopedic Physician Assistant, Radiologic Technician, Registered Dietitian/Registered Nutritionist, Registered Nurse, Registered Respiratory Therapist, Speech and Language Pathologist. Some Practitioners within these health care fields may be eligible for a BlueCross BlueShield of Tennessee provider ID number.

Supervising Physicians, Chiropractors, or Psychologists are required to supervise the provision of delegated services for this category of Providers. If the actual provider of the service needs the direction or supervision of a Chiropractor, Physician or Psychologist to legally perform a service and is ineligible to bill under their own number, then the Chiropractor, Physician or Psychologist will be allowed to bill those services under their name and provider number. The actual provider of service must also be listed on the billing form (i.e., in Block number 31 of the CMS-1500 claim form).

Supervising Physicians, Chiropractors and Psychologists must:

- Annually review and document the licensure or certification of any office staff or employees to whom they delegate medical services;
- Only delegate services that are within the scope of the Practitioner's certification or license as determined by law. Such services should not require the exercise of independent professional judgment;
- Include the following documentation: 1) an evaluation of the patient prior to delegating or ordering any services, 2) a specific order for the service to be delegated, and 3) notation of the results obtained from the service ordered.
- Use treatment protocols from nationally recognized professional sources and have them available on-site for review by BlueCross BlueShield of Tennessee.

Specific Billing Requirements:

Block 31 Practitioner rendering the service
Block 33 Supervising Practitioner name, billing address and telephone number. Indicate BlueCross BlueShield of Tennessee designated provider number for supervising Practitioner in the PIN# Field. Provider number should be seven digits with leading zeros to satisfy seven digits if necessary; e.g., 0001234.

➢ Certified Providers Requiring Direct and Close Supervision

Direct and Close Supervision requires that the supervising Physician have, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (e.g., facility, office) and readily available during the time that a delegated service is rendered. (Note: See Extenuating Circumstances.) Being available via telephone does not constitute direct and close supervision.

Certified Providers requiring Direct and Close Supervision include Certified Chiropractic Therapy Assistant, Certified Medical Assistant, Certified Nursing Assistant, Certified Occupational Therapy Assistant, Certified Podiatric Assistant, Licensed Physical Therapy Assistant, and Medical Laboratory Technician. These health care practitioners are **not** eligible for a BlueCross BlueShield of Tennessee Provider ID number.

Supervising Physicians, Chiropractors and Therapists must:

- Annually review and document certification of any office staff or employees to whom they delegate medical services.
- Only delegate services in which the supervising Practitioner materially participates. "Materially participate" means the supervising Practitioner must evaluate the patient immediately prior to the service, prepare a detailed written order, and perform a final evaluation of the patient and the service performed prior to the patient leaving the facility. The final evaluation should ensure that the service was delivered appropriately and was clinically effective. The supervising Practitioner must be on-site and available at all times. Documentation in the patient medical record must reflect that these steps occurred.
- Follow required treatment protocols from nationally recognized sources. Protocols must be kept on-site and be made available for review by BlueCross BlueShield of Tennessee.
- Only delegate services that do not require clinical judgment or could not be construed as a service requiring the expertise of Practitioners in categories 1&2.

Extenuating Circumstances

Under extenuating circumstances (e.g., network inadequacy in rural areas) a licensed/ certified therapy assistant may render services through a home health provider in the home health setting under the general supervision of a licensed therapist. Under these conditions, a licensed therapist must evaluate the patient, develop a treatment plan, and implement the plan. General supervision requires initial direction and periodic re-evaluation by the registered therapists; however, the supervisor does not have to be physically present or on the premises.

Specific Billing Requirements:

Block 31 Physician rendering the service

Block 33 Supervising Physician's name, billing address and telephone number. Indicate BlueCross BlueShield of Tennessee designated provider number for supervising Practitioner in the PIN# Field. Provider number should be seven digits with leading zeros to satisfy seven digits if necessary; e.g., 0001234.

Clarification of terms used within this policy:

Autonomous Providers – Providers who by their state license are qualified to diagnose and initiate treatment independently. For example, a Doctor of Chiropractic (DC) is licensed to diagnose and initiate chiropractic treatment without an order to treat from another profession. A DC is an autonomous Provider and as such, does not require supervision or orders from another profession.

Supervision by retrospective review – Supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an

individual's medical record (i.e., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (i.e., facility, office) during the time that a delegated service is performed.

Minimal supervision – Requires that the supervising/treating Practitioner evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

Direct and close supervision – Requires that the supervising Practitioner has, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (i.e., facility, office) and readily available during the time that a delegated service is rendered. (Note: Extenuating circumstances above.) Being available via telephone does not constitute direct and close supervision.

H. Locum Tenens Policy (eff. 8/26/99 – last modified 1/14/04)

A "locum tenens" is a temporary Practitioner who fills in for a Practitioner on a short-term basis. A Practitioner who is to be a permanent member of a practice or who performs services for over ninety (90) days does not meet the definitions of a "locum tenens" and must initiate contracting and credentialing with BlueCross BlueShield of Tennessee.

The substitute Practitioner generally does not have a practice of his/her own and moves from area to area as needed. The regular practitioner generally pays the substitute practitioner or an agency a fixed amount per diem, giving the substitute practitioner the status of independent contractor rather than an employee.

A BlueCross BlueShield of Tennessee Participating Practitioner may submit a claim for a Member's Covered Services (including emergency visits and related services) of a "locum tenens" Practitioner who is not an employee and whose services for Members of the regular Practitioner are not restricted to the regular Practitioner's office, if:

- The Member has arranged or seeks to receive services from the regular Practitioner;
- The regular Practitioner is unavailable to provide the visit services due to leave of absence for illness, vacation, pregnancy, continuing medical education, etc.;
- The regular Practitioner has left a group practice and the group has engaged a "locum tenens" Practitioner as a temporary replacement until a permanent replacement Practitioner is obtained. In this case, group must select a member of the group as an oversight Practitioner.
- The regular Practitioner, or group practice acting on his behalf, sends a letter to the appropriate BlueCross BlueShield of Tennessee Regional Manager, Provider Relations stating the reason for "locum tenens". The letter should state the date the services will begin and the estimated end date;
- The regular Practitioner, or group practice acting on his behalf, has ascertained that the "locum tenens" is qualified by training and experience to temporarily maintain the regular Practitioners' practice;
- The regular Practitioner pays the "locum tenens" for his/her services on a per diem or similar fee-for-time basis; Compensation paid by a group to the "locum tenens" Practitioner is considered paid by the regular Practitioner for purposes of this policy.
- The services are not provided over a continuous period of longer than ninety (90) days. The regular Practitioner, or group practice acting on his behalf, must keep on file a record of each service provided by the substitute Practitioner and make the records available to BlueCross BlueShield of Tennessee upon request;

- CMS-1500 claims should be submitted with BlueCross BlueShield of Tennessee Participating Practitioner's name and individual provider number in Block 33 and "locum tenens" name in Block 31 as the servicing Provider. In case of regular Practitioner who has left group practice, claims should be submitted with BlueCross BlueShield of Tennessee Participating Oversight Practitioner name and individual provider number in Block 33 and "locum tenens" name in Block 31 as the servicing Provider.

I. Teleradiology Services

BlueCross BlueShield of Tennessee Medical Policy considers the professional component for the diagnostic service of Teleradiology Medically Necessary if the Medical Appropriateness criteria detailed in the policy are met.

BlueCross BlueShield of Tennessee allows facilities and Practitioner groups that participate in BlueCross BlueShield of Tennessee Provider Networks to sub-contract for Teleradiology services under the following conditions:

- Medical Appropriateness criteria detailed in BlueCross BlueShield of Tennessee Medical Policy on Teleradiology must be met.
- The sub-contract for Teleradiology services enhances Member access to radiology services.
- Sub-contractor is reimbursed by facility or Practitioner group for the services rendered pursuant to their sub-contract agreement for Teleradiology services.
- Participating Provider notifies BlueCross BlueShield of Tennessee in writing of the sub-contract arrangement.

BlueCross BlueShield of Tennessee will review the written notice of sub-contracted Teleradiology services to assure compliance with this policy. If compliant, approval will be granted in writing.

Upon receipt of BlueCross BlueShield of Tennessee 's approval of the sub-contract arrangement, a BlueCross BlueShield of Tennessee participating Provider may submit a claim for Medically Necessary Teleradiology services for which they have sub-contracted. In these cases, the participating Radiologist that is responsible for overseeing the Teleradiology sub-contract should submit a global charge. Claims should be submitted with the BlueCross BlueShield of Tennessee Participating Radiologist's name and individual provider number in Block 33 and the name of the Physician rendering the professional component of the diagnostic service in Block 31 as the servicing Provider. BlueCross BlueShield of Tennessee Participating Provider is responsible for assuring the servicing Provider is not sanctioned by Medicare and/or Medicaid or excluded by the Federal Procurement and Nonprocurement Programs.

As with all sub-contracted services, the provisions of the Participating Provider's Agreement with BlueCross BlueShield of Tennessee will prevail for sub-contracted Teleradiology services, including the Member hold harmless provision.

J. CMS-1450 Facility Claim Form

The following billing guidelines are designed to give the facility the basic information required to properly file a CMS-1450 paper claim with BlueCross BlueShield of Tennessee. Except where noted in these billing guidelines, form locator fields are to be completed in accordance with the Tennessee CMS-1450 Uniform Billing Guide. These billing guidelines are based on information available to BlueCross BlueShield of Tennessee at the time they were written. Final determinations for reimbursement are made at the time claims are adjudicated. Coding instructions are subject to change due to the Health Insurance Portability and Accountability Act (HIPAA).

Billing guidelines are subject to change and are not intended to determine the amount of reimbursement for a specific service. Reimbursement for each facility is addressed in the Schedule of Payments and associated fee schedules found in individual facility contracts.

1. General Instructions

The CMS-1450 contains individual Fields or Form Locators. The Form Locators instruct the BlueCross BlueShield of Tennessee claims administration system as to:

- The type of services being billed;
- Dates of Service;
- Patient Identity;
- Facility Identity; and
- Other necessary information needed to process a claim.

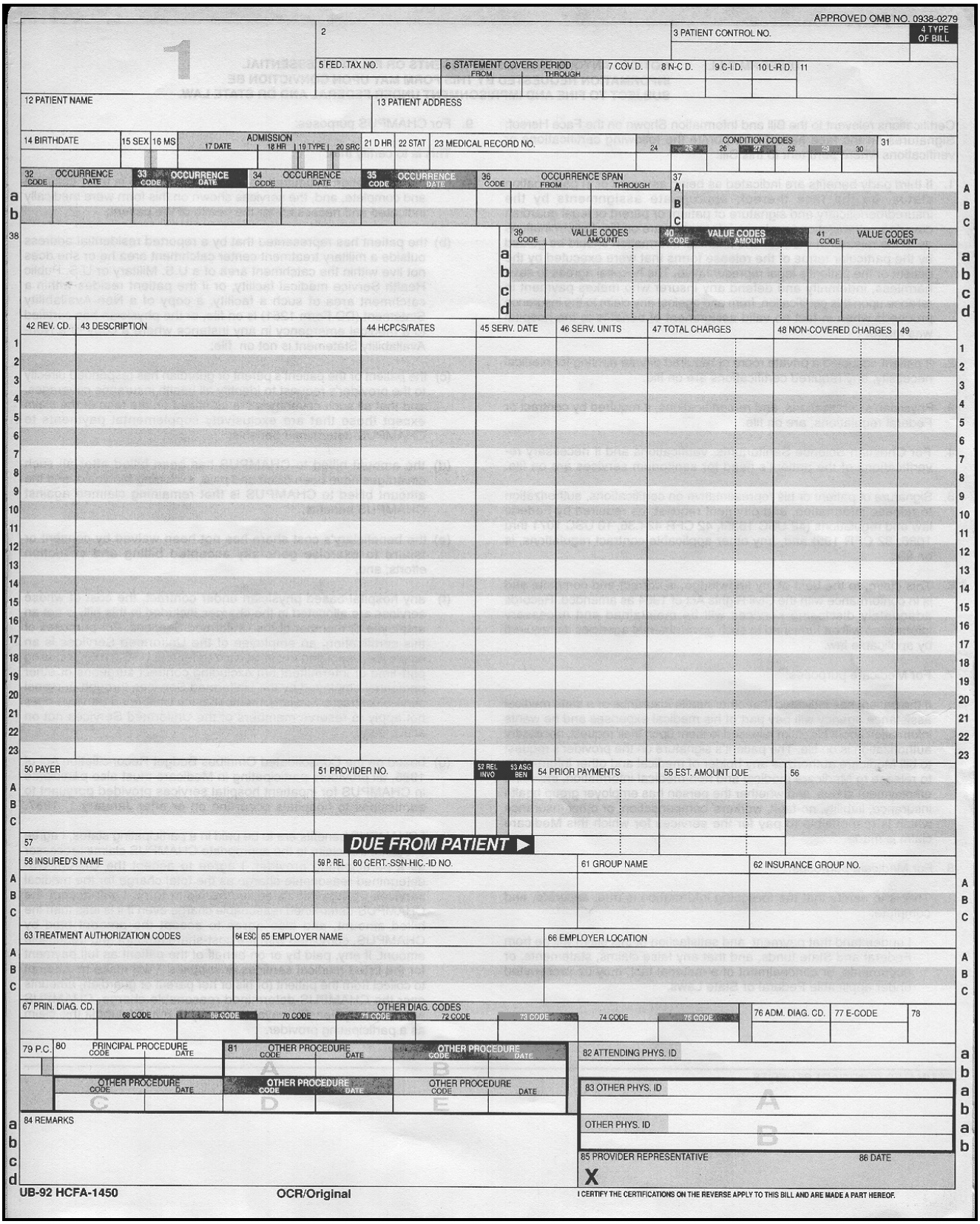
A sample copy of the CMS-1450 paper claim form and field descriptions appear in this section. Each Form Locator has a unique number (indicator). Please review each Form Locator and its definition.

There are specific Form Locators required which must be completed to correctly file a claim with BlueCross BlueShield of Tennessee. If the facility does not provide the required information, the claim may be denied or returned to the provider.

BlueCross BlueShield of Tennessee has contracted specific inpatient and outpatient services for each facility network and line of business. In situations where services shown on these contracts have not been contracted, a rate must be negotiated prior to billing those services or reimbursement will be set at zero. In addition, services not included in the contract and require a separate contract for payments of those services are listed in the table below. For specific information regarding the services listed in the following table or to discuss contracting those services not currently contracted, please call your Provider Relations Representative.

Service	
Retail Pharmacy	Home Health
Independent or Outreach Laboratory	Home Infusion Therapy
Clinic Based Services	Dialysis
Durable Medical Equipment	Prosthetic and Orthotic Device or Procedures
Sub Acute Care	Physician Services
Hospice	

A sample copy CMS-1450 paper claim form follows:


APPROVED OMB NO. 0938-0279
1
2
3 PATIENT CONTROL NO.
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D.
8 N-C D.
9 C-I D.
10 L-R D.
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIRTHDATE
15 SEX
16 MS
ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC
21 D HR
22 STAT
23 MEDICAL RECORD NO.
CONDITION CODES 24 25 26 27 28 29 30
31
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE CODE DATE
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS/RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
50 PAYER
51 PROVIDER NO.
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56
57
DUE FROM PATIENT ▶
58 INSURED'S NAME
59 P. REL
60 CERT.-SSN-HIC.-ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS
85 PROVIDER REPRESENTATIVE
86 DATE
X
UB-92 HCFA-1450
OCR/Original
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Rev 03/03

2. CMS-1450 Form Locator and Field Description

Form Locator 1	Provider Name, Address, Telephone Number***
Form Locator 2	Unlabeled Field
Form Locator 3	Patient Control Number***
Form Locator 4	Type of Bill***
Form Locator 5	Federal Tax Number***
Form Locator 6	Statement Covers Period***
Form Locator 7	Covered Days
Form Locator 8	Non-Covered Days
Form Locator 9	Coinsurance Days
Form Locator 10	Lifetime Reserve Days
Form Locator 11	Unlabeled Field
Form Locator 12	Patient Name***
Form Locator 13	Patient Address
Form Locator 14	Birthdate***
Form Locator 15	Sex***
Form Locator 16	Marital Status
Form Locator 17	Admission Date***
Form Locator 18	Admission Hour
Form Locator 19	Type of Admission
Form Locator 20	Source of Admission
Form Locator 21	Discharge Hour
Form Locator 22	Patient Status***
Form Locator 23	Medical/Health Record Number
Form Locator 24-30	Condition Codes
Form Locator 32-35	Occurrence Codes and Dates
Form Locator 36	Occurrence Span Code and Dates
Form Locator 39-41	Value Codes and Amounts
Form Locator 42	Revenue Code***
Form Locator 43	Revenue Description
Form Locator 44	HCPCS/Rates***
Form Locator 45	Service Date
Form Locator 46	Units of Service***
Form Locator 47	Total Charges***
Form Locator 48	Non-Covered Charges
Form Locator 49	Unlabeled Field
Form Locator 50	Payer Identification***
Form Locator 51	Provider Number***
Form Locator 52	Release of Information Certification Indicator
Form Locator 53	Assignment of Benefits Certification Indicator
Form Locator 54	Prior Payments -- Payer and Member
Form Locator 55	Estimated Amount Due
Form Locator 56	Unlabeled Field
Form Locator 57	Unlabeled Field
Form Locator 58	Insured's Name***
Form Locator 59	Patient’s Relationship to Insured
Form Locator 60	Certificate/Social Security Number/Health Insurance Claim/Identification Number***
Form Locator 61	Insured Group Name
Form Locator 62	Insurance Group Number
Form Locator 63	Treatment Authorization Codes

Form Locator 64	Employment Status Code
Form Locator 65	Employer Name
Form Locator 66	Employer Location
Form Locator 67	Principal Diagnosis Code***
Form Locator 68-75	Other Diagnosis Codes
Form Locator 76	Admitting Diagnosis***
Form Locator 77	E Code
Form Locator 78	Unlabeled Field
Form Locator 79	Procedure Coding Method Used
Form Locator 80	Principal Procedure Code and Date**
Form Locator 81	Other Procedure Codes and Date
Form Locator 82	Attending Physician Name and UPIN Number (If UPIN is NOT available, enter "OTH000")**
Form Locator 83	Other Physician ID (UPIN Number)/ Admitting Physician Admitting Physician/ BCBST Individual Provider Number
Form Locator 84	Remarks
Form Locator 85	Provider Representative
Form Locator 86	Date

** Required Fields by Pre Adjudication Edits
*** Required Fields by BlueCross BlueShield of Tennessee Electronic Billing

Revenue Code (FL42)

Complete this field with the revenue code related to the services that are being billed to BlueCross BlueShield of Tennessee. For specific instructions regarding each revenue code, refer to the billing guidelines defined below:

Billing Guidelines (Form Locator 42) Field Definitions
Each field contains specific billing information critical to understanding how to file a claim with BlueCross BlueShield of Tennessee. By following these guidelines the facility will maximize reimbursement.

Revenue Code – The Revenue Code is the initial indicator to the claims administration system as to what type of services were performed. Revenue Codes for inpatient and outpatient services are included in the billing guidelines.

Category – The Category defines a general description of the type of service provided under the Revenue Code. Some Revenue Codes fall into several Categories such as Revenue Code 110. Revenue Code 110 is generally used to file services under Medical, Surgical, Orthopedic, Trauma, Trauma Medical and Trauma Surgical, among others. The participating Provider contract outlines which Revenue Codes can be filed under each Category.

Reimbursement Rule - The Reimbursement Rule explains what type of reimbursement the facility should expect if billed properly. It is extremely important to have the facility's contract on hand when reviewing how a claim should be reimbursed. BlueCross BlueShield of Tennessee claims administration system in some cases will default to another Category in the event that there is no specifically contracted rate for a service. In addition, some services are ineligible as "Not Medically Necessary," or there is no negotiated fee.

Principal Diagnosis - The Principal Diagnosis determines the Category for reimbursement. The Principal Diagnosis should always be billed in Form Locator 67 on the CMS-1450 claim form. This field indicates to our system the primary reason for the services rendered to the patient.

Principal Procedure Code – The Principal Procedure Code is an ICD-9 Procedure Code. This code will help determine the Category of service. The facility should bill the correct Principal Procedure Code in Form Locator 80 of the CMS-1450.

CPT®/HCPCS Required – CPT® Codes should always be billed on the CMS-1450 in Form Locator 44. This field indicates when a Revenue Code must be filed with a CPT®/HCPCS Code. If a required CPT™ /HCPCS Code is missing, the claim may be denied and returned to the facility for proper coding.

Note: *Billing outpatient procedures using* CPT®*/HCPCS Codes on the CMS-1450 is a new requirement for BlueCross BlueShield. However, Medicare already requires this information.*

HCPCS Codes/Rates (FL44)

Complete this field with the CPT®/HCPCS Code related to the service being provided. To determine which CPT®/HCPCS Codes are to be filed with a related Revenue Code, refer to the FL44 – BlueCross BlueShield of Tennessee CPT®/HCPCS Code Requirement.

Note: *For the related contract, BlueCross BlueShield of Tennessee accepts only valid* CPT®*/HCPCS Codes that can be billed in a hospital acute care setting. Prior to payment, unlisted procedures must be filed hard copy with the supporting medical record.*

Billing Guidelines (Form Locator 44) Field Definitions

Each field contains specific billing information critical to understanding how to file a claim with BlueCross BlueShield. By following these guidelines, the facility will maximize reimbursement. These guidelines only apply to Revenue Codes stated in the Billing Guidelines (Form Locator 42) as requiring a CPT®/HCPCS Code.

Codes ranging from 10000-69999 are generally surgical codes and require individual negotiated rates for outpatient services. Please refer to the correct Network Attachment for reimbursement schedules.

Codes ranging from 70000-79999 are generally radiology codes. Please refer to the Provider Network Attachment for any Procedure Codes that have individual negotiated rates.

Codes ranging from 80000-89999 are generally laboratory or pathology codes. Please refer to your Provider Network Attachment for any Procedure Codes that have individual negotiated rates.

CPT® – The CPT® *Field* lists the CPT®/HCPCS Code or Range of Codes eligible to be filed in Form Locator 44 of the CMS-1450.

MOD – The *Modifier (MOD) Field* states any code that must be filed with a modifier in addition to a CPT®/HCPCS Code.

Required Revenue Code(s) - The *Required Revenue Code(s) Field* is provided so the facility will know exactly what Revenue Codes are eligible to bill BlueCross BlueShield for each CPT®/HCPCS Code. Without the correct Revenue Code and CPT®/HCPCS Codes, BlueCross BlueShield will not accept the claim for consideration of benefits. Incorrectly filed claims may be returned to the provider for correction.

Billing Instructions – The *Billing Instruction Field* explains the requirements to bill the selected CPT®/HCPCS Code. This field also provides an insight as to how BlueCross BlueShield adjudicates the claim.

Service Units (FL46)
In general, report the quantitative measure of service, by revenue category, to or for the patient; such as, the number of accommodation days, visits, miles, pints of blood, units or treatments. Units for related CPT®/HCPCS Codes are to be based on the number of times the service or procedure was performed, as defined by the CPT®/HCPCS Code. Visit codes are not to be reported as units.

Principal Diagnosis Code (FL67)
Depending on your contract, the Principal Diagnosis Code may be required for proper adjudication of an inpatient claim. For specific instructions, see Billing Guidelines (Form Locator 42). If applicable, report the full ICD-9 CM Code that describes the principal diagnosis.

Principal Procedure Code and Date (FL80)
Depending on your contract, the Principal Procedure Code may be required for proper adjudication of an inpatient claim. For specific instructions refer to Billing Guidelines (Form Locator 42). If applicable, report the ICD-9-CM Code for the principal procedure performed during the period covered by the bill and the date that the principal procedure was performed.

Attending Physician (FL82)
Report the name and UPIN Number of the licensed Physician who is expected to certify the Medical Necessity of the services rendered and who is primarily responsible for the patient's care. (If UPIN is NOT available, enter "OTH000" in this field.

K. Specific CMS-1450 Claim Form Billing Guidelines

1. Split and Interim Billing
All services rendered must be reported on the claim. For example, an emergency room revenue code with the related CPT® code cannot be omitted, if in fact the patient received care or was admitted through the emergency room. Such omissions are recoverable by BlueCross BlueShield of Tennessee and if deemed to be intentional, the network contract is subject to cancellation. To correct a claim with a coding error the entire claim must be refiled.

A split bill is appropriate only when requested by BlueCross BlueShield of Tennessee. Split bills are used to reflect covered charges allocated for approved and denied days. Split bills that have not been requested by BlueCross BlueShield of Tennessee are subject to denial or recovery.

Interim bills are claims filed for a portion of a large inpatient hospital stay. All interim billing submitted by a facility is required in no less than (30) thirty-day increments, with the exception of final billing. Any interim bill, with the exception of that associated with final billing, which contains fewer than (30) thirty days is subject to denial or recovery.

Interim bills are identified by the last digit of the Type of Bill code found in field locator #4 on the CMS-1450 Claim form. When billing electronically, the ANSI-837I (Institutional) format must be used.

First Claim	Type of Bill (last digit) =2	11**2** or 12**2**
Continuing Claim	Type of Bill (last digit) =3	11**3** or 12**3**
Last Claim	Type of Bill (last digit) = 4	11**4** or 12**4**

2. Electronic Billing Instruction - For those facilities wishing to submit claims electronically, additional information may be obtained from BlueCross BlueShield of Tennessee e-Commerce. If desired, a copy of the Electronic Billing Format Specifications is available for download on the BlueCross BlueShield Internet Web site, www.bcbst.com, in the "For Providers" – "e-Commerce" section. You may make additional e-Commerce inquiries to:

BlueCross BlueShield of Tennessee, Inc., e-Commerce, 801 Pine Street, Chattanooga, TN. 37402
Phone: 423-755-5717 Fax: 423-752-7523 e-mail Address: ecomm_support@bcbst.com

3. Lesser of Calculation

There are two methodologies for calculating lesser of, the line item level and the claim level. Both represent a lesser of calculation but incorporate a different methodology for calculating each. The lesser of methodology utilized in adjudicating the claim is dependent on the facility's contract in effect on the date the services are rendered. Prior to January 1, 2002, all BlueCross BlueShield of Tennessee Institution Contracts utilized line item lesser of calculation. Effective January 1, 2002, BlueCross BlueShield began offering claim level lesser of language to some acute care facilities at their contract renewal date. Claims processed under facility contracts containing claim level lesser of language are adjudicated using a claim level lesser of calculation. All other claims are adjudicated using a line item lesser of calculation.

Note: In accordance with Medicare anti-fraud statutes at 42 USC 1320 et seq, when Medicare is primary, Providers may not accept secondary payments above the Medicare allowed amounts. This rule overrides any lesser of contractual agreements allowing amounts greater than charges.

Methodologies for calculating lesser of follow:

Line Item Lesser Of Calculation:

In the Line Item Lesser Of Calculation, the lesser of calculation for an inpatient claim is based on a per day methodology. The covered ancillary charges shown on each claim are totaled and divided by the number of total days shown on the claim to calculate an average covered ancillary charge per day. This average covered ancillary charge per day is then added to the actual room charge per day for each service category (defined by each facility's contract) to arrive at a total charge per day for that service category.

The total covered charge per day applicable to each service category is multiplied by total days associated with same and a comparison of total covered charges by service category is made to that of negotiated payment per contract for that same category. The lower of these two amounts is the amount that will be paid on the claim for that service category.

This same methodology is used for the outpatient lesser of calculation when it is applicable. Some outpatient services stand alone and do not receive allocations while others roll to a case or per procedure pricing method. If an outpatient claim has two or more of these cases or per procedure items then the appropriate ancillary lines will be allocated to each, based on a percentage of number of cases/procedures to total. Total covered charges for the case/procedure will then be compared to the negotiated rate for each and the lower of the two amounts is paid.

The following examples show two inpatient scenarios, one is not impacted by lesser of while the other is:

***2 days @ $900**

Not Impacted by Lesser Of						
Days	**Type of Service**	**Charges**	**Allocation**	**Re-allocated**	**Per Diem**	**Reimb.**
2	Medical	$700	$1,533	$2,233	*$1800	$1800
1	ICU	500	767	1,267	1,200	1,200
	Ancillary Charges	2,300				
	Total	$3,500	$2,300	$3,500	$3,000	$3,000

****3 days @ $900**

Impacted by Lesser Of						
Days	**Type of Service**	**Charges**	**Allocation**	**Re-allocated**	**Per Diem**	**Reimb.**
3	Medical	$1,050	$1,875	$2,925	**$2,700	$2,700
1	ICU	500	625	1,125	1,200	1,125
	Ancillary Charges	2,500				
	Total	$4,050	$2,500	$4,050	$3,900	$3,825

Claim Level Lesser Of Calculation:

Acute Care facilities holding contracts with Claim Level Lesser Of language will have claims with dates of services on or after the contract effective date processed according to the following methodology. Claim Level Lesser Of calculation compares the lesser of total charges for Covered Services against the contracted rates outlined in Schedules 1 and 2 of the Institution Contract. If the total covered charges filed on the claim are less than the amounts outlined in the contract, BlueCross BlueShield of Tennessee will allow the lesser of the total covered charges as submitted by the facility. Claims adjudicated using Claim Level Lesser Of Calculation are dependant upon the date of service and the contract in effect at the time of service.

Items excluded from Claim Level Lesser Of Calculation

When calculating the lesser of total covered charges for inpatient or outpatient services, there are three categories of services that are excluded. Examples of these exclusions are listed below:

- Services reimbursed based on a percentage of covered charges, or discount off of charges are not included when calculating Claim Level Lesser Of. Typically, these services include, but are not limited to: Other Diagnostics/Therapeutics or High Cost Drugs.

- Services that are considered incidental, or part of the primary service are not included when calculating Claim Level Lesser Of. Typically these services include, but are not limited to: Drugs incidental to Other Diagnostic Services, Drugs Incidental to Radiology, General Medical/Surgical Supplies or IV Infusion Pumps.

- Services that are identified as non-covered under the Institution Contract, or the member's health care plan are also not included when calculating Claim Level Lesser Of. Typically, these services include but are not limited to: Patient Convenience Items, Admission Kits, or Private Linen Service.

The following examples illustrate Claim Level Lesser Of Calculation for both inpatient and outpatient services.

Note: *The reimbursement amounts contained in these examples are fictitious and for illustration purposes only. Refer to your facility-specific Provider agreement when calculating payment for services rendered.*

In some cases of Claim Level Lesser of Calculation the allowables shown on the Remittance Advice are allocated evenly across all Covered Service lines and will not match the detail in these examples. However, the total allowed dollars illustrated in these examples will be the same.

Inpatient Examples

Example 1: Inpatient services: Allowable using Claim Level Lesser Of Calculation

Units	Type of Service	Charges	Ancillary Allocation	Re-Allocated	Per Diem	Allowed
3	Medical (Rev Code 110)	$100.00	$187.50	$287.50	$270.00	
1	ICU (Rev Code 201)	$50.00	$62.50	$112.50	$120.00	
	Ancillary Charges (Rev Code 250)	$250.00	———	———	———	
Total		**$400.00**		**$400.00**		**$390.00**

In Example 1 the contracted amount is less than the total covered charges.

Example 2: Inpatient services: Claim with services that are reimbursed as a percentage of charge

Units	Type of Service	Charges	Ancillary Allocation	Re-Allocated	Per Diem	Services reimbursed % of charge	Allowed
3	Medical (Rev Code 110)	$100.00	$18.75	$118.75	$270.00	———	↓
1	ICU (Rev Code 201)	$50.00	$6.25	$56.25	$120.00	———	
	Ancillary Charges (Rev Code 250)	$25.00	———	———	———	———	
	Miscellaneous (Rev Code 27X)	$200.00	———	———		$50.00	Excluded from lesser of calculation because reimbursement is based on a percentage of charge (25% of covered charges in this illustration).
Total		**$375.00**		**$175.00**		**$50.00**	**$225.00**

In example 2 the total covered charges are less than the amounts outlined in the contract. Because revenue code 27X is reimbursed based on a percentage of charge, this service is excluded from the Claim Level Lesser Of Calculation.

Example 3: Inpatient services that are identified as non-covered under the facility's contract or the Member's health care plan

Units	Type of Service	Charges	Ancillary Allocation	Re-Allocated	Per Diem	Allowed
3	Medical (Rev Code 110)	$100.00	$18.75	$118.75	$270.00	↓
1	ICU (Rev Code 201)	$50.00	$6.25	$56.25	$120.00	
	Ancillary Charges (Rev code 250)	$25.00	———	———	———	
	Patience Convenience Items (Revenue Code 990)	$20.00	———	———	———	Excluded from lesser of calculation because general patient convenience items are a non-covered service.
Total		**$195.00**		**$175.00**		**$175.00**

In example 3 the total covered charges are less than the amounts outlined in the contract. Revenue code 990 is excluded from the overall calculations because patient convenience items are considered a non-covered service under the facility's contract or the Member's health care plan.

Example 4: Inpatient surgical services reimbursed via per diem

Units	Type of Service	Charges	Ancillary Allocation	Re-Allocated	Per Diem	Services reimbursed % of charge	Allowed
7	Medical (Rev Code 110)	$245.00	$573.27	$818.27	$1,242.50		$818.27
	Ancillary Charges (Rev Code 250)	$165.15					
	Pharmacy-IV Solutions (Rev Code 258)	$13.85					
	Med/Surg Supplies (Rev code 270)	$70.41					
	Med/Surg Supplies-Sterile (Rev Code 272)	$111.82					
	Miscellaneous (Rev Code 27X)	$96.07				$24.01	Excluded from lesser of calculation because reimbursement is based on a percentage of charge (25% of covered charge in this illustration)
	Laboratory (Rev code 300)	$.74					
	Lab-Immunology (Rev Code 302)	$12.07					
	Lab-Hematology (Rev Code 305)	$8.22					
	Lab- bacteriology-microbiology (Rev Code 306)	$3.16					
	Lab-Urology (Rev Code 307)	$4.54					
	Lab- pathological – histology (Rev Code 312)	$12.07					
	Operating room services (Rev Code 360)	$10.04					
	Anesthesia (Rev Code 370)	$76.20					
	Imaging services - ultrasound (Rev Code 402)	$59.50					
	Recovery Room- (Rev Code 710)	$25.50					
Total		**$914.34**		**$818.27**		**$24.01**	**$842.28**

In example 4 the surgical per diem outlined in the contract is greater than the facility charges. Because revenue code 27X is reimbursed based on a percentage of covered charge, this service is excluded from the Claim Level Lesser Of Calculation.

Outpatient Examples

Example 1: Services reimbursed as a percentage of charge (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
300	81000	$.50	$.60
300	82565	$5.00	$6.00
320	71020	$5.00	$4.00
420	N/A	$5.00	25% of covered charges

Example 1: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
300	81000	$.50	$.60		The total charges for these three services are less than the contracted amounts. Therefore, reimbursement is based on the lesser of total covered charges.
300	82565	$5.00	$6.00		
320	71020	$5.00	$4.00		
Sub total		**$10.50**	**$10.60**	**$10.50**	
420	N/A	$5.00	$1.25	$1.25	Excluded from lesser of calculation because reimbursement is based on a percent of covered charge.
Totals		**$15.50**	**$11.85**	**$11.75**	

Example 2: Procedures considered part of the primary service (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
300	81000	$1.50	$.70
300	82565	$5.00	$7.50
250	N/A	$5.00	25% of covered charges
261	N/A	$5.00	Not paid in addition to primary service.

Example 2: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
300	81000	$1.50	$.70		The total charges for these two services are less than the contracted amounts. Therefore, reimbursement is based on the lesser of total covered charges.
300	82565	$5.00	$7.50		
Sub Total		**$6.50**	**$8.20**	**$6.50**	
250	N/A	$5.00	$1.25	$1.25	Excluded from lesser of calculation because reimbursement is based on a percent of covered charge.
261	N/A	$5.00	$0.00	$0.00	Excluded from lesser of calculation because is not paid in addition to the primary service.
Totals		**$16.50**	**$9.45**	**$7.75**	

In example 2 revenue code 250 is excluded when calculating Claim Level Lesser Of as it is reimbursed on a percentage of covered charges. Revenue code 261 is also not included in the calculation because it is not paid in addition to the primary service.

Example 3: Services that are identified as non-covered under the facility's contract or the Member's health care plan (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
300	81000	$.50	$.60
300	82565	$5.00	$6.00
320	71020	$5.00	$4.00
990	N/A	$5.00	General patient convenience items are non-covered services.

Example 3: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
300	81000	$.50	$.60		The total charges for these three services are less than the contracted amounts. Therefore, reimbursement is based on the lesser of total covered charges.
300	82565	$5.00	$6.00		
320	71020	$5.00	$4.00	▼	
Sub Total		**$10.50**	**$10.60**	**$10.50**	
990	N/A	$5.00	$0.00	$0.00	Excluded from lesser of calculation because general patient convenience items are a non-covered service.
Totals		**$15.50**	**$10.60**	**$10.50**	

In example 3 revenue code 990 is excluded from the overall calculations because patient convenience items are considered a non-covered service under the facility's contract or the Member's health care plan. When this type of service is billed, the charges are excluded when the claim is processed.

Example 4: Claim billed with both Surgery and ER services (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
300	81000	$.50	Allocated to All inclusive service
300	82565	$5.00	Allocated to All inclusive service
320	71020	$5.00	Allocated to All inclusive service
360	15261	$80.00	$100.00
450	99283	$20.00	$30.00
230	N/A	$12.50	Not a Contracted service
981	99283	$5.00	Not a contracted service. The facility contract outlines eligible ER revenue codes.

Example 4: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
300	81000	$.50	$0.00		The total charges for all five of these services are less than the contracted amounts. Therefore, reimbursement is based on the lesser of total covered charges.
300	82565	$5.00	$0.00		
320	71020	$5.00	$0.00		
360	15261	$80.00	$100.00		
450	99283	$20.00	$30.00		
Sub Total		**$110.50**	**$130.00**	**$110.50**	
230	N/A	$12.50	$0.00	$0.00	Excluded from lesser of calculation because is not a contracted service.
981	99283	$5.00	$0.00	$0.00	Excluded from lesser of calculation because is not a contracted service. The contract outlines eligible ER revenue codes.
Totals		**$128.00**	**$130.00**	**$110.50**	

In Example 4 the same Emergency Room CPT® code was billed with different revenue codes. The facility's contract identifies the revenue codes that are to be used in conjunction with ER CPT® codes. In this example, revenue code 981 is not a contracted service.

Example 5: Multiple and Bilateral Surgeries (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
250	N/A	$120.00	Allocated to All inclusive service
270	N/A	$80.00	Allocated to All inclusive service
360	58180	$185.00	$282.06
360	10081-50 (50 modifier)	$212.50	Contract rate is $95.19 ($126.93 * 150% / 2). This is a secondary bilateral procedure.

Example 5: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
250	N/A	$120.00	$0.00		In this example, the contracted amounts were less than the total billed charges. Therefore, the reimbursement was based on the contracted amounts.
270	N/A	$80.00	$0.00		
360	58180	$185.00	$282.06		
360	10081-50 (50 modifier)	$212.50	$95.19		
Sub Total		**$597.50**	**$377.25**	**$377.25**	
Total		**$597.50**	**$377.25**	**$377.25**	

In example 5 the final allowable was based on the contracted amounts rather than the total billed charges.

Example 6: Outpatient Case Rates service with ancillaries (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
250	N/A	$.35	Allocated to All inclusive service
320	73070	$9.75	Allocated to All inclusive service
450	99283	$12.25	$22.35

Example 6: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
250	N/A	$.35	$0.00		In this example, the contracted amount for CPT® 99283 was equal to the total billed charges. Therefore, the reimbursement was based on the contracted amount.
320	73070	$9.75	$0.00		
450	99283	$12.25	$22.35		
Sub Total		**$22.35**	**$22.35**	**$22.35**	

Example 7: Outpatient services with no Case Rates (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
255	N/A	$28.62	Not paid in addition to primary service.
310	83305	$19.07	$18.42
310	88313	$9.54	$17.36
310	88311	$3.47	$.67
311	88180	$34.52	$14.08
352	74160	$123.60	$42.55
352	72193	$83.07	$42.55

Example 7: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
255	N/A	$28.62	$0.00	$0.00	Excluded from lesser of calculation because is not paid in addition to the primary service.
310	83305	$19.07	$18.42		In this example, the contracted amounts were less than the total billed charges. Therefore, the reimbursement was based on the contracted amounts.
310	88313	$9.54	$17.36		
310	88311	$3.47	$.67		
311	88180	$34.52	$14.08		
352	74160	$123.60	$42.55		
352	72193	$83.07	$42.55		
Sub Total		**$273.27**	**$135.63**	**$135.63**	
Total		**$301.89**	**$135.63**	**$135.63**	

In example 7 revenue code 255 is excluded from the lesser of calculation because this is not paid in addition to the primary service. The remaining eligible charges were greater than the amounts allowed under the facility's contract. Therefore, the reimbursement was based on the contracted rates.

Example 8: Case Rate with Observation (OBS) (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charge	Contracted Amount
250	N/A	$22.54	$0.00
258	N/A	$2.77	$0.00
270	N/A	$9.53	$0.00
272	N/A	$54.39	$0.00
300	G0001	$.80	$0.00
301	80048	$6.60	$0.00
305	85027	$2.50	$0.00
481	93510	$273.50	$291.50
480	93556	$65.90	$0.00
480	93555	$43.40	$0.00
480	93545	$7.00	$0.00
480	93543	$6.60	$0.00
622	N/A	$33.94	$0.00
730	93005	$10.10	$0.00
732	93012	$15.78	$0.00
762	N/A	$37.60	$133.40

Example 8: Final allowable using Claim Level Lesser Of Calculation Example

Revenue Code	HCPCS/CPT® Code	Charge	Contracted Amount	Allowed	Comments
250	N/A	$22.54	$0.00		Included in Case Rate
258	N/A	$2.77	$0.00		Included in Case Rate
270	N/A	$9.53	$0.00		Included in Case Rate
272	N/A	$54.39	$0.00		Included in Case Rate
300	G0001	$.80	$0.00		Included in Case Rate
301	80048	$6.60	$0.00		Included in Case Rate
305	85027	$2.50	$0.00		Included in Case Rate
481	93510	$273.50	$291.50		
480	93556	$65.90	$0.00		Included in Case Rate
480	93555	$43.40	$0.00		Included in Case Rate
480	93545	$7.00	$0.00		Included in Case Rate
480	93543	$6.60	$0.00		Included in Case Rate
622	N/A	$33.94	$0.00		Included in Case Rate
730	93005	$10.10	$0.00		Included in Case Rate
732	93012	$15.78	$0.00		Included in Case Rate
762	N/A	$37.60	$133.40		In this example, the contracted amounts were less than the total billed charges. Therefore, the reimbursement was based on the contracted amounts.
Total		**$592.95**	**$424.90**	**$424.90**	

In Example 8 the charges were greater than the amounts allowed under the facility's contract. Therefore, the reimbursement was based on the contracted rates.

Example 9: Multiple Surgeries filed on the claim form (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
360	10061	$120.00	$80.00
360	10120-51 (51 Modifier)	$60.00	$40.00

Example 9: Final allowable using Claim Level Lesser Of Calculation Example

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
360	10061	$120.00	$80.00		In this example, the contracted amounts were less than the total billed charges. Therefore, the reimbursement was based on the contracted amounts.
360	10120-51 (51 Modifier)	$60.00	$40.00	▼	
Sub Total		**$180.00**	**$120.00**	**$120.00**	
Total		**$180.00**	**$120.00**	**$120.00**	

In example 9 multiple surgeries were filed on the same claim form. When multiple surgeries are filed, the CPT® code with the highest allowable is paid at 100% of the allowable. The CPT® code(s) with the lower allowable is paid at 50% of the allowable.

Example 10: Physical Therapy Services billed with Observation charges (1st Grid details facility's claim submission).

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount
250	N/A	$15.73	$0.00
258	N/A	$5.54	$0.00
272	N/A	$8.64	$0.00
300	G0001	$1.49	$0.00
301	80048	$19.80	$0.00
301	80061	$12.59	$0.00
301	82550	$4.49	$0.00
301	82553	$8.88	$0.00
301	83735	$4.88	$0.00
305	85027	$5.46	$0.00
320	71010	$8.40	$0.00
420	N/A	$8.50	$0.00
480	93556	$32.90	$0.00
730	93005	$40.40	$0.00
762	N/A	$28.60	$137.88

Example 10: Final allowable using Claim Level Lesser Of Calculation

Revenue Code	HCPCS/CPT® Code	Charges	Contracted Amount	Allowed	Comments
250	N/A	$15.73	$0.00		Included in Case Rate
258	N/A	$5.54	$0.00		Included in Case Rate
272	N/A	$8.64	$0.00		Included in Case Rate
300	G0001	$1.49	$0.00		Included in Case Rate
301	80048	$19.80	$0.00		Included in Case Rate
301	80061	$12.59	$0.00		Included in Case Rate
301	82550	$4.49	$0.00		Included in Case Rate
301	82553	$8.88	$0.00		Included in Case Rate
301	83735	$4.88	$0.00		Included in Case Rate
305	85027	$5.46	$0.00		Included in Case Rate
320	71010	$8.40	$0.00		Included in Case Rate
420 (Physical Therapy)	N/A	$8.50	$0.00		Included in Case Rate
480	93556	$32.90	$0.00		Included in Case Rate
730	93005	$40.40	$0.00		Included in Case Rate
762	N/A	$28.60	$137.88		In this example, the contracted amounts were less than the total billed charges. Therefore, the reimbursement was based on the contracted amount.
Sub-Total		**$206.30**	**$137.88**	**$137.88**	
Total		$206.30	$137.88	$137.88	

In example 10 physical therapy and other ancillary charges are billed in conjunction with Observation charges. Reimbursement for observation services is all-inclusive, therefore separate reimbursement is not provided for physical therapy.

4. Explanation Codes – Explanation Codes are the processing codes found on the Member Explanation of Benefits (EOB) and Provider Remittance Advice. Listed below are a sampling of processing codes and their definitions:

Code	Definition
W01	The maximum amount allowable for this equipment has been reached.
W02	This charge exceeds the Medicare allowable for this service. The member is not responsible for this amount.
W03	Benefits can not be provided until a special review is completed.
W04	The Provider must submit the NDC, drug name, strength, and quantity before benefits can be provided.
W05	The Provider must submit a copy of the manufacturer's invoice for this item before benefits can be provided.
W06	The Provider must submit the operative report or office notes before benefits can be provided.
W07	Provider must submit a procedure code before benefits can be provided.
W08	The information on this claim does not match the medical records submitted.
W09	The Provider has not contracted to provide this service.
W10	This procedure is NOT eligible for benefits when performed in a hospital setting.
WA1	We cannot provide benefits for services that have been determined not to be a standard medical procedure.

5. Diagnosis Related Groups (DRG) Business Rules

The following guidelines apply to all hospitals having DRG contracts with BlueCross BlueShield of Tennessee that participate in Blue Networks K, S and P. These guidelines are not applicable to Blue Network C.

Grouper
BlueCross BlueShield of Tennessee will make DRG assignment via Center for Medicare/Medicaid Services (CMS) Based Grouper purchased from a Third Party Software Vendor. Under normal circumstances, CMS usually makes their changes effective on October 1. BlueCross BlueShield of Tennessee grouper updates are installed no later than ninety (90) days after the CMS effective date.

DRG Payment Application
The DRG assignment will be based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. If CMS changes the DRG assignment criteria, BlueCross BlueShield of Tennessee will comply upon the installation date of the revised grouper. The base rate and relative weights in effect at the admission date are used to calculate the payment level.

Implants and Prosthetics
Implants and prosthetics are not reimbursed separately. Reimbursement for these items is included in the base rate and relative weights that determine the DRG payment.

Regular DRG Payment The formula to calculate the Regular DRG Allowed follows:

Regular DRG Allowed = DRG Relative Weight X Facility Base Rate
Total Payment = Regular DRG Allowed – Deductible and Coinsurance

Outlier Payments
The formula for calculating the Total Allowed Amount for an inpatient stay qualifying as an Outlier Stay is as follows:

Total Allowed Amount = Regular DRG Payment + ((Regular DRG Payment/ ALOS x 70%) x (Approved LOS – Outlier Day Threshold)).

Claim Assumptions			Allowed Calculation	
Admit Date	July 1, 2002		**Normal DRG:**	
Discharge Date	July 18, 2002		Base Rate	$3,992
Authorization Date	July 8, 2002		Relative Weight	1.1120
DRG	014		Normal DRG Allowed	$4,439
DRG (ALOS)	4			
Relative Weight	1.1120		**Outlier:**	
Outlier Threshold	12		Total Outlier Days	6*
Base Rate	$3,992		Outlier Per Diem	$777
Outlier Per Diem	$777		Outlier Allowed	$4,662*
Length of Stay	17		Total Claim Allowed	$9,101*

*Outlier days will be reviewed for Medical Necessity. In order to be eligible for outlier days, facility must contact Utilization Management on Day 8 with clinical information.

Pre-Admission Services
BlueCross BlueShield of Tennessee will not pay separate outpatient claims for pre-admission services performed up to 72 hours before the Member is admitted to inpatient facility that relates to the admission. This includes, without limitation, pre-admission testing, emergency room services that result in the admission, and observation room services that result in the admission. This provision includes only services performed at the same (or related) facility as the admission.

Exclusions from DRG Reimbursement
The following conditions and/or treatments are specifically excluded under the DRG Network Attachment. Facilities intending to provide these services for BlueCross BlueShield of Tennessee Members must execute a separate Network Attachment covering the provision of these services.

MDC or DRG	Description
MDC 19	Mental Disease and Disorders
MDC 20	Alcohol and Drug Use
DRG 103	Heart Transplant
DRG 480	Liver Transplant
DRG 481	Bone Marrow Transplant
DRG 495	Lung Transplant

Transfer Payments
BlueCross BlueShield of Tennessee allows a transfer per diem times the number of days not to exceed the amount allowed under the DRG to the transferring hospital. The receiving hospital is reimbursed according to its acute care contract with BlueCross BlueShield of Tennessee. These claims are identified by the “02” discharge status filed on the claim.

Interim Billing
The hospital should only bill BlueCross BlueShield of Tennessee once every thirty (30) days for the same stay. BlueCross BlueShield of Tennessee will not make payment on DRGs 469 or 470. Any interim bill, with the exception of that associated with final billing, which contains fewer than (30) days is subject to denial or recovery.

Split Billing
Unless requested, BlueCross BlueShield of Tennessee does not accept split billing. As outlined under the payment application, the base rates and relative weights in effect at the time of admission determine payment. This applies to:

- transition to the DRG reimbursement methodology,
- other changes affecting the rates for the agreement, and
- eligibility changes.

Private Room Differential
The DRG payment is a total payment to include all room and board services provided during the inpatient stay. Private room differentials are considered part of the DRG and are not to be balance billed to any BlueCross BlueShield of Tennessee Member.

Re-admissions
Claims for patients that are re-admitted to the same facility for the same or related diagnosis within a fourteen (14)-day period should be filed as one claim.

Adjusted Claims
To adjust a claim previously filed with BlueCross BlueShield of Tennessee a complete corrected claim must be resubmitted.

Late Charges
BlueCross BlueShield of Tennessee does not accept late charges. To receive consideration for late charges a corrected claim should be resubmitted.

Mother and Newborn
A combined claim is required for both mother and newborns. A separate DRG payment will not be made for DRG 391 (Normal Newborn) because payment for this claim is combined with the mother's DRG payment.

Bundling/Unbundling of Services
Practitioner services provided by the facility should be filed to BlueCross BlueShield of Tennessee on a CMS-1500 claim form.

Relative Weight Revisions
Relative weights are updated according to one of two schedules for revisions. To determine which schedule you are on refer to your contract.

Annual Base Rate Adjustments
Base rates are updated annually on January 1of each year in accordance with the contract.

Observation Services
Observation services require prior authorization and must be billed with an outpatient place of service.

Facility and Member Liability

- Revenue codes considered facility liability and may **not** be billed to a BlueCross BlueShield of Tennessee Member under the DRG reimbursement methodology follow:

Facility Liability Revenue Codes			
Revenue Code	**Service**	**Revenue Code**	**Service**
253	Take-home drugs	762	Observation Room
273	Take-home supplies	769	Other Treatment/Observation Room
277	Oxygen-take-home	820	General - Hemodialysis
290	General-DME	821	Hemodialysis/Composite or other Rate
291	Rental-DME	822	Home Supplies
292	Purchase of new DME	823	Home Equipment
293	Purchase of used DME	824	Maintenance/ 100%
294	Supplies/Drugs for DME Effectiveness (Home Health Agency only)	825	Support Services
299	Other Equipment	829	Other Outpatient hemodialysis
500	General - Outpatient Services	830	General - Peritoneal Dialysis Outpatient
509	General - Outpatient Services	831	Peritoneal/composite or other Rate
510	General Clinic	832	Home supplies
511	Chronic Pain Center	833	Home Equipment
512	Dental Clinic	834	Maintenance/FPDI Facility; Pertoneal Dialysis Inpatient 100%

Facility Liability Revenue Codes			
Revenue Code	**Service**	**Revenue Code**	**Service**
513	Psychiatric Clinic	835	Support Services
514	OB-GYN Clinic	839	Other Outpatient Peritoneal Dialysis
515	Pediatric Clinic	840	General - CAPD Dialysis Outpatient or Home
516	Urgent Care Clinic	841	CAPD/Composite or other Rate
517	Family Practice Clinic	842	Home supplies
519	Other Clinic	843	Home equipment
520	General -Freestanding Clinic	845	Revenue code not valid for place of service inpatient, outpatient is noncontracted
521	Rural health-clinic	848	Maintenance 100%
522	Rural health-home	849	Other Outpatient CAPD
523	Family practice	850	General - CCPD Dialysis Outpatient or Home
526	Urgent Care Clinic	851	CCPD/Composite or other Rate
529	Other Freestanding Clinic	852	Home supplies
530	General - Osteopathic Services	853	Home equipment
531	Osteopathic Therapy	854	Maintenance 100%
539	Other Osteopathic Services	855	Support Services
550	General - Skilled Nursing	859	Other Outpatient
551	Visit Charge	882	Home Dialysis aid visit
552	Hourly charge	890	Other Donor Bank
559	Other Skilled Nursing	891	Organ Donor Bank- Bone
560	General - Medical Social Services	892	Organ Donor Bank- organ other than kidney
561	Visit Charge	893	Other Donor Bank-Skin
562	Hourly Charge	899	Other Donor Bank-Other Donor Bank
569	Other Med. Social Services	900	General - Psychiatric/Psychological Treatments
570	General - Home health Aide (Home Health)	901	Electroshock Treatment
571	Visit Charge	902	Milieu therapy
572	Hourly Charge	903	Play Therapy
579	Other Home Health Aide	904	Activity therapy
580	General - Other Visits (Home Health)	909	Other
581	Visit Charge	910	General - Psychiatric/Psychological Services
582	Hourly Charge	911	Rehabilitation
589	Other Home Health Visits	912	Partial Hospitalization - Less Intensive

Facility Liability Revenue Codes			
Revenue Code	**Service**	**Revenue Code**	**Service**
590	General - Units of Service (Home Health)	913	Partial Hospitalization - Intensive
599	Home Health Other Units	914	Individual therapy
600	General - Oxygen (Home Health)	915	Group Therapy
601	Oxygen-State/Equip/Suppl/or Cont	916	Family therapy
602	Oxygen-State/Equip/Suppl/ under 1 LPM	917	Bio Feedback
603	Oxygen-State/Equip/Over 4 LPM	918	Testing
604	Oxygen-Portable Add-on	919	Other
609	Other Oxygen	941	Recreational Therapy
613	Reserved	944	Drug Rehab
617	Reserved	945	Alcohol Rehab
640	General - Home IV Therapy Services	960	General - Professional Fees
641	Nonroutine Nursing, Central Line	961	Psychiatric
642	IV Site Care, Central Line	962	Ophthalmology
643	IV Start/Change, Peripheral Line	963	Anesthesiologist (MD)
644	Nonroutine Nursing, Peripheral Line	964	Anesthetist (CRNA)
645	Training Patient/Caregiver, Central Line	969	Other Professional Fees
646	Training Disable Patient Central Line	971	Laboratory
647	Training, Patient/Caregiver, Peripheral Line	972	Radiology - Diagnostic
648	Training, Disable patient, Peripheral Line	973	Radiology - Therapeutic
649	Other IV therapy services	974	Radiology - Nuclear Medicine
650	General - Hospice Services	975	Operating Room
651	Routine Home Care	976	Respiratory Therapy
652	Continuous Home Care	977	Physical Therapy
653	Reserved	978	Occupational Therapy
654	Reserved	979	Speech Pathology
655	Inpatient Respite Care	980	General - Professional Fees
656	General Inpatient Care (non-respite)	981	Emergency Room
657	Physician Services	982	Outpatient Services
659	Other Hospice	983	Clinic
660	General - Respite Care (HHA Only)	984	Medical Social Services
661	Hourly Charge/Skilled Nursing	985	EKG
662	Hourly Charge/Home Health Aide/Homemaker	986	EEG
669	Other Respite Care	987	Hospital Visit
760	General - Treatment/Observation Services	988	Consultation
761	Treatment Room	989	Private Duty Nurse

- Revenue codes considered Member liability and may be billed to a BlueCross BlueShield of Tennessee Member follow:

Member Liability Revenue Codes	
Revenue Code	**Service**
624	FDA Investigational Devices (requires Member consent)
990	General - Patient Convenience Items
991	Cafeteria/Guest tray
992	Private Linen Service
993	Telephone/Telegraph
994	TV/Radio
995	Non patient Room Rentals
996	Late Discharge Charge
997	Admission Kits
998	Beauty Shop/Barber
999	Other Patient Convenience Items

Kidney Transplants
Kidney transplants, DRG 302, are reimbursed under BlueCross BlueShield of Tennessee's DRG agreement.

Kidney Transplants will be assigned to DRG 302, Kidney Transplant. Every participating hospital is contracted for both the DRG and the Organ Acquisition Cost. The Schedule of Payments in the contract contains the Relative Weight, Base Rate, and Outlier Per-Diem for DRG 302. Organ Acquisition Cost has been included in the relative weight and is reimbursed through the DRG payment. Organ Acquisition Cost as defined below are the responsibility of the Transplant hospital.

Note: *For Blue Network C, Kidney Transplants are reimbursed a case rate. The case rate is all-inclusive and represents payment for the transplant and related services. Rules and definitions in regards to the Organ Acquisition Cost apply to the BlueClassic Kidney Transplant case rate.*

Administrative and Payment Policies in regards to Kidney Transplants are:

- Requires prior authorization and must be within BlueCross BlueShield of Tennessee Utilization Management Guidelines.

- The claim should be filed in accordance with the Tennessee Uniform Billing Guidelines.

- Organ acquisition costs, which are billed by other Providers to and subsequently paid by BlueCross BlueShield of Tennessee will be accumulated by BlueCross BlueShield of Tennessee and deducted from the DRG payment to the transplant hospital via BlueCross BlueShield of Tennessee's retrospective audit process.

- Practitioner costs associated with organ acquisition cost are not included in the definition of organ acquisition cost and are to be billed separately to BlueCross BlueShield of Tennessee on a CMS-1500/ANSI-837P.

- Organ Acquisition Costs Include:

  Living Donor:
  - Kidney recipient registration fees
  - Laboratory test (including tissue typing of recipient and donor)
  - Hospital services that are directly related to the excision of the kidney

  Cadaver Kidneys:
  - Operating room services
  - Intensive care cost
  - Preservation supplies (perfusion materials and equipment)
  - Preservation technician's services
  - Transportation cost
  - Tissue typing of the cadaver organ

- The lesser of total covered charges or DRG allowed adjusted for deductible and coinsurance represents payment for the transplant including the organ acquisition cost.

- Hospitals not contracted under a DRG reimbursement methodology need to contact BlueCross BlueShield of Tennessee to negotiate a single patient agreement prior to providing services to a BlueCross BlueShield of Tennessee Member.

6. Reimbursement Guidelines for Inpatient Services Based on Admission Date **(eff. 1/1/02)**

Effective for dates of service January 1, 2002, and after BlueCross BlueShield of Tennessee updated its reimbursement policy for inpatient facilities participating in Blue Networks C, P, S and K. These facilities were transitioned to a reimbursement methodology based on the *earliest agreement date*.

For these providers, reimbursement for inpatient services will be based on the contracted rates in effect at the time of admission. The contracted rates in effect on the admit date will be used in calculating payment for the entire stay. In some instances, a patient's admission date may span multiple provider agreements. In this situation, charges for all approved days will still be reimbursed based on the rates that were in effect on the date of admission and will remain in effect until the patient's discharged.

The grid below lists provider types that may be affected by this methodology. Please refer to your specific contract in effect on the date of the patient's admission to determine applicable reimbursement rates.

Provider's affected by Earliest Agreement Date
Acute Care Hospital
Freestanding Inpatient Rehabilitation Hospital
Skilled Nursing Facility
Hospice Facility

7. Outpatient Services

a. Observation Services

Observation Services include the use of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to evaluate a patient's condition.

BlueCross BlueShield of Tennessee will consider reimbursement for the following outpatient Observation Services:

- Observation Services for Members who receive urgent necessary treatment that lasts longer than 12 hours but does not require admission;

- Observation Services for Members, who, after six hours of recovery for outpatient services, are not medically stable for discharge, provided an authorization is obtained.

BlueCross BlueShield of Tennessee will not consider reimbursement for the following outpatient Observation Services:

- Observation Services the day before an elective inpatient surgery;

- Inpatient stays which are billed as Observation Services. Those Members who are inpatient must have an authorization within one business day from the date of admission;

- Charges for Observation Services in addition to payment for inpatient services;

- Charges for Observation Services following an outpatient surgical procedure unless authorization is given. On those authorized, Observation Services may not be billed until six hours after surgery. Recovery times up to 6 hours are included in the Outpatient Surgery Global Rates.

- Observation Services billed for convenience such as holding a Member overnight in the hospital if his or her regular post-surgery recovery period ends late at night.

Observation Services require prior authorization, excluding Labor and Delivery. BlueCross BlueShield of Tennessee does not reimburse Labor Room/Delivery services billed under Revenue Code 721 “Labor Room/Delivery – Labor” or 722 “Labor Room / Delivery – Delivery”. These services should be billed under Revenue Code 762 “Treatment or Observation Room – Observation Room”.

BlueCross BlueShield of Tennessee will allow up to 23 hours for the Observation Services if Medically Necessary and Medically Appropriate. Hours billed in excess of 23 hours will not be allowed

Revenue Code	Type of Service	HCPCS/ CPT® Code	Allowed
762	Observation Room	N/A	Allowed at an hourly rate per contract, not to exceed 23 hours.

How to calculate Observation Services

Less than 23 Hour Stay	
Observation Services Maximum Allowed Charge	$900.00
Hourly Rate	$39.13
Total Hours Billed by Facility (1-hour increments)	3
Total Allowed Amount for Revenue Code 762	$117.39

Greater than 23 Hour Stay	
Observation Services Maximum Allowed Charge	$900.00
Hourly Rate	$39.13
Total Hours Billed by Facility (1-hour increments)	30
Total Allowed Amount for Revenue Code 762	$900.00

b. Cardiac Catheterization and Angioplasty Services

Cardiac Catheterization Services
Cardiac Catheterization services are all-inclusive and reimbursement will fully compensate the facility for all Covered Services provided in connection with these services with the exception of outpatient surgery, approved observation services, MRI/CT-Scans, emergency room services, implants, ambulance services, and additional outpatient case rates all of which will be paid in addition to Cardiac Catheterization. Claims billed with multiple contracted codes for Revenue Code 481 may be reviewed for rebundling.

Angioplasty Services
Angioplasty services, including stents, are all-inclusive and reimbursement will fully compensate the facility for all Covered Services provided in connection with these services with the exception of outpatient surgery, approved observation services, MRI/CT-Scans, emergency room services, implants, ambulance services, and additional outpatient case rates all of which will be paid in addition to Angioplasty. Claims billed with multiple contracted codes for revenue code 480 may be reviewed for rebundling.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
480	Angioplasty	Requires a valid HCPCS/CPT® Code	Reimbursement is based upon the contract
481	Cardiac Catherization	Requires a valid HCPCS/CPT® Code	

c. Radiology, Laboratory, Other Diagnostic Procedures and Other Therapeutic Procedures

Radiology Services

Radiology Services include pharmacy, anesthesia, and/or supplies used in conjunction with the radiology procedure. When filed with all-inclusive services, the radiology procedure will be bundled with the all-inclusive service. The Fee Schedule will be allowed when filed separately. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
320	Radiology Diagnostic	Requires a valid HCPCS/CPT® Code.	Reimbursement is based upon the contract. Refer to Radiology Fee Schedule.
321	Angiocardiography		
322	Arthrography		
323	Arteriography		
324	Chest X-ray		
329	Other Radiology Services		
330	Radiology Therapeutic		
333	Radiation Therapy		
350	General Scans		
351	Head Scans		
352	Body Scans		
400	Other Imaging Services		
401	Diagnostic Mammography		
402	Ultrasound		

Laboratory Services

Laboratory Services will be allowed according to the contract unless performed with an all-inclusive service. When filed with an all-inclusive service, the Laboratory Services will be bundled with the all-inclusive service. The Fee Schedule will be allowed when filed separately. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
300	Laboratory	Requires a valid HCPCS/CPT® **Code**.	Reimbursement is based upon the contract. Refer to Laboratory Fee Schedule.
301	Chemistry		
302	Immunology		
304	Non-Routine Dialysis		
305	Hematology		
306	Bacteriology & Microbiology		
307	Urology		
309	Other Laboratory		
310	General		
311	Cytology		
312	Histology		
314	Biopsy		
319	Other		

Other Diagnostic Services - (eff. 8/1/04)

The Other Diagnostic Services will be allowed according to the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
920	Other Diagnostic Services	HCPCS/CPT® Code does not affect reimbursement	Reimbursement is based upon the contract.
921	Peripheral Vascular Lab		See All Other Outpatient Services
922	Electromyelgram		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
923	Pap Smear	HCPCS/CPT® Code does not affect reimbursement	Reimbursement is $0.00
924	Allergy Test		
925	Pregnancy Test		
929	Other Diagnostic Services		

Other Therapeutic Services - (eff. 8/1/04)

Other Therapeutic Services will be allowed according to the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
940	Other Therapeutic Services	HCPCS/CPT® Code does not affect reimbursement	Reimbursement is based upon the contract.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
941	Recreational Therapy	HCPCS/CPT® Code does not affect reimbursement	Reimbursement is $0.00
944	Drug Rehabilitation		
945	Alcohol Rehabilitation		
946	Complex medical equipment - routine		
947	Complex medical equipment - ancillary		
949	Other therapeutic services		

d. MRI/MRA/CT Scan

MRI/MRA/CT Scan reimbursement includes pharmacy, anesthesia, and /or supplies used in conjunction with the Radiology Services. MRI/MRA/CT Scan claims are allowed via a Fee Schedule. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year. These services are allowed in addition to the all-inclusive rate(s).

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
350	General Scans	Requires a valid HCPCS/CPT® Code.	Reimbursement is based upon the contract. Refer to MRI/CT Scan Fee Schedule.
351	Head Scan		
352	Body Scan		
359	Other CT Scan		
610	Magnetic Resonance Technology (MRT)		
611	MRI – Brain (including brainstem)		
612	MRI – Spinal Cord (including spine)		
614	MRI – Other		
621	Supplies incidental to radiology		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
615	MRA – Head and Neck	HCPCS/CPT® Code does not affect reimbursement	Reimbursement is $0.00. See Revenue Code 610 for MRA, and 621 for supplies incidental to radiology services.
616	MRA – Lower Extremities		
618	MRA - Other		
619	MRT – Other		
622	Supplies incidental to other diagnostic services		

e. Outpatient Surgery

Outpatient Surgery is reimbursed based on a Global Rate. This Global Rate is all-inclusive and will fully compensate Facility for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing which is provided up to three (3) days prior to the surgery is included in the all inclusive rate.

When multiple covered procedures are performed on the same day, payment shall be made at 50% of the Global Rate for the second and subsequent procedures, subject to the lesser of provision found in the facility's contract. When a procedure is repeated on the same day, no additional amount will be allowed on the second procedure.

Bilateral procedures are to be filed on a single line item using the most appropriate CPT® code with modifier 50. They are to be reported using one (1) unit. Bilateral procedures are considered as one service.

Primary bilateral procedures are considered for reimbursement at 150% of the Global Rate, subject to the lesser of provision found in the facility's contract. Secondary or subsequent bilateral procedures are considered for reimbursement based upon 75% of the Global Rate, subject to lesser of provision found in the facility's contract.

Outpatient Surgery Groupings are defined in the applicable Schedule in the contract. All procedures performed in an Outpatient Surgery setting and not shown in the applicable Schedule in the contract will be assigned to an Outpatient Surgery Grouping for payment by BlueCross BlueShield of Tennessee. Rebundling of charges will occur when appropriate.

Revenue Codes 360, 490 and 499 are only to be billed when the surgery service is rendered in the Operating Room. BlueCross BlueShield of Tennessee will assign the code to an Outpatient Surgery Grouping when applicable. The outpatient surgery is considered to be an all- inclusive service. Rebundling of charges will occur when appropriate.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
360	Operating Room Services	Requires a valid CPT® Code.	Will reimburse under Group 0 through Group 10
Revenue Code	**Type of Service**	**HCPCS/CPT® Code**	**Allowed**
490	Ambulatory Surgical Care	Requires a valid CPT® Code.	Will reimburse under Group 0 through Group 10
Revenue Code	**Type of Service**	**HCPCS/CPT® Code**	**Allowed**
499	Other Ambulatory Surgical Care	Requires a valid CPT® Code.	Will reimburse under Group 0 through Group 10

f. Minor Surgery

Minor Surgery Codes are outpatient surgery codes that according to Medicare or BlueCross BlueShield of Tennessee's medical staff should be performed in a Physician office setting. These codes have been assigned to Group 0. The agreed upon Maximum Allowed between the Facility and BlueCross BlueShield of Tennessee is $0.00. BlueCross BlueShield of Tennessee will not make any payment for the supplies or room charges when these procedures are performed in the facility.

If a minor surgery (Revenue Code 361) is performed in conjunction with an all-inclusive service, the minor surgery will bundle to the all-inclusive service. If an all-inclusive service is not billed on a claim then the line item will disallow.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
361	Minor Surgery	Requires a valid HCPCS/CPT® Code	Reimbursement is based upon the contract.

g. Emergency Room Services:

Emergency room services for an emergency condition do not require prior authorization. However, if the Member is admitted to the hospital as inpatient from the emergency room, the facility is required to obtain an authorization within 24 hours or the next business day of the date of admission. These claims will be reimbursed an all-inclusive negotiated case rate or covered charges, subject to the lesser of provision found in the facility's contract.

h. Prosthetic/Orthotic Devices

Prosthetic and Orthotic devices must be billed with an appropriate HCPCS code under Revenue Code 274. Facilities that bill BlueCross BlueShield of Tennessee in excess of the contracted amount are subject to recovery.

i. Pacemaker & Implants

Facilities that bill BlueCross BlueShield of Tennessee in excess of the contracted amount are subject to recovery. Likewise, hospitals that can not support a charge for a Pacemaker or Implant with a manufacturer's invoice, or other documentation, meeting BlueCross BlueShield of Tennessee satisfaction verifying the cost and a medical record indicating that it was provided to a BlueCross BlueShield of Tennessee Member are subject to recovery.

j. Clinic Visits

BlueCross BlueShield of Tennessee does not make payment for the clinic revenue codes. BlueCross BlueShield of Tennessee will allow other eligible services based on the contracted rate or covered charges, whichever is less when filed in conjunction with clinic visits.

k. Wound Care Services

BlueCross BlueShield of Tennessee may reimburse Wound Care services if they have been contracted. Wound Care services ***will not*** be reimbursed if they have not been contracted.

Wound Care services must be performed by a certified wound care nurse or other qualified health care professional. The services must meet the clinical criteria outlined in BlueCross BlueShield of Tennessee's *Wound Care Utilization Management Guidelines for Home Health & Outpatient*. In an acute care setting, and in accordance to the Current Procedural Terminology (CPT®) 2004 Standard Edition codebook, these services may be classified into one of the following categories for billing:

New Patient

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

1. A problem focused history
2. A problem focused examination; and
3. Straightforward medical decision-making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problems are self limited or minor. The Health Care Professional typically spends 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

1. An expanded problem focused history;
2. An expanded problem focused examination; and
3. Straightforward medical decision-making.

Counseling and/or coordination of care with other Providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. The Health Care Professional typically spends 20 minutes face-to-face with the patient and/or family.
99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

1. A detailed history
2. A detailed examination; and
3. Medical decision making of low complexity.

Counseling and/or coordination of care with other Providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs

Usually, the presenting problem(s) are of moderate severity. The Health Care Professional typically spends 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

1. A comprehensive history
2. A comprehensive examination; and
3. Medical decision-making of moderate complexity.

Counseling and/or coordination of care with other Providers or agencies are provided consistent with the nature of the problems(s) and the patient's and/or family needs.

Usually, the presenting problem(s) are of moderate to high severity. The Health Care Professional typically spends 45 minutes face-to face with the patient and /or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

1. A comprehensive history
2. A comprehensive examination and
3. Medical decision-making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. The Health Care Professional typically spends 60 minutes face-to-face with the patient and/or family.

Established Patient

99211 Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a Practitioner. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following key components:

1. A problem focused history;
2. A problem focused examination; or
3. Straightforward medical decision-making.

Counseling and/or coordination of care with other Providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. The Health Care Professional typically spends 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following key components:

1. An expanded problem focused history;
2. An expanded problem focused examination; or
3. Medical decision-making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. The Health Care Professional typically spends 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following key components:

1. A detailed history;
2. A detailed examination; or
3. Medical decision-making of moderate complexity.

Counseling and/or coordination of care with other Providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. The Health Care Professional typically spends 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following key components:

1. A comprehensive history;
2. A comprehensive examination; or
3. Medical decision-making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. The Health Care Professional typically spends 40 minutes face-to-face with the patient and/or family.

At least one of the HCPCS codes listed in the contract must be billed in Form Locator 44 on the CMS-1450 claim form. HCPCS codes not listed should not be billed. All wound care services should be billed with Revenue Code 519, Other Clinic, in Form Locator 42. Only Wound Care services should be billed under Revenue Code 519. Any Non-Wound Care services billed with Revenue Code 519 are subject to recovery by BlueCross BlueShield of Tennessee.

l. Lithotripsy Services

Lithotripsy will reimburse the contracted rate when billed with Revenue code 790 or 799. Lithotripsy services are all-inclusive services.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
790 799	Lithotripsy	50590	Reimbursement is based upon the contract.

m. Venipuncture

Venipuncture services will be allowed according to the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
300	Venipuncture	Requires a valid HCPCS/CPT® Code	Reimbursement is based upon the contract.

n. Outpatient Revenue Code Treatment

BlueCross BlueShield of Tennessee has three categories of revenue codes that are not paid under the outpatient agreement. Outlined below is a brief description of those codes:

- **Incidental to Acute Service:** Services that are considered part of the contracted rate and not paid in addition to the rate. For example, Revenue Code 235, Incremental Nursing Services would not be paid in addition to a case rate or fee schedule.
- **Invalid/Excluded Revenue Codes:** Revenue codes associated with services not covered under the acute care contract, and those, which are invalid via the revenue, code description.
- **Revenue Codes that Require a More Detailed Revenue Code:** In some cases BlueCross BlueShield of Tennessee requires the detail revenue code in lieu of the general revenue code.

o. Ambulance Services

The ambulance codes are based on those established by Centers for Medicare and Medicaid Services (CMS) codes. These codes are updated April 1 of each year.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
540	General Ground Transport	All Codes listed on the Ambulance Maximum Allowed Fee Schedule.	Reimbursement is based upon the contract.
541	Supplies		
542	Medical Transport		
543	Heart Mobile		
544	Oxygen		
546	Neonatal Ambulance Services		
547	Pharmacy		
548	Telephone Transmission EKG		
549	Other Ambulance		
545	Air Ambulance	A0430 A0431 A0435 A0436	

p. Non-Contracted Services

BlueCross BlueShield of Tennessee has contracted specific outpatient services for each facility network and line of business. In situations where services shown on these contracts have not been contracted, a rate must be negotiated prior to billing those services or reimbursement will be set at zero. In addition, services not included in the contract that would require a separate contract for payment of those services are listed in the table below. For specific information regarding the services listed below or to discuss contracting those services not currently contracted, please call your Provider Relations Representative.

Services

Retail Pharmacy	Home Infusion Therapy	Dialysis
Independent or Outreach Laboratory	Durable Medical Equipment	Sub Acute Care
Clinic Based Services	Skilled Nursing Facilities	
Home Health	Physician Services	
Hospice		

q. Cardiac and Pulmonary Rehabilitation

Effective August 1, 2003, the requirement that all cardiac and pulmonary rehabilitation services be prior authorized to be eligible for payments has been removed for Hospitals and Ambulatory Surgical Facilities participating in Blue Networks C, P, S and K.

Prior Authorization requirements for cardiac and pulmonary rehabilitation services will be driven by the Member's health care benefits plan.

To ensure appropriate payment is made for cardiac and pulmonary rehabilitation services, providers are encouraged to verify available benefits and prior authorization requirements under the member's health care benefits play by calling the Provider Services line at 1-800-934-7141 or via *e-health Services*® on the company Web site, www.bcbst.com. For those health care benefits plans requiring prior authorization penalties will continue to apply for non-compliance.

r. Endoscopic Gastrointestinal Procedures

Revenue Code 750 indicates Endoscopic Gastrointestinal procedures that are performed in the GI Lab and not in an Operating Room. The Endoscopic Gastrointestinal procedure is considered an all-inclusive service. Rebundling of charges will occur when appropriate.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
750 759	Gastrointestinal Services	Requires a valid CPT® Code.	Will reimburse under Group 0 through Group 10

s. All Other Outpatient Services

All other Outpatient Services are defined as those services that cannot be appropriately categorized for reimbursement in other sections within the Outpatient Services in Schedule 2 of the applicable Schedule in the facility's contract and that are approved for reimbursement by BlueCross BlueShield of Tennessee.

The following Revenue Codes will be considered according to the All Other Outpatient Services section of the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
250	Pharmacy	HCPCS/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based upon the contract.
251	Generic Drugs		
252	Non-Generic Drugs		
257	Non-Prescription		
258	IV Solutions		
263	IV Therapy/Drug Supply Delivery		
272	Sterile Supply		
280	Oncology		
289	Other oncology		
331	Radiology/Therapeutic and/or chemotherapy administration		
332	Radiology/Therapeutic/ chemotherapy - oral		
335	Radiology/therapeutic chemotherapy - IV		
370	Anesthesia		
379	Other Anesthesia		
380	Blood		
381	Blood - packed red cells		
382	Blood - whole blood		
383	Blood - plasma		
384	Blood - platelets		
385	Blood - leucocytes		
386	Blood - other components		
387	Blood - other derivatives (Cryopricipitates)		
389	Blood - other blood		
390	Blood storage & processing		
391	Blood storage & processing - blood administration		
399	Blood storage & processing - other blood storage & processing		
410	Respiratory services		
412	Respiratory services - inhalation services		

s. All Other Outpatient Services (cont'd)

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
413*	Respiratory services - Hyperbaric oxygen therapy	HCPCS/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based upon the contract.
419*	Respiratory services - other respiratory services		
420*	Physical therapy		
421*	Physical therapy - visit charge		
422*	Physical therapy - hourly charge		
423*	Physical therapy - group rate		
424*	Physical therapy - evaluation or re-evaluation		
429*	Physical therapy - other physical therapy		
479*	Audiology - other Audiology		
482	Cardiology - stress test		
483	Cardiac Echocardiology		
489	Cardiology - other cardiology		
637	Drugs Requiring Specific Identification - Self-Administrable Drugs		
730	EKG/ECG (Electrocardiogram)		
731	EKG/ECG (Electrocardiogram) - Holter Monitor		
732	EKG/ECG (Electrocardiogram) - Telemetry		
739	EKG/ECG (Electrocardiogram) - Other EKG/ECG		
740	EEG (Electroencephalogram)		
749	EEG (Electroencephalogram) - Other EEG		
770	Preventive Care Services		
771	Vaccine Administration		
779	Other Preventive Care Services		
820	Hemodialysis - Outpatient or Home		
821	Hemodialysis - Hemodialysis/Composite or Other Rate		
829	Hemodialysis - Outpatient or Home - Other Outpatient Hemodialysis		
830	Peritoneal Dialysis - Outpatient or Home		
831	Peritoneal Dialysis - Peritoneal/Composite or Other Rate		
839	Peritoneal Dialysis - Other Outpatient Peritoneal Dialysis		

*Refer to Schedule 2 of facility contract

s. All Other Outpatient Services (cont'd)

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
840	Continuous Ambulatory Peritoneal Dialysis (CAPD)	HCPCS/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based upon the contract.
841	Cont Ambulatory Peritoneal Dialysis-CAPD/Composite or Other Rate		
849	Cont Ambulatory Peritoneal Dialysis (CAPD) - Other Outpatient CAPD		
850	Continuous Cycling Peritoneal Dialysis (CCPD)		
851	Cont Cycling Peritoneal Dialysis - CCPD/Composite or Other Rate		
859	Cont Cycling Peritoneal Dialysis (CCPD) - Other Outpatient CCPD		
880	Miscellaneous Dialysis		
881	Miscellaneous Dialysis - Ultra filtration		
882	Miscellaneous Dialysis - Home Dialysis Aid Visit		
889	Miscellaneous Dialysis - Miscellaneous Dialysis Other		
921	Peripheral Vascular Lab		
922	Electromyelgram		
942	Other Therapeutic Services - Education/Training		

t. Disclaimer

Presence of a fee is not a guarantee the procedure, service, or item will be eligible for reimbursement. Final reimbursement determinations are based on Member eligibility on the date of service, Medical Necessity, applicable Member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BlueCross BlueShield of Tennessee medical policy.

Freestanding Inpatient Rehabilitation hospitals, Freestanding Outpatient Rehabilitation facilities, and Skilled Nursing Facilities should bill BlueCross BlueShield of Tennessee for rendered services on a CMS-1450/ANSI-837I using CMS-1450 National Uniform Billing guidelines. For those providers filing electronic claims, please refer to the Electronic Billing Instructions at the end of this section.

8. Inpatient Rehabilitation

- Inpatient Rehabilitation claims must be billed following the CMS-1450 format.
- Inpatient services must be billed with a Type of Bill 11X in Form Locator 4.

Revenue Code	Description
118	Private Room and Board
128	Semi-Private Room and Board (2 Beds)
138	Semi-Private Room and Board (3 or 4 Beds)
148	Private Deluxe Room and Board
158	Ward Room and Board

When incidental revenue codes are filed, they will be included with the room and board charges and the appropriate per diem rate will be applied.

The appropriate admitting, principal, and subsequent diagnosis codes are to be filed in accordance to the current International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) according to the patient's date(s) of service. Form Locator 67 is reserved for the principal diagnosis code, where as the subsequent diagnosis codes would be indicated in Form Locators 68 through 75. Form Locator 76 is to be used for the admitting diagnosis code.

Prior authorization is required for all inpatient admissions. When obtaining prior authorization for a patient on a ventilator, the Provider must specify authorization is for a vent patient in order to receive the vent per diem.

9. Outpatient Rehabilitation – Not Applicable to Acute Care

Units being billed should be appropriate for each code as described in the "Current Procedural Terminology" (CPT®) and/or in the HCPCS Level II codes for the current year codes.

Outpatient rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:

Type of Bill	Type of Facility
13X	Freestanding Inpatient Rehabilitation Facilities Providing outpatient therapy services
23X	Skilled Nursing Facilities Providing outpatient therapy services
74X or 75X	Freestanding Outpatient Rehabilitation Facilities

The appropriate Revenue Code should be billed according to the following:

Revenue Code	Description
270	General Supplies
413	Hyberbaric oxygen Therapy
42X	Physical Therapy
43X	Occupational Therapy
44X	Speech Therapy
47X	Audiology
51X	Clinic Visit
55X	Skilled Nursing Visit
623	Surgical Dressings

- Only those CPT® and HCPCS codes that are appropriate to bill under the Revenue Codes listed in the previous table will be paid. Codes that are not appropriate to the Revenue Codes billed will be subject to recovery by audit.

- Revenue Code 413, Hyberbaric Oxygen Therapy, can only be billed when Medically Necessary. Unit being billed under Revenue Code 413 should be appropriate for each code as described in the *Current Procedural Terminology* (CPT®) and/or the *HCPCS Level II Codes* for the year of the codes.

- Evaluation and Management (E&M) codes are not reimbursed in addition to Rehabilitation Therapies.

- The following guidelines apply when billing G0128:
  - G0128 cannot be billed with any other codes other than supplies and 99211.
  - G0128 can be billed when a registered nurse provides direct (face to face with the patient) skilled nursing services in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes. The first 5 minutes can be billed with CPT® code 99211.

- G0128 and 99211 can be billed to BlueCross BlueShield of Tennessee only in conjunction with wound care services and must be provided by a certified wound care nurse. Practitioner cannot bill for these codes. All other evaluation and management (E&M) codes for Practitioner are not reimbursed unless wound care services are contracted.
- G0128 cannot be billed when debridement services are performed.

➢ Visit/Unit/Service – Bill in increments of one (1) each time Visit/Unit/Service is performed.

➢ Modalities are limited to:
- A limit of three charged modalities to one specific body area per treatment session should be used as a billing practice.
- Any billing beyond three modalities per body part per treatment session will be subject to review of documentation by BlueCross BlueShield of Tennessee auditors for appropriate billing practice.
- When billing multiple modalities, redundancies of the same CPT® code will also be subject to audit for appropriate billing practice.

10. Skilled Nursing Facility

Skilled Nursing Facility (SNF) claims must be billed on a CMS-1450/ANSI 837I. Inpatient services billed on CMS-1450 claim form must be billed with a Type of Bill 21X or 22X in Form Locator 4. The related levels of care outlined in the Skilled Nursing Fee Schedule must be billed according to the table listed below. Reimbursement for SNF services will be based on the lesser of covered charges or the listed per diem.

Revenue Code	Description
191	Level I ~ Skilled Care
192	Level II ~ Comprehensive Care
193	Level III ~ Complex Care

➢ Outpatient services must be billed with a Type of Bill of 23x in Form Locator 4.
➢ The revenue codes for eligible ancillaries will be combined with the appropriate per diem code. The revenue codes for non-Covered Services will be denied as Member liability.
➢ A participating DME Provider must submit charges/claims for customized wheelchairs.
➢ All other DME/supplies are to be submitted by the Skilled Nursing Facility.
➢ The per diems are all inclusive (excluding customized wheelchairs).

11. Home Health and Private Duty Nursing –

Blue Network K (Effective Jul. 1, 2002)
Blue Network C, S, and P (Effective Feb. 1, 2003)

All Home Health and Private Duty Nursing services should be billed on the CMS-1450 claim form using CMS-1450 Type of Bill 33X. When submitting ANSI-837 electronic claims, the Institutional format must be used.

Home Health visits and Private Duty Nursing services should be billed using the following revenue codes and billing units:

Type of Service	Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Visits	Home Health Agency Physical Therapy	421	Not required	1 unit per visit
	Home Health Agency Occupational Therapy	431	Not required	1 unit per visit
	Home Health Agency Speech Therapy	441	Not required	1 unit per visit
	Home Health Agency Skilled Nursing (RN or LPN)	551	Not required	1 unit per visit
	Home Health Agency Medical Social Services	561	Not required	1 unit per visit
	Home Health Agency Home Health Aide	571	Not required	1 unit per visit
Private Duty Nursing	Private Duty Nursing (RN or LPN)	552	Not required	1 unit per hour
	Private Duty Nursing (Home Health Aide)	572	Not required	1 unit per hour

One unit per hour should be billed for Private Duty Nursing Services. Fractional hours should be rounded to the nearest whole hour (e.g., 1 hour 15 minutes should be rounded to 1 unit, 1 hour 29 minutes should be rounded to 1 unit, 1 hour 30 minutes should be rounded to 2 units, 1 hour 31 minutes should be rounded to 2 units, 1 hour 45 minutes should be rounded to 2 units).

Home Health visits and Private Duty Nursing services not billed with the indicated revenue codes will be rejected or denied. A procedure code may be billed to further identify the service provided, but is not required.

To facilitate claims administration, a separate line item must be billed for each date of service for the services previously indicated.

Supplies on the BlueCross BlueShield of Tennessee Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) manual.

Supplies not billed with the indicated revenue codes and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the BlueCross BlueShield of Tennessee Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health or Private Duty Nursing service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit or Private Duty Nursing service are the responsibility of the Home Health Agency.

Supplies not used in conjunction with a Home Health visit or Private Duty Nursing services are not billable by the Home Health Agency or Private Duty Nursing provider.

The only supplies that may be billed in addition to the above services are those indicated on the following BlueCross BlueShield of Tennessee Home Health Agency Non-Routine Supply List.

The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 270:

A4212 A4330 A4354 A4368 A4383 A4397 A4413 A4427 A4626 A5081 A7501 A7524 T4527
A4248 A4331 A4355 A4369 A4384 A4398 A4414 A4428 A5051 A5082 A7502 A7526 T4528
A4310 A4333 A4356 A4371 A4385 A4399 A4415 A4429 A5052 A5093 A7503 A7527 T4529
A4311 A4334 A4357 A4372 A4387 A4400 A4416 A4430 A5053 A5102 A7504 K0614 T4530
A4312 A4338 A4358 A4373 A4388 A4404 A4417 A4431 A5054 A5105 A7505 K0620 T4531
A4313 A4340 A4359 A4375 A4389 A4405 A4418 A4432 A5055 A5112 A7506 S8185 T4532
A4314 A4344 A4361 A4376 A4390 A4406 A4419 A4433 A5061 A5113 A7507 S8210 T4533
A4315 A4346 A4362 A4377 A4391 A4407 A4420 A4434 A5120 A5114 A7508 T4521 T4534
A4316 A4348 A4363 A4378 A4392 A4408 A4422 A4455 A5062 A5121 A7509 T4522 T4535
A4320 A4349 A4364 A4379 A4393 A4409 A4423 A4462 A5063 A5122 A7520 T4523 T4537
A4321 A4351 A4365 A4380 A4394 A4410 A4424 A4481 A5071 A5126 A7521 T4524 T4540
A4326 A4352 A4366 A4381 A4395 A4411 A4425 A4623 A5072 A5131 A7522 T4525 T4541
A4328 A4353 A4367 A4382 A4396 A4412 A4426 A4625 A5073 A7045 A7523 T4526 T4542

The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 623:

A6010 A6202 A6219 A6236 A6252 A6406 A6451
A6011 A6203 A6220 A6237 A6253 A6407 A6452
A6020 A6204 A6221 A6238 A6254 A6410 A6453
A6021 A6205 A6222 A6239 A6255 A6440 A6454
A6022 A6206 A6223 A6240 A6256 A6441 A6455
A6023 A6207 A6224 A6241 A6258 A6442 A6457
A6024 A6208 A6228 A6242 A6259 A6443 A6456
A6154 A6209 A6229 A6243 A6261 A6444 A7040
A6196 A6210 A6230 A6244 A6262 A6445 A7041
A6197 A6211 A6231 A6245 A6266 A6446 A7043
A6198 A6212 A6232 A6246 A6402 A6447
A6199 A6213 A6233 A6247 A6403 A6448
A6200 A6214 A6234 A6248 A6404 A6449
A6201 A6215 A6235 A6251 A6405 A6450
A6199 A6213 A6233 A6247 A6403 A6448
A6200 A6214 A6234 A6248 A6404 A6449

12. Home Obstetrical Management –

Blue Network K (Effective Jul. 1, 2001)
Blue Networks C, S, and P (Effective Feb. 1, 2003)

All Home Obstetrical Management services should be billed on the CMS-1450 claim form using Type of Bill 33X. When submitting ANSI-837 electronic claims, the Institutional format must be used.

Home Obstetrical Management services must be billed using the following revenue codes, procedure codes, and billing units:

Description	Revenue Code	Procedure Code	Billing Unit
Home management of preterm labor	559	S9208	1 unit per day
Home management of gestational hypertension	559	S9211	1 unit per day
Home management of preeclampsia	559	S9213	1 unit per day
Home management of gestational diabetes	559	S9214	1 unit per day

Home Obstetrical Management services not billed with the indicated revenue codes **and** procedure codes will be rejected or denied. To facilitate claims administration, a separate line item must be billed for each date of service for the above services.

The maximum allowable for Home Obstetrical Management services per diems constitutes full reimbursement for all administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment.

The per diem does not include home health agency skilled nursing (RN or LPN) visits. Home health agency skilled nursing (RN or LPN) visits should be billed in accordance with the BlueCross BlueShield of Tennessee Home Health Billing Guidelines.

13. Dialysis

- **Composite Rate** – BlueCross BlueShield of Tennessee allows the lesser of covered charges or a percentage of all-inclusive composite rates negotiated in the contract. Except where specifically noted in the contract, the composite rate includes all services, drugs, and supplies associated with dialysis, dialysis training, or a combination of dialysis and training.

  Form locators related to the composite rate should be completed on the CMS-1450 as described in the following table. Use ANSI-837-I when submitting electronic claims.

Service	Revenue Code FL 42	Unit/ Frequency FL 46	Composite Rate FL 47
Hemodialysis - Composite or Other Rate	821	Per Visit	Composite Rate
Peritoneal Dialysis - Composite or Other Rate	831	Per Visit	Composite Rate
CAPD - Composite or Other Rate	841	Per Visit	Composite Rate
CCPD - Composite or Other Rate	851	Per Visit	Composite Rate

- **No Shows** – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started (the patient never arrives), no payment is made. The composite rate should only be billed to BlueCross BlueShield of Tennessee or the Member when an actual dialysis treatment has been performed.

Home Supplies & Equipment – Home supplies and equipment listed in the contract may be billed to BlueCross BlueShield of Tennessee. HCPCS codes are required. Codes not specifically listed in the contract are not allowed and may not be billed to a BlueCross BlueShield of Tennessee Member. Units should be billed in accordance with the Healthcare Common Procedure Coding System (HCPCS). To insure proper payment, the fields on the CMS-1450 claim form should be completed as defined in the following table. Use ANSI-837I when submitting claims electronically.

Supplies & Equipment				
Service	Revenue Code FL 42	HCPCS/ Rates FL 44	Unit/ Frequency FL 46	Total Charge FL 47
Hemodialysis – Home Supplies	822	HCPCS Code	Appropriate	Charge
Hemodialysis – Home Equipment	823	HCPCS Code	Appropriate	Charge
Peritoneal Dialysis – Home Supplies	832	HCPCS Code	Appropriate	Charge
Peritoneal Dialysis – Home Equipment	833	HCPCS Code	Appropriate	Charge
CAPD – Home Supplies	842	HCPCS Code	Appropriate	Charge
CAPD – Home Equipment	843	HCPCS Code	Appropriate	Charge
CCPD – Home Supplies	852	HCPCS Code	Appropriate	Charge
CCPD – Home Equipment	853	HCPCS Code	Appropriate	Charge

- **Erythropoietin (EPO)** – BlueCross BlueShield of Tennessee will allow for EPO to be paid in addition to the composite rate. The appropriate revenue code, 634 or 635 should be billed in FL 42. The HCPCS code associated with the EPO should be included in Field 44. FL 46 should be completed in accordance with Healthcare Common Procedure Coding System (HCPCS). Total charges should be billed in FL 47. Total charges should not exceed the amount agreed to in the contract. Excess amounts are subject to recovery by BlueCross BlueShield of Tennessee.

- **Laboratory, drugs and blood** - BlueCross BlueShield of Tennessee will allow for laboratory, drugs and blood in addition to the composite rate. The relevant CPT® or HCPCS code is required in FL 44. Units should be billed in accordance with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS), whichever is appropriate. The following table defines the revenue codes to which BlueCross BlueShield of Tennessee has the respective fee schedules attached. To adjudicate, the claim should be filed as indicated.

Fee Schedules					
Revenue Code FL 42	**Service**	**Description**	**HCPCS/ Rates FL 44**	**Service/ Units FL 46**	**Total Charges FL 47**
300	Laboratory	General	Fee Schedule	Appropriate	Charges
301	Laboratory	Chemistry	Fee Schedule	Appropriate	Charges
302	Laboratory	Immunology	Fee Schedule	Appropriate	Charges
303	Laboratory	Renal Patient (Home)	Fee Schedule	Appropriate	Charges
304	Laboratory	Non-routine Dialysis	Fee Schedule	Appropriate	Charges
305	Laboratory	Hematology	Fee Schedule	Appropriate	Charges
306	Laboratory	Bacteriology and Microbiology	Fee Schedule	Appropriate	Charges
307	Laboratory	Urology	Fee Schedule	Appropriate	Charges
309	Laboratory	Other	Fee Schedule	Appropriate	Charges
310	Laboratory Pathological	General	Fee Schedule	Appropriate	Charges
311	Laboratory Pathological	Cytology	Fee Schedule	Appropriate	Charges
312	Laboratory Pathological	Histology	Fee Schedule	Appropriate	Charges
314	Laboratory Pathological	Biopsy	Fee Schedule	Appropriate	Charges
319	Laboratory Pathological	Other	Fee Schedule	Appropriate	Charges
390	Blood Storage and Processing	General	Fee Schedule	Appropriate	Charges
391	Blood Storage and Processing	Blood administration	Fee Schedule	Appropriate	Charges

Fee Schedules					
Revenue Code FL 42	**Service**	**Description**	**HCPCS/ Rates FL 44**	**Service/ Units FL 46**	**Total Charges FL 47**
399	Blood Storage and Processing	Other blood storage and processing	Fee Schedule	Appropriate	Charges
636	Drugs Requiring Specific Identification	Drugs Requiring Detailed Coding	Fee Schedule	Appropriate	Charges
380	Blood	General	Fee Schedule	Appropriate	Charges
381	Blood	Packed Red Cells	Fee Schedule	Appropriate	Charges
382	Blood	Whole Blood	Fee Schedule	Appropriate	Charges
383	Blood	Plasma	Fee Schedule	Appropriate	Charges
384	Blood	Platelets	Fee Schedule	Appropriate	Charges
385	Blood	Leukocytes	Fee Schedule	Appropriate	Charges
386	Blood	Other Components	Fee Schedule	Appropriate	Charges
387	Blood	Other Derivatives	Fee Schedule	Appropriate	Charges
389	Blood	Other	Fee Schedule	Appropriate	Charges

- **Member Benefits and Medical Policy** – Presence of a fee is not a guarantee the procedure, service or item will be eligible for reimbursement. Final reimbursement determinations are based on Member eligibility on the date of service, Medical Necessity, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitation, authorization/referral requirements and BlueCross BlueShield of Tennessee Medical Policy.

- **Non-Reimbursable Revenue Codes** – Unless specifically indicated in the contract, BlueCross BlueShield of Tennessee will not reimburse for services billed in addition to the composite rate. In order to administer the contract, BlueCross BlueShield of Tennessee does not utilize the general revenue codes. Detail revenue codes are required.

14. Hospice - **Blue Network K (Effective Jul. 1, 2002)**
Blue Networks C, S, and P (Effective Feb. 1, 2003)

Hospice services must be billed in accordance with BlueCross BlueShield of Tennessee Billing Guidelines:

- Hospice claims must be billed on a CMS-1450/ANSI-837I.

- To facilitate claims administration, a separate line item must be billed for each date of service.

- Inpatient services should be billed with a Type of Bill 82X in Form Locator 4. Outpatient services should be billed with a Type of Bill 81X in Form Locator 4. Hospice claims should be billed with the Hospice provider number referenced in the Network Attachment.

In all cases reimbursement for Hospice services is based on:
- Per diems allowed on a per day, not per visit;
- The lesser of covered charges or maximum allowable Hospice Fee Schedule;

Note: *Charges submitted for non-Covered Services are not eligible for meeting the per diem amount.*

The related levels of care outlined in the Hospice Fee Schedule should be billed according to the table listed below:

Revenue Code	Description/Service
651	Routine Home Care – less than 8 hours of care (1 day = 1 unit)
652	Continuous Home Care Full Rate - 24 hours of care based on an hourly rate. A separate line item must be billed for each date of service using the hours in the unit field
653	Invalid
654	Invalid
655	Inpatient Respite Care – Family member or other caregiver requiring a short relief period (limited to 5 consecutive days)
656	General Inpatient Care – Inpatient stays, which meet general inpatient care criteria.

Providers are contractually obligated to provide service at the agreed upon rates regardless of patient acuity.

Allowed amounts are all-inclusive with the exception of Practitioner services not related to Hospice care. This includes but is not limited to Hospice Practitioner services, drugs, DME, medical supplies, etc. Practitioner services not related to Hospice care are excluded from the Hospice allowed amounts and should be billed to BlueCross BlueShield of Tennessee on a CMS-1500/ANSI-837P.

When a Member is receiving care for Hospice services and is admitted as “Inpatient” for Hospice related care, the assigned Hospice provider is to bill BlueCross BlueShield of Tennessee for the services and will receive the contracted rates for Covered Services. BlueCross BlueShield of Tennessee should not receive any claims from the “Admitting Facility”. It is the responsibility of the Hospice Provider to reimburse the “Admitting Facility”. BlueCross BlueShield of Tennessee reserves the right to audit. (See Section XXIII. Provider Audit Guidelines.)

Presence of a fee is not a guarantee the service will be eligible for reimbursement. Final reimbursement determinations are based on member eligibility on the date of service, medical necessity, applicable Member co-payments, coinsurance, deductibles, benefits plan exclusions/limitations, authorization/referral requirement and BlueCross BlueShield of Tennessee Medical Policy.

L. Provider Overpayment Recovery Policy/Process

Effective for claims paid January 1, 2004, and later, the following guidelines apply to provider recoveries as a result of overpayments:

- Requests for reimbursement of overpayment shall be made no later than eighteen (18) months after the date that BlueCross BlueShield of Tennessee paid the claim submitted by the Provider, except in the case of Provider fraud, in which case no time limit shall apply;
- As for acute care facilities that are currently under contract this eighteen (18) –month limitation shall not apply to recoveries as a result of audits of said acute care facilities. The audit recovery provision for said acute care facilities shall be as provided in the acute care facility’s Institution Agreement until such time as that Institution Agreement renews (“Renewal Date”). For the purposes of this policy, the Renewal Date is defined as the date the initial term of the agreement expires or the anniversary of the one-year continuation period, whichever is later;
- Not withstanding anything to the contrary, BlueCross BlueShield of Tennessee’s review of relevant financial and/or medical records shall not be limited for the time period of eighteen (18) months nor shall BlueCross BlueShield of Tennessee be prohibited to pursue any other available remedy, either at law or in equity.

The following instructs Providers how to read BlueCross BlueShield of Tennessee's Remittance Advice transactions when overpayment recovery activity is reflected:

1. Automatic Overpayment Recovery

- **Auto-recovery adjustment/moneys recovered:** (when full recovery of overpayments is taken from ***current*** BlueCross BlueShield of Tennessee Remittance Advice):

  - If there is a negative amount in the "Amount Paid" column on the remit, this indicates an overpayment adjustment has occurred on the Member's account.

  - For each account that is being adjusted, there will be a second line entry immediately following the adjustment line. This line entry reflects the corrected net amount paid for the claim (adjusted amount subtracted from the original payment).

    Exception: *If the overpayment was the result of 1) payment made to an incorrect provider, 2) a duplicate payment, 3) a claim billed in error, or 4) payment made on an incorrect Member, the negative adjustment line will indicate the recovery and there will* ***not*** *be a second line entry.*

    - The second line entry has the corrected amounts listed in the "Covered Charges", "Provider Contract Adjustment" and "Patient Owes" columns. Please use the corrected amount in these columns to adjust the Member's account accordingly.

    - The explanation code reflected in the "Note" column indicates the reason for the adjustment.

    - On the last page of the Remittance Advice, (bottom of page), the columns are totaled, including any negative adjustments listed on the remit. In the "Amount Paid" column, the amount listed should equal the amount of payments and adjustments listed in the "Remittance Advice Detail".

  Note: *The "Amount Paid" column will not always equal the amount of the check when BlueCross BlueShield of Tennessee recovery amounts are carried from one Remittance Advice to the next.*

It is important that Providers post all negative adjustments to a "payables" account when posting from the remit. By posting to a "payables" account, the provider's records will show funds owed to BlueCross BlueShield of Tennessee. This account can then be adjusted when the moneys are actually recovered by BlueCross BlueShield of Tennessee.

- **Auto-recovery adjustment/credit balance remains:**
  - On the last page of the Remittance Advice, (bottom of page), the columns are totaled, including any negative adjustments listed on the remit. A negative amount in the "Amount Paid" column indicates there were insufficient funds on the remit to recover all the funds owed to BlueCross BlueShield of Tennessee. In this situation, the credit balance will be forwarded to the next remit and deduction will be made from the total payment due the Provider on that remit.

    Note: *If there is a negative amount in the "Amount Paid" column, no check will be issued. However, the Remittance Advice detail should be used to post all Member accounts listed on the remit.*

  - When a credit balance is created, a "Remittance Adjustment" and "Adjustment Details" section will be added to the remit. These sections list any negative balances that have been carried over from any previous remits. These sections also indicate how much of the negative balance was applied to the current remit payment. Any remaining negative balance will continue to be recorded in this section until the negative balance is satisfied.

- The "Adjustment Details" section reflects the overpayments deducted from the current remit and those carried forward for deduction from a future remit. The dollar value of overpayments deducted from the current remit will be reflected in the "Currently Applied" field. The dollar amount still owed BlueCross BlueShield of Tennessee to be recovered from future remits will be reflected in the "Balance Outstanding" field.

- The "Activity Date" under the Adjustment Details" section is critical to posting Member accounts. The "Activity Date" communicates the remit date of the original adjustment transaction. In order for the Provider to identify Member-specific details required to post accounts due to overpayment recoveries carried forward from previous remits, the remit with a date matching the date listed in the "Activity Date" field must be retrieved. (It is important to retain copies of all BlueCross BlueShield of Tennessee remits for future reference.) To obtain the Member-specific claim payment details, refer to the claim number listed under the "Adjustment Details" section on previous remits.

2. Manual Overpayment Recovery

BlueCross BlueShield of Tennessee utilizes a manual recovery transaction to recover overpayment dollars from the Provider's check and Remittance Advice when normal activities are not successful in resolving an overpayment situation.

This process can involve transferring of overpayment dollars from one line of business to another, or one Provider number to another (e.g., inactive to active), that share the same tax identification number. **Note**: *Prior to a manual recovery transaction, all actions required by BlueCross BlueShield of Tennessee Corporate Provider Overpayment Recovery Policy have been exhausted.*

These manual overpayment recoveries will appear on the last page of the Provider's remittance advice with a narrative description of "Manual Reduction". Instructions on the remittance advice state "Manual Recovery Detail Sent Separately". These claim details are mailed to the Provider's office in advance of the BlueCross BlueShield of Tennessee check and Remittance Advice.

An overpayment claim detail fax hotline telephone number is listed on the Provider's remit beside the "Manual Reduction Transaction" narrative. Provider's office staff can call this hotline telephone number to request claim details supporting the manual reduction. The additional information will assist Providers when posting their BlueCross BlueShield of Tennessee Member accounts.

M. Electronic Funds Transfer

Reimbursement payments for Commercial, BlueCare and TennCare*Select* lines of business can be deposited electronically into your bank account.

In order to participate in the Electronic Funds Transfer (EFT) process, you will need to complete the EFT Enrollment Form and return it **along with a voided check** to:

BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402
Attn: Provider Management - 3TC

The EFT Enrollment Form is located on the Provider page of the company Web site, www.bcbst.com. To access this form, go to the "Administration" section and click on the "Forms" tab.

A few things to note regarding the EFT process:

- As part of receiving your funds via EFT, you are also agreeing to no longer receive a paper copy of your Commercial, BlueCare and TennCare*Select* remittance advice. As was

communicated in the August 2004 issue of the BlueAlert Newsletter, you can now view/print a copy of your remittance advice by accessing e-Health Services® through the BlueAccess link on www.bcbst.com

If you are a first time user of e-Health Services, just click on the BlueAccess link located on the Provider page of our company Web site. Follow the simple instructions to obtain a user ID and password.

- EFT does not currently apply to ITS or FEP lines of business. You will continue to receive a check and paper remittance advice for these lines of business.
- BlueCross BlueShield of Tennessee will not notify your electronic vendor of your participation in the EFT Program.
- If the date for your scheduled EFT payment occurs on a holiday recognized by your bank, your payment will be posted on the next business day.
- For information regarding the EFT Program Process, please call the BlueCross BlueShield of Tennessee Enrollment Department at 423-535-5174.

N. Federal Employees Plan (FEP) Claims Filing Guidelines

BlueCross BlueShield of Tennessee commercial timely filing period is **180 days** from the date of service or, for facilities, within 180 days from the date of discharge. Exception, for claims filed by out-of-network Providers, all claims must be submitted no later than December 31 of the calendar year following the year during which the service or supply is received. For example, if a Member receives Covered Services on May 8, 2004, a claim for reimbursement must be submitted no later than December 31, 2005. Claims for long hospital stays or other long-term care should be submitted every 30 days.

The BlueCross BlueShield Plan serving the area where the services are received or where the Member resides processes most FEP Member claims. All Plans are responsible for processing claims within their FEP service area. A claim for services obtained outside the Plan's service area can only be processed by that Plan if the claim is for outpatient services for a Member residing in the Plan's service area. However, to take advantage of Participating Provider arrangements when possible, claims should be processed by the Plan that serves the area where the services were rendered. Claims not meeting those criteria should be forwarded (by the Plan) to the Plan where the services were rendered.

Claims for Covered Services provided to FEP Members are submitted by Providers in the same manner as other local BlueCross BlueShield of Tennessee, Inc. contracts.

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VII. PRIMARY CARE PRACTITIONER (PCP) POS BENEFIT PLANS

Primary care is defined as medical services provided to individual Members up to the level where specialty care would reasonably be expected to provide added value to a Member's health care.

Through regular contact, the PCP is the Practitioner who can understand each Member's health status and how it may be impacted by lifestyle. The PCP is called on to exercise independent clinical judgment on a case-by-case basis and to discuss options with Members.

A. Primary Care Practitioner Responsibilities

Primary Care Practitioners (PCPs) are responsible for the overall health care of BlueCross BlueShield of Tennessee Members assigned to them. Responsibilities associated with the role include:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all Medically Necessary and Appropriate and Covered Services;
- Initiating and/or authorizing referrals for specialty care;
- Monitoring the continuity of Member care services;
- Routine office visits for new and established Members;
- Providing 24-hour-a-day, 7-day-a-week service;
- Immunizations;
- Medically Necessary and Medically Appropriate X-ray and laboratory services;
- In-office tests/procedures during the office visit;
- Adhering to all contract requirements and compliance with records and audit requirements;
- Adhering to the access and availability standards as outlined in this manual; and
- Participating in BlueCross BlueShield of Tennessee's Utilization and Quality Improvement programs.

B. PCP Changes (Member/Practitioner)

BlueCross BlueShield of Tennessee Members may change their assigned Primary Care Practitioner as frequently as they wish, but are encouraged to establish a relationship with their PCP. A **PCP change is initiated when a Member submits an enrollment change form to BlueCross BlueShield of Tennessee Member Services or by contacting BlueCross BlueShield of Tennessee Customer Service at 1-800-565-9140.**

PCP Change Effective Date Guidelines:

- PCP changes requested on or before the 20th day of the month are effective the 1st day of the following month. *Example: If the Member changes PCPs on June 9, he/she can begin seeing the new PCP on July 1.*

- PCP changes requested after the 20th day of the month are effective the first day of the second month. *Example: If the Member changes PCPs on June 22, he/she can begin seeing the new PCP on August 1.*
- Immediate PCP changes are limited to:

- Case management determination;
- Inappropriate behavior of either the Member or the PCP;
- Death, illness, or retirement of Practitioner;
- Practitioner leaves BlueCross BlueShield of Tennessee network;
- Access issues;
- Newborn;
- New BlueCross BlueShield of Tennessee Member;
- Existing BlueCross BlueShield of Tennessee Member sibling, parent or spouse; or
- Gender preference.

Note: *If a PCP wants to change his/her acceptance criteria, he/she must submit a written request. This request can be submitted on PCP letterhead. Fax or mail requests to your local Provider Relations Representative. (See Section II. for specific numbers and addresses.)*

C. Member/Practitioner Relationship Termination

There are situations in which it is appropriate for a Practitioner to discontinue the Member/Practitioner relationship. Those situations include, but are not limited to, when Members refuse to follow the recommended procedure(s) and/or treatment plan(s).

All requests for termination of a Member or service must be documented in the Member's medical record. It must also state whether termination is for an individual Practitioner or for the group practice.

The steps to initiate the transfer of a Member are as follows:

1. Notify the Provider Relations Representative in writing of Member's name, certificate number and the reason for dismissal. (See Section II. for specific numbers and addresses.)
2. BlueCross BlueShield of Tennessee will initiate a letter to the Member requesting the selection of a new Primary Care Practitioner (PCP).
3. The PCP will continue to provide care until PCP selection by Member is made. If the Member does not select a new PCP within 30 days, a letter will be sent by BlueCross BlueShield of Tennessee notifying the Member of a change in PCPs. The PCP will be notified of the effective date of change.
4. If the request for a Member dismissal is of an urgent nature, the PCP should notify a Customer Service Representative at 1-800-565-9140.

Note: ***Until the Member is reassigned, the current Practitioner is responsible for the care***.

VIII. UTILIZATION MANAGEMENT PROGRAM

A. Program Overview

BlueCross BlueShield of Tennessee's Utilization Management Program (UM) is committed to providing quality and cost effective health care services to its Members. The UM program is designed to manage, evaluate and improve the quality, appropriateness and accessibility of health care services while achieving Member and Provider satisfaction.

The UM Program monitors compliance with the American Accreditation Healthcare Commission, also known as URAC, standards in order to maintain accreditation. The program is directed, guided and monitored by the Corporate Medical Director who actively seeks input from network-participating Practitioners and other regulatory agencies. The Corporate Medical Director is ultimately responsible for facilitating medical management in the following UM areas:

- Prior Authorization Review
- Provider Appeals
- Medical Quality Management
- Specialty Services
- Concurrent Review
- Medical Policy
- Retrospective Review
- Delegate Oversight
- Disease Management
- Technology Assessment
- Transition of Care/Discharge Planning

Evaluation of the UM Program

- The UM Program is formally evaluated on an annual basis and revised as needed. The program is reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- Marketing, Customer Services and UM departments provide Member satisfaction data which are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- UM nurses coordinate referrals to the Clinical Risk Management Department and the Medical Director. Trend reports are utilized to determine areas of need for corrective action, as well as areas that show improvement.

B. Medical Review

Medical reviews are prospective or retrospective reviews of selected interventions and are performed where evidence suggests safe, effective alternatives exist or because of mandates from oversight agencies. Prior authorization review results in efficient use of covered health care services and helps to ensure Members receive the appropriate level of care in the appropriate setting.

Note*: BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered. If the Member is still within his/her pre-existing condition waiting period, benefits will* ***not*** *be available if the condition is determined to be pre-existing.*

If the Provider chooses to render services that have not received prior authorization, or that do not meet Medical Necessity criteria according to BlueCross BlueShield of Tennessee guidelines, the Member is not financially liable for the charges. However, if the Provider obtains an Acknowledgement of Financial Responsibility for The Cost of Services for the specific procedure, which is signed by the Member prior to the services being rendered, the Member may be held liable. When obtaining services out of network or outside the state of Tennessee, the Member could be liable for these charges.

Review is required for all hospital admissions, observation admissions, select procedures and skilled nursing facility/restorative care unit admissions. Based on the line of business, home health services, e.g., skilled nursing visits, private duty nursing, home infusion therapy and hospice may require prior authorization. Some health care benefits plans also require review for speech therapy, occupational therapy, physical therapy, pulmonary rehabilitation (if applicable), durable medical equipment (greater than $500, if applicable) and cardiac rehabilitation (if applicable).

To promote consistent utilization management across all product lines, BlueCross BlueShield of Tennessee uses Milliman Care Guidelines®, BlueCross BlueShield of Tennessee adopted guidelines and Medical Policy to make utilization management decisions. The widely accepted guidelines are updated annually by a panel of consultants consisting of Practitioners and registered nurses. Clinical review criteria for medical decisions can be obtained by submitting a written request to the UM Department. BlueCross BlueShield of Tennessee will supply, at no charge, up to three Milliman Care Guidelines® as they pertain to a specific medical decision.

Modified Milliman Care Guidelines

BlueCross BlueShield of Tennessee uses Milliman Care Guidelines® to assist in its clinical decision-making processes. There are times when BlueCross BlueShield of Tennessee must modify or redefine certain Milliman Care Guideline criteria to meet practice patterns in Tennessee (i.e., a guideline does not exist, the length of stay needs to be defined, or the decision criteria needs to be modified). Beginning Sept. 1, 2004, the Milliman Care Guidelines® that have been modified by BlueCross BlueShield of Tennessee will be published on the company Web site, www.bcbst.com. This allows providers the opportunity to review and be aware of any changes or variances made to Milliman Care Guidelines® by BlueCross BlueShield of Tennessee. Providers will be notified through *BlueAlert*, BlueCross BlueShield of Tennessee's Provider newsletter, 30 days in advance of subsequent changes to these guidelines. Providers may appeal BlueCross BlueShield of Tennessee modifications to Milliman Care Guideline® criteria by following the *Modified Milliman Care Guideline Appeals Process* available in the Utilization Management section on the Provider Page of the company Web site, www.bcbst.com.

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 BlueShield of Tennessee to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.** Scheduled admissions/services must be authorized up to 24 hours prior to admission. Emergent inpatient admissions/services must be authorized within 24 hours or next business day of an admission.

When a request for an 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 BlueShield of Tennessee's non-payment is applicable to both facility and Practitioner rendering care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider.

Nurse reviewers receive written requests for prior authorization, including necessary medical information. The nurse reviews the medical information, applying Milliman Care Guidelines®, BlueCross BlueShield of Tennessee adopted guidelines and/or medical policies to render decisions. Nurses have the authority to approve all situations that meet those guidelines, e.g., approve admissions, assign lengths of stay and number of services.

For **Urgent Care**, the decision must be completed as soon as possible based on the clinical situation, but no later than 72 hours of the receipt of the request for a UM determination. For **Non-urgent Care**, the decision must be made within 15 calendar days.

The Practitioner and/or the facility are notified via telephone and/or fax of the decision determination. Written confirmation to the Practitioner, facility and Member follows. Timeframes begin with receipt of the UM requests and include the issuance of the initial notification and written confirmation of the decision.

The nurses refer potential denials or questionable cases to a Medical Director for review. Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative. If a BlueCross BlueShield of Tennessee Medical Director denies a request for prior authorization, the Provider or Member may appeal the decision. (See Provider Appeals Process at the end of this section.)

Concurrent/extended stay reviews are performed for inpatient admissions and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates Medical Necessity, must be submitted by the facility/Practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request.

BlueCross BlueShield of Tennessee Providers can submit authorization requests for inpatient and 23-hour observation via telephone, facsimile or via *e-Health Services®,* a secured area on the company Web site, www.bcbst.com. To access *e-Health Services®*, enter your ID number and password in the secured area log in box or for first-time users, click on the Providers tab. From the Provider Page, click on the *e-Health Services®* tab under Electronic Commerce and then on e-Health Service Demo for a quick overview and to register for access. When demo is complete, click on First Time Users, Register Here then follow the registration instructions.

Prior authorization requests for Inpatient, Outpatient Procedures and 23-hour Observation can receive online approval. Simply select the option to apply Milliman Care Guideline Criteria and answer a few clinical questions. If the authorization meets specific criteria you will receive online approval and a reference number. Your request will be recorded in our computer system real time as it is received. This service is available 24-hours-a-day, 7-days-a-week for all registered BlueCross BlueShield of Tennessee commercial providers.

DRG Inpatient Stays Lasting More than Seven (7) Days

- Contact the BlueCross BlueShield of Tennessee UM Department with the required clinical information on day eight (8) of an inpatient stay that lasts longer than seven (7) days. The UM staff will indicate if the continued stay appears to meet Medical Necessity criteria. When a stay continues beyond day seven (7), the facility is encouraged to contact the UM Department periodically to determine if criteria continues to be met and to discuss discharge planning efforts.
- All claims submitted for DRG reimbursement with outlier days will be reviewed for Medical Necessity.

Per Diem Admissions Needing Extensions

- Contact the BlueCross BlueShield of Tennessee UM Department with the required clinical information on the originally scheduled day of discharge when a Member's condition indicates a need for additional days.

C. Medical Review Requirements

Types of reviews required are subject to change. Providers will be notified of any changes in review requirements through quarterly updates to the BlueCross BlueShield of Tennessee *Commercial*

Provider Administration Manual, *BlueAlert* monthly provider newsletter, and other BlueCross BlueShield of Tennessee communications, including the BlueCross BlueShield of Tennessee Internet Web site, www.bcbst.com. All information is subject to verification by review of the medical record and other sources.

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 non-compliance, and BlueCross BlueShield of Tennessee participating providers will not be allowed to bill Members for Covered Services rendered, except for any applicable copayment/deductible and coinsurance amounts.

Requests for tests, procedures, or services requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day for urgent requests, or by the end of the second business day for non-urgent requests will be denied for lack of information. Covered Services that have not been authorized may **not** be billed to the Member. The Practitioner may appeal a denial due to lack of information to BlueCross BlueShield of Tennessee within sixty (60) days of notification of denial providing reasons for failure to obtain prior authorization.

BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements as well as benefit coverage may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered. . If the Member is still within his/her pre-existing condition waiting period, benefits will **not be available if the condition is determined to be pre-existing.*

The following describes specific medical review guidelines:

1. Inpatient Admission

a. Acute Care Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name;
- Hospital/Facility's name, provider number, address, telephone number, caller's name.

Clinical information required for prior authorization:

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact patient's condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications.

b. Skilled Nursing Facility (SNF)

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name;
- Hospital/Facility's name, provider number, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a covered benefit, SNF admission may be approved for Members with **all** the following:

- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner's order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.

Evaluation and Plan of Care

- Evaluation of the Member must be submitted including the following as appropriate:

  - Primary diagnosis
  - Ordering Practitioner and date of last visit
  - Date of diagnosis onset
  - Baseline status
  - Current functional abilities
  - Functional potential
  - Strength
  - Range of Motion
  - Circulation and sensation
  - Gait analysis
  - Cooperation and comprehension
  - Developmental delays (pediatric patients)
  - Other therapies or treatments
  - Patient's goals
  - Medical compliance
  - Support system

- Plan of care must be submitted including the following as appropriate:

  - Short- and Long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

Therapy Services
Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

Nursing Services
Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed
  - Tracheostomy
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Levin tube
  - Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique
- Treatment of Grade 3 or higher decubitus ulcers or widespread skin disorder

Nursing and Therapy Services Not Requiring SNF Placement
Skilled nursing facility placement is not necessary for the services listed below. This list is **not** all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of Occupational Therapy services being provided or vice versa;
- Invasive procedures (i.e., iontophoresis involving needle);
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. *Nerve supply to the muscle must be intact.*

Extension of Services
Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with any ordered therapy
- Discharge plans & target date

c. Rehabilitation Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a minimum of 3 hours of daily therapy. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member's impairment.

Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, or spinal cord injury.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name;
- Hospital/Facility's name, provider number, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, Member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a Covered Service, inpatient rehabilitation admission may be approved for Members with **all** the following:

- Rehabilitative potential, to include assessment and/or Functional Independence Measure (FIM) Score of impairment from illness or injury and premorbid condition;
- Ability and willingness to actively participate in a minimum of 3 hours of daily therapy, 7-days-per-week;
- A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a Practitioner with special training in the field of rehabilitation;
- A requirement for at least 2 therapies and a multidisciplinary team approach;
- Expectation for significant reportable improvement within a predictable amount of time;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice);
- Acute medical condition stabilized;
- Rancho Los Amigos Scale score of 4 or greater;
- Reasonable and reportable goals in a written plan of care submitted with the request for admission; and
- Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

Specific diagnoses generally not appropriate for inpatient rehabilitation include:

- total hip replacement
- unilateral knee replacement
- amputation
- hip fracture
- acute exacerbation of chronic illness
- coma stimulation
- cognitive therapy
- routine post-operative recovery

In addition, a request for an additional inpatient rehabilitation admission for a Member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or skilled nursing facility (SNF) placement.

Evaluation and Plan of Care

- Evaluation of the Member must be submitted including the following as appropriate:

  - Ordering Practitioner and date of last visit
  - Primary diagnosis
  - Date of diagnosis onset
  - Baseline status
  - Current functional abilities
  - Functional potential
  - Strength
  - Range of Motion
  - Gait analysis
  - Circulation and sensation
  - Cooperation and comprehension
  - Developmental delays (pediatric patients)
  - Other therapies or treatments
  - Patient's goals
  - Medical compliance
  - Support system

- Plan of care must be submitted including the following as appropriate:

  - Short- and Long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with therapy
- Discharge plans & target date
- Team conference reports (at least every two weeks or with any significant change in the Member's condition)

A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form follows:

BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402-2555
www.bcbst.com

BlueCare® TennCare℠ Select

Skilled Nursing Facility/Inpatient Rehabilitation

Initial Request____ Concurrent Review_____

Inpatient Rehabilitation [ ]
Skilled Nursing Facility [ ] Level I [ ] Level II [ ] Level III [ ]

Commercial ☐	BlueCare ☐	TennCare*Select* ☐

Member Information

Member Name: _____ Date of Birth: _____
Member Identification Number: _____ Reference Number:_____

Facility Information

Facility Name:_____ Contact Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Provider Number: _____ Tax Identification Number:_____

Provider Information

Provider Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Provider Number _____ Tax Identification Number:_____

Clinical Information

Diagnosis: _____
Height: _____ Weight: _____
Patient Level of Orientation:
[ ] Alert and Oriented [ ] Willing and Able to Participate [ ] Can Follow Commands
Types of Discipline (Therapy): [ ] Speech [ ] Occupational [ ] Physical
Number of Hours per Day: _____
Type of Surgery: _____
Date of Surgery: _____
Pain Control (by discharge): [ ] PO [ ] IV Please specify: _____
_____
Comorbidity:_____
Pre-Morbid Condition: _____

Home Environment:

Single or Multi Level: _____ Number of steps to enter home: _____

Number of steps within home: _____ Availability of caregiver: _____

Current Functional Status (DAY PRIOR TO DISCHARGE from Acute Care Facility):

	Minimum	Moderate	Maximum	CGA	SBA	Assistive Devices
EATING						
DRESSING						
BATHING						
BED/MOBILITY						
SUPINE-SIT						
SIT-STAND						
TRANSFERS						
AMBULATION ****DISTANCE****						

Wound Care description: (length, width, drainage), treatment, frequency:

Progress toward goals/Changes in Plan of Care:

Caregiver teaching/training:

If Skilled Nursing Facility request, what are other skilled needs? (i,e,: IV antibiotics, TPN, oxygen, CPM etc.) Please be specific regarding dosage amounts, frequencies and CPM settings:

_____

_____

Requested length of stay:_____

Behavioral Health Organization Issues (if applicable):

Discharge Goals:

Destination/Functional (Home with or without assist, facility, etc.

_____

Rev 12/03

2. Emergency Admission

In-network Providers are responsible for contacting BlueCross BlueShield of Tennessee within 24 hours or the next business day of the admission. Although emergency procedures do not require prior authorization, benefits are subject to verification for Medical Necessity and Medical Appropriateness and eligibility of coverage.

In the event that an emergency hospital admission or emergency outpatient service occurs after normal office hours, you may submit the information via our Web site at www.bcbst.com, for registered users, or contact the Utilization Management Department within 24 hours or the next business day. If the Member is still admitted at that time, an admission review will be initiated. If the Member has been admitted and discharged, or has already received an emergency outpatient service, a retrospective review will be completed.

3. Observation Stays

Observation stays require prior authorization. For example, BlueCross BlueShield of Tennessee Members reporting to the Emergency Room with symptoms of abdominal pain who are treated and released without extensive intervention should not be granted 23-hour observation status. However, if after review it appears that the Member might have an acute abdomen and is being kept for hydration and observation and requires further studies to establish the diagnosis, 23-hour observation status is appropriate.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission, or within the next business day for emergency admissions to determine Medical Necessity and Medical Appropriateness.

23-Hour Observation Room Services Policy

The medical record must support the need for observation and a specific Practitioner's order for observation must be documented. The record must also show the time and date of arrival and discharge from the facility.

4. Non-Compliance

Services requiring prior authorization rendered without obtaining approval are considered "non-compliant." Emergency admissions require authorization within **24 hours or one (1) business day after services have started**. When prior authorization is required, Provider must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. BlueCross BlueShield of Tennessee Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

If a Member does not inform the Provider that he/she has BlueCross BlueShield of Tennessee coverage and the Provider discovers that the Member **does have** BlueCross BlueShield of Tennessee coverage, the Provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, to the UM Appeals Department.

An appeal will only be overturned if both Medical Necessity is determined and there is clear evidence that the facility was not aware that the Member had BlueCross BlueShield of Tennessee coverage at the time services were rendered.

5. Maternity, Labor and Delivery

Maternity services require notification to BlueCross BlueShield of Tennessee by the obstetric Practitioner at the time of the first prenatal visit. When the obstetric Practitioner determines that the Member is pregnant, he/she should complete the OB Global Authorization form and fax it to BlueCross BlueShield of Tennessee (see Section X. for sample OB Global Authorization form). POS labor and delivery services require prior authorization by the facility on the date of admission or the next business day.

Regardless of line of business, newborns require notification/prior authorization if:

- continued hospitalization is required after the mother has been discharged; or
- admitted to any level other than well-baby nursery; or
- transferred to another facility due to their fragile condition.

6. Home Health Services/Skilled Nursing Visits

Home health services may require prior authorization. Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the Member's health or to facilitate treatment of the Member's illness or injury. In order for the services to be covered under BlueCross BlueShield of Tennessee, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical Appropriateness criteria. Documentation must support the Member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in Member's care.

Home Health Services <u>normally covered</u> include, but are not limited to:

- Part-time intermittent Skilled Nursing Services
- Medical Social Service
- Home Infusion Therapy
- Dietary guidance
- Rehabilitative Therapies such as physical therapy, occupational therapy, etc.

Home Health Services <u>not normally covered</u> include, but are not limited to:

- Non-treatment services
- Routine transportation
- Homemaker or housekeeping services
- Behavioral counseling
- Supportive environmental equipment
- Maintenance or custodial care
- Social casework
- Meal delivery
- Personal hygiene
- Convenience items
- Home Health Aides
- Private Duty Nursing

In order for an approval of Skilled Nursing/Home Health Visit services to be issued, the following criteria must be met:

- The Member requires the skills of a nurse on an intermittent basis;
- The Member has a condition that requires active skilled care;
- The services must be reasonable and necessary to the care of the condition; and
- The Member must be determined by BlueCross BlueShield of Tennessee to be homebound during the episode of care.

Documentation for prior authorization:

- Practitioner's verbal or signed medical orders and plan of care for dates of service;
- Number of services requesting;
- Nurse's visit and progress notes;
- Therapist's visit and progress notes, if applicable;
- Availability of a caregiver; and
- Homebound status.

Home health visits should be for skilled nursing services. Visits for assessment and teaching should be for services beyond those one would expect to be taught in the Practitioner's office and the request must include the frequency and duration of services, and must specify what services are to be provided. An insulin-dependent diabetic may have up to three skilled nursing visits to teach diabetic care. However, these visits should be lengthy, comprehensive and show evidence that clinical problem solving is actively used.

7. Transitional Care/Discharge Planning

BlueCross BlueShield of Tennessee acknowledges a vested interest in assuring patient care is provided in the most appropriate setting and will continue to assist Providers with discharge planning for its patients who are BlueCross BlueShield of Tennessee Members. Transitional care/discharge planning should begin upon admission, during the prior authorization process, or prior to admission if admission is scheduled. Authorization for the following services should be completed and Providers notified of the determination prior to anticipated discharge and service date:

- Hospital admissions, observation admissions, select procedures;
- Skilled nursing facility/restorative care unit admissions;
- Home health services (skilled nursing visits, private duty nursing and home infusion therapy);
- Durable medical equipment (greater than $500) (POS products, if applicable);
- Hospice;
- Speech therapy, occupational therapy, physical therapy (POS products);

8. Cosmetic Surgery

Cosmetic surgery is not a Covered Service. However, breast reconstructive and symmetry surgery following a mastectomy is a Covered Service.

- Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.
- Surgery on the non-diseased breast, to establish symmetry between the two breasts in the manner chosen by the Member and the Practitioner is considered Medically Necessary.

9. Out-Of-Network Services

Benefits may be limited, reduced or not be available in accordance with the terms of the Member's health care benefits plan even if required prior authorization is obtained.

Emergency out-of-network services (based on admitting and discharge diagnosis filed on claim) are covered, but must be reported to BlueCross BlueShield of Tennessee within 24 hours or the next business day. BlueCross BlueShield of Tennessee may need to assist the Provider in returning the Member to the network when it is medically safe.

10. Transplant Services

Please see Section X. Medical Case Management for transplant specifics.

11. Hospice Services – **Blue Network K (Effective Jul. 1, 2002)**
Blue Networks C, S, and P (Effective Feb. 1, 2003)

Hospice services are for terminally ill Members where life expectancy is six (6) months or less and may require prior authorization.

Hospice services normally covered include, but are not limited to:

- Part-time intermittent nursing care
- Medical social services
- Bereavement counseling
- Medications for control or palliation of the illness
- Home health aide services
- Physical or respiratory therapy for symptom control

Hospice services not normally covered include, but are not limited to:

- Homemaker or housekeeping services
- Meals
- Convenience or comfort items not related to the illness
- Supportive environmental equipment
- Private Duty Nursing
- Routine transportation
- Funeral or financial counseling
- Practitioner visits
- Inpatient and outpatient care
- Ambulance
- Chemotherapy
- Radiation therapy
- Enteral and parenteral feeding
- Home hemodialysis
- Psychiatric care

12. Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures

Some outpatient surgical/diagnostic procedures (appropriateness review) may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in Practitioners' offices. Providers may call Customer Service at the phone number listed on the Member's ID card to determine Appropriateness Review requirements. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to thirty (30) days, but not less than 24 hours prior to the scheduled procedure.

Failure to obtain prior authorization will result in denial of payment for Covered Services.

Covered Services that have not been authorized may **not** be billed to the Member if rendered by a BlueCross BlueShield of Tennessee network Provider. Denials for failure to request an authorization must be appealed within sixty (60) days of notification of denial. This does not preclude Provider responsibility for claims timely filing requirements. The Practitioner may appeal a Medical Necessity denial to BlueCross BlueShield of Tennessee within 180 days of notification of denial.

Effective January 1, 2005, Appropriateness Review is no longer required for a Hysterectomy performed in an outpatient setting. For Inpatient requests, Appropriateness Review is required for all fully insured accounts and some self-funded accounts. Providers may call Customer Service at the phone number listed on the Member's ID card to determine Appropriateness Review requirements for a planned Hysterectomy procedure in an inpatient setting. Prior Authorization continues to be required on a Hysterectomy in an inpatient setting since our utilization rates per thousand continue to far exceed national rates.

Note: *Select outpatient procedures are subject to focused retrospective review*.

After April 1, 2004, Appropriateness Review for EGD, colonoscopy and T&A will be done on a retrospective basis utilizing chart review and standardized criteria on cases identified by recently developed, highly sensitive predictive modeling software.

13. Specialty Pharmacy Medications – (Effective May 1, 2005)

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization for all lines of business. This authorization requirement applies to all provider types including home infusion therapy providers and hospitals providing outpatient infusions and injections.

A complete listing of specialty pharmacy medications can be viewed online at http://www.bcbst.com/pharmacy/SpecialtyProgram/SpecialtyPharmacyDrugList.pdf. Those requiring prior authorization under the Member's medical benefits plan are identified by an (*) and are listed below:

- Amevive®
- Avastin™
- Erbitux®
- Flolan®
- Remicade®
- Remodulin®
- Rituxan®
- Synagis®
- Velcade (eff. 8/1/05)

Practitioners may contact one of our specialty pharmacy vendors to obtain prior authorization and bill for these drugs or they may request prior authorization and bill BlueCross BlueShield of Tennessee directly by calling 1-800-924-7141.

Specialty Pharmacy Vendors:

Caremark Specialty Pharmacy Services
Phone 1-866-295-2779
Fax 1-866-295-2778

CuraScript Pharmacy
Phone 1-888-773-7376
Fax 1-888-773-7386

Priority Healthcare
Phone 1-866-225-5670
Fax 1-866-225-5671

The following information is required when requesting prior authorization on any of the above listed drugs:

- HCPCS code (J, Q or S code)
- Drug name
- National Drug Code (NDC)
- Frequency
- Dosage
- Clinical information to support the request

Note: *Authorization listing is subject to change; Changes will be communicated via BlueAlert newsletter or updates to this Manual.*

Rev 09/05

The pharmacology section of the BlueCross BlueShield of Tennessee Medical Policy Manual includes decision support trees to assist providers considering use of these medications. Providers can select the appropriate drug from the manual at http://www.bcbst.com/MPManual/Pharmacology.htm and connect to the decision support tree in the policy.

For additional information on Specialty Pharmacy Medications, see Section XIX. Pharmacy, in this Manual.

14. Home Infusion Therapy - **Blue Network K (Effective July 1, 2002)** **Blue Networks C, S, and P (Effective Feb. 1, 2003)**

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the member's private residence. A request for HIT originates with prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

When prior authorization is required, the following drugs must be authorized*:

Effective May 1, 2005
- Immune Globulin (IVIG)
- Amevive®
- Avastin™
- Erbitux®
- Flolan®
- Remicade®
- Remodulin®
- Rituxan®
- Synagis®

Effective Aug. 1, 2005
- Velcade®

*Authorization listings are subject to change; Changes will be communicated via *BlueAlert* newsletter or updates to this Manual.

Case Management may assist the Practitioner in arranging HIT for extraordinary cases and when Medical Necessity and Medical Appropriateness warrants close attention.

When an authorization is needed, specific information is required. Authorizations are valid for thirty (30) days; any break in service requires a new authorization. HIT Providers requesting approval of HIT services should submit the following information to the Utilization Management Department:

- Member's name, address, date of birth, sex, ID#;
- Practitioner's name, address, phone number;
- HIT agency's name, address, phone number, HIT-related provider number and a contact person;
- Type of request: initial prior authorization, extension of services or change of services;
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC#, HCPCS code and grams of protein for TPN;
- Primary and HIT diagnosis;
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services; and
- A Practitioner's verbal or signed medical order.

The administration of IM drugs (Rocephin, Phenergan, Procrit, etc.) is not considered HIT and therefore, should not receive HIT benefits. If nursing is required to administer the drug and/or conduct teaching for the Member, these services may require prior authorization under Home Health guidelines. If the HIT Provider is dispensing the drug, they are required to follow the pharmacy benefits manager (PBM) requirements for prior authorization. All self-administered drugs must be authorized and billed through the Member's appropriate PBM. (See Section XIX. Pharmacy in this Manual.)

Authorization decisions will be phoned, faxed or sent electronically to the HIT Provider and a letter is mailed to the prescribing Practitioner and Member. Adverse decisions are rendered if Medical Necessity and Medical Appropriateness are not shown.

Extension of Services
When prior authorization is required and services are needed beyond the number of days authorized by BlueCross BlueShield of Tennessee, the HIT supplier must have the additional services authorized.

Changes/Termination in Services
When prior authorization is required, the HIT Provider must notify BlueCross BlueShield of Tennessee of any changes in therapies/medication, dosages, and/or an order for discontinuation by the ordering Practitioner, during the time frame authorized.

Note: *HIT services will only be reimbursed on a per diem basis for days on which services are actually rendered.*

14. Rehabilitation Therapy Outpatient Services

Therapies/Rehabilitative services must be Medically Necessary and Medically Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as a result of illness or injury.

Effective Aug. 1, 2003, the requirement that all cardiac rehabilitation services be prior authorized in order to be eligible for payment was removed for Hospitals and Ambulatory Surgical Facilities participating in Blue Networks C, P, S, and K. Instead, the prior authorization requirement for cardiac rehabilitation services will be driven by the Member's health care benefits plan.

BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements and because of differences in relationships, some prior authorization requirements may differ.

To ensure appropriate payment is made for cardiac and pulmonary rehabilitation services, Providers are encouraged to verify the Member's health care benefits plan's prior authorization requirements by calling the Provider Services line at 1-800-934-7141 or via e-Health Services® on the company Web site, www.bcbst.com. For those health care benefits plans requiring prior authorization, penalties will continue to apply for non-compliance.

Therapy services normally covered include:

- Outpatient, home health or office therapeutic and rehabilitative service which are expected to result in significant and measurable improvement in the Member's condition resulting from an Acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner. (See medical policy regarding "Staff Supervision Requirement for Delegated Services" and "Staff Practitioner to Whom Services may be Delegated" in the BlueCross BlueShield of Tennessee Medical Policy Manual at http://www.bcbst.com/providers/prov_man.shtm);
- Services must be performed in a Practitioner's office, outpatient facility or home health setting;
- Physical Therapy;
- Speech Therapy (limited to coverage for disorders of articulation and swallowing, following an Acute illness);
- Occupational Therapy;
- Manipulative Therapy; and
- Cardiac and Pulmonary Rehabilitative services.

Therapy services normally not covered include, but are not limited to:

- Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy which is designed to improve the Member's physical status beyond their pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, which include, but are not limited to:
  - Massage therapy
  - Acupuncture
  - Aquatic Therapy
  - Cranioscacral Therapy
  - Neuromuscular Reeducation
  - Vision Exercise Therapy
  - Cognitive Therapy
- Modalities that do not require the attendance or supervision of a licensed therapist:
  - Activities which are primarily social or recreational in nature
  - Simple exercise programs
  - Hot and cold packs applied in the absence of associated therapy modalities
  - Repetitive exercises or tasks which can be performed by the Member without a therapist, in a home setting
  - Routine dressing changes
  - Custodial services that can ordinarily be taught to a caregiver or the Member themselves.
  - Behavioral therapy
  - Play therapy,
  - Communication therapy
  - Therapy for self correcting language dysfunctions
  - Duplicate therapy (therapies should provide different treatments and not duplicate the same treatment).

14a. Speech Therapy Services (provided in a non-acute setting)

In order for Speech Therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. A prior authorization is required for speech therapy for some POS lines of business. Unskilled services are not eligible for coverage.

Assessment Requirements (Evaluation and Plan of Care)

Evaluation

- Ordering Practitioner and date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status / current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Therapy compliance
- Prior speech therapy received and outcome

Plan of Care

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
- Duration of therapy
- Frequency of therapy
- Date therapy is to begin
- Specific therapy techniques

Speech Therapy Criteria

Speech therapy, if a covered benefit, may be approved for Members with all of the following:

- Performed by a speech/language pathologist licensed in the state they are practicing.
- Prescribed by a Practitioner to achieve a diagnosis-related goal as documented in the plan of care.
- Used in the treatment of communication impairment or swallowing disorders due to disease, trauma, congenital anomaly or prior therapeutic process.
- Service rendered must be directly related to a written treatment regime that includes goals & designed as approved by the attending Practitioner.
- Reasonable expectation must exist that the therapy will result in a significant improvement in the patient's condition within a predictable period of time.
- Progress must be objectively measurable with progress toward goals established in evaluation.
- Services must be considered acceptable standards of medical practice that are specific to the treatment of the patient's condition.
- Speech/language pathologist must sign all documentation (notes and evaluations).
- Documented plan of care and evaluation that includes specific criteria as noted in this guide must be submitted.
- Patient compliance, cooperation, and ability to comprehend are consistent with the written treatment regimen and goals.
- Patient must be making reasonable progress.
- Services rendered must include instruction to patient & family/caregiver that includes teaching of home program.
- Services rendered require the skills of a qualified provider of speech therapy services.
- The evaluation should demonstrate that an actual hands-on assessment occurred as opposed to a limited screening assessment.
- Documentation should be specific as to the patient's ability to retain instruction and follow directions to preserve safety.
- Re-evaluation/re-examination is the process by which an individual’s status is updated following the initial examination. A re-evaluation/re-examination must meet the following requirements:

- The re-evaluation/re-examination is performed because of:

  1. New clinical indications
  2. Failure to respond to interventions
  3. Failure to establish progress from baseline data

- The re-evaluation/re-examination must be prior authorized by BlueCross BlueShield of Tennessee.

14b. Occupational Therapy Services (provided in a non-acute setting)

In order for occupational therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. A prior authorization is required for occupational therapy for some POS lines of business. Unskilled services are not eligible for coverage.

Assessment Requirements (Evaluation and Plan of Care)

Evaluation

- Ordering Practitioner and date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status / current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of dysfunction or disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Prior occupational therapy received and outcome

Plan of Care

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Duration of therapy
- Frequency of therapy
- Dates of service
- Specific modalities and therapy

Occupational Therapy Criteria

Occupational therapy Medical Necessity and Medical Appropriateness determinations are based on the following factor(s):

- Goal of services is to restore to Member's previous functional abilities, (i.e., rehabilitative).

Occupational therapy, if a covered benefit, may be approved for Members with <u>all</u> of the following:

- Performed by or under the direct supervision of a licensed occupational therapist with a Practitioner's order.
- In an outpatient setting, a certified/licensed therapy assistant, under the direct supervision of a licensed occupational therapist, may render services. A qualified therapist must be physically present & actively involved in the treatment.
- Under extenuating circumstances (e.g., network inadequacy in rural areas), a certified/licensed therapy assistant may render services through a home health provider in the home health setting under the general supervision of a licensed therapist. Under these conditions, a licensed therapist must evaluate the patient, develop a treatment plan, and implement the plan. General supervision requires initial direction and periodic of the patient by the registered therapists; however, the supervisor does not have to be physically present or on the premises.
- Services must be performed by a certified occupational therapist licensed in the state they are practicing.
- Prescribed by a Practitioner to achieve a diagnosis-related goal as documented in the plan of care.
- Appropriate for the treatment of the individual's illness or injury.
- Performed to treat the needs of a patient suffering physical impairment due to disease, trauma, congenital anomalies, or prior therapeutic intervention.
- Services rendered must be directly related to a written treatment plan that includes goals as approved by the attending Practitioner.
- Reasonable expectation must exist that the therapy will result in a significant practical improvement in the level of functioning within a reasonable period of time.
- Progress must be objectively measurable with progress toward goals established in evaluation.
- Services must be considered acceptable standards of medical practice that are specific to the treatment of the patient's condition.
- Occupational therapist must sign all documentation (notes and evaluations).
- Documented plan of care and evaluation that includes specific criteria, as noted in this guide, must be submitted.
- Patient and /or caregiver compliance, cooperation, and ability to comprehend are consistent with the written treatment regimen and goals.
- Patient must be making reasonable progress.
- Services rendered must include instruction to patient and family/caregiver that include teaching of home program.
- Services rendered must require the skills of a qualified provider of occupational therapy services.
- The evaluation should demonstrate that an actual hands-on assessment occurred as opposed to a limited screening assessment.
- Re-evaluation/re-examination is the process by which an individual's status is updated following the initial examination. A re-evaluation/ must meet the following requirements:

    - The re-evaluation/re-examination is performed because of:
        1. New clinical indications
        2. Failure to respond to interventions
        3. Failure to establish progress from baseline data.
    - The re-evaluation/re-examination must be prior authorized by BlueCross BlueShield of Tennessee.
- Documentation should be specific as to the patient's ability to retain instruction and follow directions to preserve safety.
- The focus of therapy should be on activities the patient needs within their living environment.
- Activities of daily living include self-maintenance tasks, but are not limited to:
    * Grooming

    - Oral hygiene
    - Bathing or showering
    - Toilet hygiene
    - Dressing
    - Feeding / eating
    - Functional mobility
- Home management activities include, but are not limited to:
    - Meal preparation and clean up
    - Safety procedures
    - Household maintenance
- Teaching of compensatory techniques to improve the level of independence should be conducted in conjunction with therapy.

14c. Physical Therapy Services (provided in a non-acute setting)

In order for physical therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. A prior authorization is required for physical therapy for some POS lines of business. Unskilled services are not eligible for coverage.

Assessment Requirements (Evaluation and Plan of Care)

Evaluation

- Ordering Practitioner and date of last visit
- Primary diagnosis
- Baseline status
- Functional potential
- Current functional abilities
- Strength
- ROM
- Circulation and sensation
- Cooperation and comprehension
- Support system
- Developmental delays/pediatrics
- Other therapies, treatments, chiropractic
- Patient’s goals
- Medical compliance
- Homebound status

Plan of Care

- Short- and Long-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home exercise program
- Time frame (frequency and duration)
- Date therapy is to begin
- Frequency of treatment
- Specific modalities, therapy, exercise
- Safety and preventive education
- Community resources

BlueCross BlueShield of Tennessee utilizes Milliman Care Guidelines when reviewing requests for physical therapy services provided in a non-acute setting.

15. Medical Supplies (Outpatient Rehabilitation Services)

The following coverage criteria apply to medical supplies billed to BlueCross BlueShield of Tennessee:

- Records must clearly support that supplies were used during the Member's treatment.
- Must be prescribed by the Member's Practitioner.
- Must be Medically Necessary and Medically Appropriate for treating illness or injury.
- Generally recognized as therapeutically effective and primarily medical in nature.
- Must be at the level and quality required (not "luxury" in nature).
- Cannot be for environmental control, personal hygiene, comfort, or convenience.
- Cannot be reusable.
- Supplies required for use with rental items are included in the rental fee.

16. Durable Medical Equipment

Durable Medical Equipment (DME) purchases or repairs do not require prior authorization for most lines of business, however, some BlueCross BlueShield of Tennessee lines of business may require prior authorization for DME purchases or repairs greater than $500.00. DME may be subject to retrospective review for Medical Necessity.

DME may be covered if it is determined to be Medically Necessary and Medically Appropriate for the Member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The Member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the Member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of ten (10 months).
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.
- Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review.

Information that needs to be submitted with the claim and/or prior authorization (when applicable) request:

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable);
- Member's diagnosis and expected prognosis;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

The following guidelines apply to reimbursement for repair of DME equipment:

- Equipment less than one (1) year old requires documentation related to the warranty coverage. Repairs that are covered by the warranty will not be reimbursed by BlueCross BlueShield of Tennessee;

- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available; and
- Prior authorization may be required for DME repairs greater than $500 for some BlueCross BlueShield of Tennessee lines of business.

BlueCross BlueShield of Tennessee will **only** provide benefits for Medically Necessary and Medically Appropriate Equipment. Requests for extraordinary items require justification.

BlueCross BlueShield of Tennessee will **not** provide benefits for Investigational Durable Medical Equipment.

17. Performance Evaluations of Delegate Vendors and Providers

The BlueCross BlueShield of Tennessee Delegate Oversight Program provides an organized and systematic approach to ensure oversight of delegated administrative functions, which include Utilization Management, Quality Improvement, Credentialing, Independent Record Review, Case Management, Claims, Customer Service, Complaints, Grievance and/or Appeals, Transportation, EPSDT, and Medical Records Review.

BlueCross BlueShield of Tennessee will, at a minimum, complete an annual assessment of reports and annual performance evaluations of vendors/Providers to whom activities have been delegated. The purpose of a performance evaluation is to ensure compliance with standards of all of the applicable state and federal laws and regulations, as well as those of all applicable accrediting and regulatory review agencies, including but not limited to the American Accreditation Health Care Commission, also known as URAC, Tennessee Department of Commerce and Insurance (TDCI), and BlueCross BlueShield of Tennessee policies and procedures.

The performance evaluation includes, but is not limited to, the following:

- Desktop and /or onsite evaluation of the vendor's/Provider's compliance with all applicable standards
- Documentation and file review to determine the compatibility of the organization's goals and objectives with BlueCross BlueShield of Tennessee goals and objectives
- Criteria, methods, and process for determining Medical Necessity and Medical Appropriateness of care
- Written evaluation of the vendor's/Provider's capabilities to perform delegated functions, staffing capabilities, and performance record

The delegate vendor/Provider will support BlueCross BlueShield of Tennessee in meeting its requirements of annual and periodic performance evaluations by providing access to all records, policies, procedures, reports, and other documents as necessary to demonstrate compliance with the delegate program.

18. Second Surgical Opinion

BlueCross BlueShield of Tennessee will pay for any second surgical opinion requested by a Member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.) A second opinion is encouraged for the following procedures:

- Bone and Joint Surgery of the Foot;
- Cataract Extraction with and without implant;
- Cholecystectomy;
- Coronary Artery By-Pass;
- Hysterectomy;
- Knee Surgery;
- Septoplasty/Sub-Mucous Resection;
- Prostatectomy;
- Spinal and Disc Surgery;
- Tonsillectomy & Adenoidectomy;
- Mastectomy; or
- Elective C-Section.

Note: *Second surgical opinion for the above procedures is encouraged because on frequent occasions, alternate therapies may be Medically Necessary and Medically Appropriate as opposed to surgery*.

The following guidelines apply to Second Surgical Opinions:

- A surgeon (one who is not in the same group or practice as the Practitioner who rendered the first opinion) must render the second opinion.
- The Practitioner rendering the second surgical opinion must be in a BlueCross BlueShield of Tennessee network and proper referrals must be in place, if applicable.
- A referral is required from the Member's Primary Care Practitioner, if applicable.

D. Emergency Services

Emergency Room services for an emergency condition do not require prior authorization. BlueCross BlueShield of Tennessee communicates to its Members to go to the nearest emergency room if they are suffering from an emergency condition.

An emergency is defined as the sudden onset (within 24 hours) of a medical condition manifested by acute symptoms of sufficient severity that in the absence of immediate medical attention could result in:

- Permanently placing a Member's health in jeopardy;
- Causing other serious consequences;
- Causing impairments to body function; or
- Causing serious or permanent dysfunction of any body organ or part.

Reimbursement will be provided for emergency services as defined above when a prudent layperson feels it was a emergency, or when authorized by the Primary Care Practitioner (PCP), the specialist the Member was referred to by the PCP, or an authorized representative acting for BlueCross BlueShield of Tennessee. **Note**: *Prior authorization is not required for emergency room visits.*

E. Investigational Services

Investigational services are considered by BlueCross BlueShield of Tennessee to be not Medically Necessary. New and established technologies are researched and evaluated by BlueCross BlueShield of Tennessee's Medical Policy Department and are assessed using sources that rely upon evidence based studies. Input is also sought from our network Providers.

Investigational services is defined as a drug, treatment, therapy, procedure, or other services or supply that does not meet the definition of Medical Necessity:

1. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) when such approval has not been granted at the time of its use or proposed use;
2. is the subject of a current Investigational new drug or new device application on file with the FDA;
3. is being provided according to the Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial);
4. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives;
5. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IAB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS);

6. the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is Investigational or that there is sufficient data to determine if it is clinically acceptable;
7. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings;
8. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives; or
9. the service or supply is required to treat a complication of an Investigational service.

The Medical Director shall have discretionary authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Investigational service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any and all of the following, at his or her discretion:

1. the Member's medical records;
2. the protocol(s) under which proposed service or supply is to be delivered;
3. any consent document that the Member has executed or will be asked to execute, in order to receive the proposed service or supply;
4. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by the Member;
5. regulations or other official publications issued by the FDA and HHS;
6. the opinions of any entities that contract with BlueCross BlueShield of Tennessee to assess and coordinate the treatment of Members requiring non-Investigational services; or
7. the findings of the BlueCross BlueShield Association Technology Evaluation Center or similar qualified evaluation entities.

These criteria are used in making such determinations as whether a service is considered to be Investigational or Medically Necessary. Providers have access to these policies via the Medical Policy Manual in the Provider section of BlueCross BlueShield of Tennessee's Internet Web site located at www.bcbst.com and are also informed of determinations via our monthly *BlueAlert* Newsletter.

If a BlueCross BlueShield of Tennessee Network Provider renders services that are Investigational or do not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she will be responsible for the cost of the specific service(s). It is essential the signed statement be kept on file. It may be necessary to provide a copy of the written statement to BlueCross BlueShield of Tennessee if the Member questions the Member Liability amount reflected on his/her Explanation of Benefits (EOB). Once BlueCross BlueShield of Tennessee contacts the Provider, he/she will be asked to provide a copy of the signed written statement within two (2) business days. If the Provider is not able to supply the written statement, the claim will be adjusted to reflect Provider liability and the Member will not be responsible for those charges.

To help assist in this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Services* form for Provider use. A sample copy of this form is located in Section V. Member Policy, in this Manual. Providers are encouraged to use this form. The form can also be found in the Provider section of the company Web site, www.bcbst.com. This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements.

F. Medically Necessary and Medically Appropriate Policy

BlueCross BlueShield of Tennessee covers Medically Necessary and Medically Appropriate health care services not otherwise excluded under BlueCross BlueShield of Tennessee health care benefits plans.

Medically Necessary
Services, which have been determined by BlueCross BlueShield of Tennessee to be of proven value for, use in the general population. To be Medically Necessary, a service must:

1. Have final approval from the appropriate government regulatory bodies.
2. Have scientific evidence permitting conclusions concerning the effect of the service on health outcomes.
3. Improve the net health outcome.
4. Be as beneficial as any established alternative.
5. Demonstrate the improvement outside the investigational setting.
6. Not be an Investigational service.

Medically Appropriate
Services, which have been determined by the Medical Director of BlueCross BlueShield of Tennessee to be of value in the care of a specific Member. To be Medically Appropriate, a service must:

1. Be Medically Necessary.
2. Be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
3. Be consistent with current standards of good medical practice for the Member's medical condition.
4. Be provided in the most appropriate site and at the most appropriate level of service of the Member's medical condition.
5. On an ongoing basis, have reasonable probability of:
    - correcting a significant congenital malformation or disfigurement caused by disease or injury;
    - preventing significant malformation or disease; or
    - substantially improving a life-sustaining bodily function impaired by disease or injury.
6. Not be provided solely to improve a Member's condition beyond normal variation in individual development and aging including:
    - Comfort measures in the absence of disease or injury; or
    - Improving physical appearance that is within normal individual variation.
7. Not be for the sole convenience of the Provider, Member or Member's family.
8. Not be an Investigational service.

BlueCross BlueShield of Tennessee may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate. **Note:** *According To Contract, BlueCross BlueShield of Tennessee Will Not Reimburse For Photocopying Expenses.*

BlueCross BlueShield of Tennessee encourages open Practitioner/patient communication regarding appropriate treatment alternatives.

G. Retrospective Review

This review is conducted based on Milliman Care Guidelines® (if applicable), BlueCross BlueShield of Tennessee guidelines, BlueCross BlueShield of Tennessee Medical Policy, *Physician's CPT®*, *CMS Common Procedure Coding System* and the Member's health care benefits plan. Review may be initiated for:

- Possible cosmetic services;
- Potential Investigational services;
- Skilled nursing facility confinements;
- Chiropractic services;
- Outpatient therapies;
- Durable Medical Equipment (when prior authorization is not required);
- Prosthetics, orthotics, and supplies;

- Practitioner office services;
- Neuropsychological testing;
- Dental, accident related, and temporomandibular joint dysfunction;
- Pain management;
- Rider related services;
- Pre-existing;
- Unbundled codes and/or code combinations; and
- Non-participating provider or no prior authorization obtained.

Types of reviews may change based on new or updated Medical Policies, identification of the need for focused reviews, etc.

H. Provider Appeal Process

It is the policy of BlueCross BlueShield of Tennessee to make available to treating Practitioners a Physician-to-Physician review to discuss, by telephone, determinations based on Medical Appropriateness. A Physician-to-Physician review may be initiated by calling 1-800-543-8607.

Utilization Management Appeals

Reconsideration
Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative.

Expedited Appeal
- The request for an expedited appeal must be initiated by phone and should include any pertinent information not originally submitted.
- An expedited appeal may or may not require a peer-to-peer conversation.
- An expedited appeal can be requested when the Provider believes that the adverse determination:
  1. could seriously jeopardize the life or health of the Member and the ability of the Member to regain maximum function, and/or
  2. in the opinion of the Practitioner with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

An expedited appeal will be completed and notification issued to the Member and Provider no later than seventy-two (72) hours after initial request of the appeal, however, the clinical circumstances will help determine the speed of the response.

Expedited appeals may be requested by calling the appropriate prior authorization number. (Refer to Quick Reference Telephone Guide in front of this Manual.)

Standard Appeal
As the Member's representative, the standard appeal process can be used if reconsideration or an expedited appeal resulted in an adverse determination. Requests for standard appeal for Medical Necessity denials **must** be received in writing by the Utilization Management department within 180 days of the date of the initial denial notification. This does not preclude timely filing requirements. All claims must be submitted within 180 days of the date of service. Appeals of non-compliance denials must be submitted within 60 days of the initial denial. The request should include a copy of any pertinent clinical information, face sheet, if applicable, and a statement from the Practitioner indicating the reasons for the appeal and a copy of the denial letter. A determination will be sent to the Provider and/or Member within thirty (30) days of the receipt of the request for appeal. The written appeal request should be mailed to:

ATT: UM Appeals Supervisor, 1G
UM Appeals
BlueCross BlueShield of Tennessee
P.O. Box 180177-7177
Chattanooga, TN 37402

Exhausting the above noted process satisfies Section II. A. and B. of the Provider Dispute Resolution Procedure (PDRP) outlined in Section XIII in this Manual. If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. D. of the PDRP. A Provider can request a specialty-matched appeal and/or a peer-to-peer discussion at any appeals level.

I. Medical Policy Manual

The Medical Policy Manual contains general policies and medical policies approved by BlueCross BlueShield of Tennessee. **General policies** are broad categories referring to disease states. Medical policies address specific technologies that relate to various disease states.

Medical policies are based upon evidence-based research that seeks to determine the scientific merit of a particular medical technology or technologies. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria are as follows:

1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is Medically Necessary, not Medically Necessary, Investigational, or Cosmetic. Definitions of these terms are found within the glossary. Many policies also contain a section on Medical Appropriateness. This is for use in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).

BlueCross BlueShield of Tennessee recognizes the occasional need for "Pilot Programs" for procedures and services which may not meet the Medical Necessity criteria established by BlueCross BlueShield of Tennessee Medical Policy, but for which there is recognized promise or other compelling reasons to test their usefulness. These Pilot Programs will allow testing for both medical and cost effectiveness of alternative Providers, procedures and services in order to determine the impact on BlueCross BlueShield of Tennessee and its Members.

Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual in its entirety on the company Web site at http://www.bcbst.com/providers/mpm.shtm.

J. Blue Network K Gold Card Policy

Blue Network K participating Practitioners are awarded Gold Card status based upon BlueCross BlueShield of Tennessee acceptable practice profiling performance parameters related to quality of care, patient satisfaction and cost efficiency.

1. Policy

Practitioners participating in Blue Network K will be gold carded for all commercial networks. Gold Card status exempts the Practitioner from prior authorization, appropriateness review, and notification **except for transplants, high risk and/or high cost medications.** Gold Card Practitioners are still subject to retrospective review.

Gold carding does not apply to pharmacy benefits **or high risk and/or high cost medications whether administered in a Provider's office, patient's home or other outpatient setting**. Gold carding does not mean that BlueCross BlueShield of Tennessee, Inc. (BCBST) will provide reimbursement for non-covered services, investigational services or services rendered to ineligible Members. In addition, gold carding does not change clinical code editing. BlueCard® Program Members will continue to require approvals as necessitated by their Home Plan.

Practitioner performance (quality, cost, Member satisfaction) will be monitored quarterly, at a minimum, by HealthCare Services. Corrective action will be initiated as necessary. Corrective action plans will be implemented by regional medical directors and regional directors and monitored by the Clinical Risk Management Department. If contract termination becomes necessary, the established procedure via the Provider Participation Standards Committee or Credentialing Committees will be activated.

Practitioners who are terminated from Blue Network K (whether voluntary or involuntary) will lose their gold card status in all commercial networks on the effective date of their Blue Network K termination.

If a Practitioner loses gold card status as a result of practice pattern analysis and/or corrective action, the loss of gold carding is applicable to all commercial networks.

2. Hospital Admissions

The admitting Practitioner's Gold Card status will determine whether notification or authorization is required by the hospital for inpatient admissions for Members covered by a BlueCross BlueShield of Tennessee commercial network. Both notification and authorization require clinical information, however, if the admitting Practitioner is Gold Carded, admission will be allowed regardless of Medical Necessity criteria. Prior authorization is required for inpatient admissions for skilled nursing and rehabilitation facilities regardless of Gold Card status.

Gold Card Practitioners are encouraged to support the servicing hospital with any necessary clinical information to ensure smooth admission for Members. Clinical information the facility will need to provide BlueCross BlueShield of Tennessee includes:

- Procedure/operation to be performed;
- Diagnosis with supporting signs and symptoms;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact the patient's condition;
- Complications;
- Prognosis or expected length of stay; and
- Current medications.

Examples of when authorization vs notification is required by a facility follow:

3. Hospital Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures

BlueCross BlueShield of Tennessee's prior authorization requirements for hospitals, outpatient surgical centers and outpatient diagnostic centers remain unchanged when performing outpatient surgical procedures.

When no prior authorization is obtained for these services, facility claims will be denied and Members may not be billed.

An exception to this requirement exists **only** when treating a Blue Network K Member. If all rendering providers (hospital, outpatient surgical center, outpatient diagnostic center, Practitioners) participate in Blue Network K when treating Blue Network K Members, appropriateness review is not required. **Facilities must obtain prior authorization when performing services for Members covered by any of our other commercial networks**.

Admitting Practitioner Gold Carded	Notification or Authorization Required by Facility	Meets Medical Necessity Criteria	Gold Card Practitioners Paid	Non-Gold Card Practitioners Paid	Facility Paid	Member Liability
Yes	Notification	Yes	Yes[1]	Yes[1,2]	Yes[1,2]	Yes, for Out-of-network Providers
Yes	Notification	No	Yes[1]	Yes[1,2]	Yes[1,2]	Yes, for Out-of-network Providers
No	Authorization	Yes	Yes[1]	Yes[1,3]	Yes[1,3]	Yes, for Out-of-network Providers
No	Authorization	No	Yes[1]	No	No	Yes, for Out-of-network Providers

[1]Paid based on participating status in Member's network (participating/non-participating). If non-participating, Member liability will apply.
[2]Paid when facility provides notice with required clinical information.
[3]Paid when facility calls for authorization with required clinical information.

K. Directing Members to Participating Providers in Members' Network

When a Member needs additional care outside your practice, you can assist them by directing them to participating Providers in the Member's network. Members seeking care outside their network will suffer significant reductions in benefits. An illustration of the increased Member liability for out-of-network utilization is found below:

Out-of-Network Utilization Example:

Physician charges = $300.00
BlueCross BlueShield of Tennessee maximum allowed = $180.00

Utilizing an ***in-network*** Provider
Provider network Physician discount = $120.00
BlueCross BlueShield of Tennessee payment = $150.00 (or 80% of $180 maximum allowed)
Member payment = $30.00

Utilizing an ***out-of-network*** Provider
Provider network physician discount = $0
BlueCross BlueShield of Tennessee payment = $108.00 (or 60% of $180 maximum allowed)
Member payment = $192.00

By helping your patients utilize **in-network** Providers, you can help ensure they receive the highest level of benefits.

An online directory of participating Providers by network-type is available on the company's Internet Web site at www.bcbst.com. Both Members and Providers may access the Provider directories from any page of our site by selecting "Find a Doctor!" located on the left-hand side of the screen.

BlueCross BlueShield of Tennessee has developed an Out-of-Network Provider Election Form for use by participating Providers when a Member in one of the commercial networks chooses to have an elective procedure performed at or from an out-of-network Provider. A sample copy of this form follows and is also available on the Provider page of the company Web site at www.bcbst.com.

BlueCross BlueShield
of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402-2555
www.bcbst.com

Out-of-Network Provider Election Form

BlueCross BlueShield of Tennessee member, _____ _____
First Name Last Name

(_____) has elected to receive services at or from the following non-participating
ID #

hospital/provider (the "Provider"), _____. Since this Provider is not
Hospital/Provider Name

participating in BlueCross BlueShield of Tennessee's networks, any benefits for Covered Services under the member's health benefits plan will be out-of-network benefits. By signing this document, the member understands that he or she could incur higher out-of-pocket Provider costs, including higher copayments, higher member coinsurance, and deductible. The member will also be responsible for charges billed by the Provider that exceed the Maximum Allowable Charge as defined by the member's health benefits plan.

In addition to the Provider charges, the member understands that providers at a hospital, such as radiologists, anesthesiologists, and others may also be out of network. Therefore, those provider's charges may be paid by the member's health benefits plan as out of network.

NOTHING IN THIS AGREEMENT IS A GUARANTEE OF BENEFITS UNDER THE MEMBER'S HEALTH BENEFITS PLAN. ALL BENEFITS WILL BE SUBJECT TO ALL TERMS AND CONDITIONS OF THE MEMBER'S HEALTH BENEFITS PLAN, INCLUDING ELIGIBILITY AND MEDICAL NECESSITY.

_____ _____
Doctor's Name (Print) Member's Name (Print)

_____ _____
Doctor's Signature Member's Signature

_____ _____
Date Date

_____
Member's Phone Number

Rev 09/03

L. Utilization Management Resources

Acquisition of Medical Necessity and Medically Appropriateness Criteria

Milliman Care Guidelines®
8910 University Center Lane, Suite 425
San Diego, California 92122-1085

- Primary & Pharmaceutical Guidelines
- Continuum of Care Guidelines
- Inpatient and Surgical Guidelines
- Home Health Guidelines (Case Management: Home Care)
- Recovery Facility Care Guidelines (Case Management: Recovery Facility Care)
- Rehabilitative Guidelines *(BlueCross BlueShield of Tennessee adopted UM Criteria)*
  - Inpatient Rehabilitation Admissions
  - Occupational Therapy
  - Skilled Nursing Facility
  - Speech Therapy
  - Physical Therapy
  - Chiropractic & Osteopathic Manipulative Medicine

IX. REFERRAL PROCESS

Information in this section has been removed. Effective January 1, 2004, BlueCross BlueShield of Tennessee no longer requires Blue Network S Point-of-Service (POS) members to:

- choose a Primary Care Practitioner; or
- obtain a referral when seeking in-network or out-of-network specialist care.

However, to receive maximum benefits, POS members should continue to seek health care services from providers that participate in Blue Network S. When Members utilize providers outside their network, benefits are substantially reduced.

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X. CARE MANAGEMENT

The BlueCross BlueShield of Tennessee Case Management Programs promote Member empowerment regarding health care decisions, Member education on health conditions and options, as well as the tools and resources necessary to assist the Member/family when making health care decisions. The BlueCross BlueShield of Tennessee Case Management Programs also offer quality and cost effective coordination of care for Members with complicated care needs, chronic illnesses and/or catastrophic illnesses or injuries.

A. Components

- Lifestyle/Health Counseling Program
  - ⇒ Lifestyle/Health Counseling is a self-directed program involving identifying Members with potential health risks and then empowering them with the tools and educational materials necessary to make the most informed decisions regarding their health.

- Care Coordination Programs
  - ⇒ Care Coordination Programs are offered to Members who suffer from a condition that requires a daily regimen of care, or serious illness that requires coordination of health care services and disease education. Care Coordination Programs include:
    - Pharmacy Care Management
    - Emergency Services Management
    - Transition of Care Coordination
    - Condition Specific Care Coordination

- Catastrophic Medical Case Management
  - ⇒ Catastrophic Medical Case Management is the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. The goal is to facilitate the delivery of appropriate individual health care services across the continuum of care in various settings for Members with complex and catastrophic conditions. The Catastrophic Medical Case Management Program monitors compliance with URAC standards in order to maintain accreditation.

- Transplant Case Management
  - ⇒ Transplant Case Management focuses on the entire spectrum of transplant care. The care of the Member is managed from the time of the evaluation for a transplant and continues for 12 months post-procedure or longer if services continue to be necessary. BlueCross BlueShield of Tennessee helps its Members in need of bone marrow or solid organ transplants receive quality care by directing them to Practitioners in the national transplant health networks. The facilities within this network and the Practitioners who practice there have been specifically selected for their expertise and quality outcomes in transplant cases.

B. Case Management Criteria and Guidelines

- Milliman Care Guidelines®
- Case Management Society of America (CMSA) Practice Guidelines
- BlueCross BlueShield of Tennessee adopted guidelines

Case Management Referral Criteria

A centralized referral unit, comprised of case managers, is responsible for screening all referrals and triaging them to the appropriate case management program. Referrals can be received both internally and externally via fax or telephone. The following list (not intended to be all-inclusive) are referral guides to recommend a Member for any of the case management programs:

Lifestyle/Health Counseling Referral Criteria:

If a Member could benefit from educational materials on these health conditions, please refer them to the Lifestyle/Health Counseling program.

Telephone 1-800-225-8698 Fax 423-535-3517

Lifestyle/Health Counseling

Allergies
Asthma
Arthritis
Cardiovascular Diseases
Diabetes
Kidney Diseases
Migraines
Pregnancy
Respiratory Diseases

Care Coordination Referral Criteria:

Telephone 1-866-834-4546 Fax 423-535-3517

Pharmacy Care Management
Acute or Post Myocardial Infarction
Hepatitis C
Migraine
Polypharmacy Issues

Emergency Services Management
ER visits greater than 6 in 3-month period

Transition of Care
Complex wounds
Inpatient Rehab and SNF admissions
Lower extremity fractures
NICU babies
Total hip replacement
Total knee replacement
Community acquired pneumonia (seasonal, October – March)
Crainiotomy
Post acute needs, but Member declines case management and/or no case management benefits
Gastric bypass
Concurrent review/Length of Stay (LOS)<7 days

Care Coordination Referral Criteria (cont'd):

Telephone 1-866-834-4546 Fax 423-535-3517

Condition Specific Care Coordination

Asthma
Cardiac rehabilitation
Cerebral palsy
Chronic obstructive pulmonary disease (COPD)
Congestive heart failure (CHF)
Coronary artery disease (CAD)
Cystic fibrosis
Diabetes
Hemophilia
Hypertension
Pulmonary rehabilitation
Rheumatoid arthritis

Healthy Focus Disease Management

(Additional service purchased by employer - Member must be eligible and between 18 and 64 years old)

Asthma
Chronic obstructive pulmonary disease (COPD)
Congestive heart failure (CHF)
Coronary artery disease (CAD)
Diabetes

Catastrophic Medical Case Management Referral Criteria:

Telephone 1-800-225-8698 Fax 423-535-3517

Catastrophic Medical Case Management

Air ambulance outside USA
AIDS
Severe burns (> 30% of body)
Cancer
Cerebral vascular accident (CVA)
Complex home health care, continuous home infusion therapy needs, and all private duty nursing patients
Crohn's disease
Cystic fibrosis
Elevated lead levels
End stage disease of any organ
Hemochromatosis
High risk infant
High risk OB
Hospice services
Lupus
Multiple Trauma
Neurological conditions
Perinatal infections
Renal failure
Sickle cell anemia
Spinal cord injury
Traumatic brain injury
Ulcerative colitis
Vent dependency

Transplant Case Management Referral Criteria:

Telephone 1-888-207-2421 Fax 423-535-3331

Transplant Case Management
Bone marrow
Solid organ
Stem cell

Requests for care management should include the following information:

- Requesting Practitioner's name and telephone number;
- BlueCross BlueShield of Tennessee Member name, BlueCross BlueShield of Tennessee ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
- Reason for request for care management (e.g., patient has COPD with frequent hospital admissions); and
- Level of urgency of care management need.

After receipt of request for care management, a care manager will make an initial call to the referral source within two (2) working days. If an urgent request is needed, please specify in the phone or fax message.

C. Care Coordination Team and Process

Care Coordination Team and Process

There are several programs within Care Coordination Services. The care coordinators, who are registered nurses, are responsible for: helping transition Members from the treatment and recovery of an acute illness back into their normal daily lives; working with Members and their caregivers to coordinate the most appropriate health care services and treatment settings; and providing Members with detailed information concerning each aspect of their condition. Medical directors are available to the care coordinators for consultation. After the initial assessment, coordination and education, the nurse care coordinator will schedule a 60-day follow up contact with the Member to ensure positive results. If the Member is stable with no further care management needs, the case will be closed. If further needs exist, the Member will be referred to the catastrophic medical case management team.

D. Catastrophic Medical Case Management Team and Process

Catastrophic Medical Case Management Team and Process

The Catastrophic Case Management Team consists of registered nurses who are case managers, medical directors who are available for consultations, and benefit specialists who have claims and benefit management experience. In the event of terminal illness, severe injury, major trauma, cognitive or physical disability, case managers work with a Member's primary caregivers to coordinate the most appropriate, cost-effective treatment path based on the Member's unique situation. Case managers stay in regular contact with Members throughout treatment, coordinate clinical and health plan coverage issues, and help families utilize available community resources.

After obtaining Member and Practitioner consent for case management participation, the case manager will collaborate with the Member, Practitioner and other appropriate Providers to coordinate and facilitate an individualized plan of treatment to meet the Member's health care needs.

The case manager will continue to evaluate the Member's progress and health care needs and communicate findings with the Member and Practitioner. When the Member becomes clinically stable and/or the plan of treatment has met the Member's needs, catastrophic care management services may be discontinued or referred to a less intensive care management program.

Prior to discontinuation of case management services, the case manager will communicate the following information to the Member:

- Reason for and specific future date for discontinuing case management services;
- Instructions for continuing prior authorization of continued services, if necessary;
- Explanation of transition of Member's case to another care management program; and
- Instructions for requesting case management services if Member's clinical condition regresses.

E. Transplant Case Management

The Transplant Case Management Team consists of registered nurses, who are certified case managers specifically trained in the areas of solid organ and bone marrow transplantation, medical directors, who are available for consultations, and benefit specialists who have claims and transplant benefit management experience.

It is critically important, to both the Practitioner and Member, that BlueCross BlueShield of Tennessee Transplant Case Management be contacted as soon as you think the Member may need an evaluation for transplant:

- If Prior authorization from Transplant Case Management is not obtained, the transplant and related services will not be covered or reimbursement will be reduced substantially.
- Most Members' health care benefits plans **require** that the transplant occur at a facility within the BlueCross BlueShield of Tennessee In-Transplant Network (see definition below).
- Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member's health care benefits plan).
- If the Member does have access to Out-of-Transplant Network Benefits, those Benefits are subject to the Transplant Maximum Allowable Charge (TMAC). **Member's liability beyond the TMAC may be substantial. The hospital and Practitioners will be at risk for these charges if the Member is unwilling or unable to pay.**

Not all BlueCross BlueShield of Tennessee In-Network Practitioners and hospitals (e.g., Blue Networks C, P, S, and K) are in the BlueCross BlueShield of Tennessee In-Transplant Network. Seeking care outside the BlueCross BlueShield of Tennessee In-Transplant Network can reduce benefits and require substantial payment by the Member. Please check with BlueCross BlueShield of Tennessee Transplant Case Management to see which hospitals are in the BlueCross BlueShield of Tennessee In-Transplant Network before referring Members for transplant evaluation or services, which could result in a transplant (e.g., high dose chemotherapy). Call the Transplant Case Management Department at 1-888-207-2421 for detailed network facility information.

BlueCross BlueShield of Tennessee In-Transplant Network
The BlueCross BlueShield of Tennessee In-Transplant Network consists of the Blue Quality Centers for Transplant (BQCT), a national network of transplant centers, as well as, selected

acute care hospitals within Tennessee. Other benefits, such as travel, may be available to some Members, when they use an In-Transplant Network facility. Benefits are based on the Member's health care benefits plan and eligibility on the date of service.

The Blue Quality Centers (BQCT) for Transplant
The BlueCross BlueShield Association administers and contracts with the transplant centers that make up The Blue Quality Centers for Transplant. This national network of transplant centers offers comprehensive transplant services through a coordinated, streamlined program of transplant management. Participating centers are major clinical programs and leading research institutions located throughout the country. The BQCT currently contracts for seven transplant types: heart, single or bilateral lung, combination heart-bilateral lung, liver, pancreas, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). BQCT does not contract for Kidney
Transplants. (For information on Kidney Transplants, see *Kidney Transplants* in this section). Since its creation, the BQCT network has offered several advantages to Participating BlueCross BlueShield Plans and our Members, including the following:

- Facility selection criteria are established for each type of procedure with the advice of a panel of nationally prominent transplant specialists;
- Morbidity and survival rates are monitored to measure the continued performance of the participating institutions and staff; and
- Medical and surgical benefits provided by the BlueCross BlueShield Plan through the network's global rate include inpatient professional services and related institutional and organ procurement services for the prior authorized transplant.

Facilities are selected by BQCT based on their ability to meet defined clinical criteria that are unique for each type of transplant. Panels of nationally recognized transplant researchers and Practitioners advise the BlueCross BlueShield Association on selection criteria that are periodically updated in response to medical advances. Facilities are surveyed for information in many areas, including:

- Volume of procedures;
- Duration of the transplant program;
- Patient outcomes specific to the particular procedure;
- Transplant team training and experience;
- Staffing and facility requirements;
- Facility licensure, accreditation, and transplant program certification;
- Patient selection process;
- Patient management protocol;
- Educational plans and support programs available for patient/family;
- Quality Assurance/Improvement programs; and
- Procedures for patient follow-up for at least 12 months post-transplant.

Fulfillment of the BQCT eligibility requirements for one type of transplant does not qualify a facility for participation for other types of transplants. Each facility transplant program is evaluated independently against established criteria and is required to have an initial on-site evaluation prior to selection. Once selected for participation, facilities are re-evaluated annually and are subject to periodic on-site reviews.

For further information about becoming a BQCT facility or questions specifically regarding the BlueCross BlueShield Association or BQCT program, contact the Blue Quality Centers for Transplant **1-800-263-7893**.

Participating facilities receive a BQCT Procedure Manual from the BlueCross BlueShield Association. This manual contains detailed instructions, forms and contact lists for Participating and Referring BlueCross BlueShield Plans. BlueCross BlueShield of Tennessee is a Referring

and a Participating Plan in the BQCT Network. The guidelines outlined in the BQCT Procedure Manual must be followed, **in addition to** those outlined in this manual, for maximum allowable reimbursement of transplants and transplant-related services.

In-Network, but not in In-Transplant Network
These facilities (e.g., Participating Blue Networks C, P, S, and K, BlueCard®/BlueCard® PPO) may receive a reduced level of reimbursement for some PPO and POS Members. If Member benefits are available, reimbursement will be subject to the Transplant Maximum Allowable Charge (TMAC) for the global transplant period. Member is liable for any amounts in excess of the TMAC up to contracted fee schedule amount.

Out-of-Network
If a facility is not contracted with BQCT; the Member's BlueCross BlueShield of Tennessee Network (e.g., Blue Networks C, P, S, and K, BlueCard®/BlueCard® PPO); or otherwise contracted with the local BlueCross BlueShield Plan, the facility is Out-of-Transplant Network. PPO and POS Members may have benefits at these facilities, but benefits and allowable reimbursement are subject to the TMAC. Reimbursement and benefits are reduced as compared with In-Transplant Network benefits and reimbursement. Amounts in excess of the TMAC are non-covered and may result in substantial Member liability.

BlueCard® The BlueCard program links participating health care Practitioners and the independent BlueCross BlueShield plans across the country and around the world. **Not all Members have BlueCard coverage. Not all BlueCard facilities participate in the BlueCross BlueShield of Tennessee In-Transplant Network.** Transplants for BlueCross BlueShield of Tennessee Members that occur at BlueCard® facilities, not in the BlueCross BlueShield of Tennessee In-Transplant Network, will be reimbursed in accordance with the Member's health care benefits plan and will be subject to the TMAC. To determine eligibility and benefits of a BlueCard® Member call 1-800-676-BLUE (2583). Provide the operator with the Member's ID, including alpha-prefix. You will be transferred to the Member's home BlueCross BlueShield Plan. For additional information regarding BlueCard®, see the BlueCard® Web site www.bluecard.com or Sec. XVI. in this Manual.

Referrals, Case Management, and Prior Authorization

Referrals
All transplants and transplant-related services, including evaluation, require prior authorization and coordination by a BlueCross BlueShield of Tennessee Transplant Case Manager in order for the Member to be eligible for coverage. It is very important that Members be referred to BlueCross BlueShield of Tennessee In-Transplant Network Practitioners or there will be significant reduction in benefits, including no benefits for some Members.

Case Management
By notifying Transplant Case Management prior to evaluation or referral for services that may lead to a transplant (e.g., high dose chemotherapy), the Practitioner and the Member can make informed decisions based on the Benefits available to the Member. The Transplant Case Manager will work with the Member and Practitioner to determine if the transplant-related service is medically appropriate as well as identify high-risk Members who will need additional assistance. The Transplant Benefits Specialists in this department can also let the Member know about other benefits, such as travel, that may be available to the Member, if they utilize the In-Transplant Network. They will also calculate the potential financial risk to both the Member and the Practitioner, if the Member chooses to go to an Out-of-Transplant Network facility or if they do not utilize Case Management**. Contact Transplant Case Management at 1-888-207-2421 for authorization prior to all Member referrals for any transplant-related medical care, including evaluation to ensure that the services are covered and that the Member receives the highest level of benefits available. (See reimbursement examples at the end of this section).**

Denials
Transplant cases determined by Transplant Case Management not to be Medically Necessary and Medically Appropriate will be referred for external review. The Member and the Practitioner will be given the determination of the external review in writing.

Appeals
Refer to Sec. VIII. and Sec. XIII in this Manual.

Prior Authorization
In addition to the above, the transplant facility must provide the BlueCross BlueShield of Tennessee Transplant Case Manager with the Member name, identification number(s), type of transplant, and proposed dates of service (inpatient/outpatient). The facility is required to submit clinical information to obtain prior authorization for the transplant once the Member has been evaluated. The facility must notify BlueCross BlueShield of Tennessee within one business day of a transplant services admission (inpatient/outpatient).

BQCT facilities must also notify the Referring BlueCross BlueShield Plan (if appropriate per BQCT Practitioner Procedures Manual) and the BlueCross BlueShield Association and submit the appropriate forms provided in the BQCT Practitioner Procedures Manual.

Length of Stay
The facility must notify BlueCross BlueShield of Tennessee to obtain initial authorization as well as provide clinical updates through out the transplant procedure and recovery. The BlueCross BlueShield of Tennessee Transplant Case Manager will authorize the initial admission for transplant and will outline the schedule for clinical updates required for extending the stay.

Transplant Global Period
Transplant benefits and reimbursement are calculated as a global period. TMAC charges apply to any and all inpatient and outpatient charges during the following time periods. Participating facilities, contracted to provide transplant services, may be eligible for additional reimbursement beyond the global rate, (outlier charges). To be eligible for outlier reimbursement the facility must contact BlueCross BlueShield of Tennessee (or the Referring BlueCross BlueShield Plan). BlueCross BlueShield of Tennessee or the referring BlueCross BlueShield Plan must authorize Outlier days. Prior authorized outlier days will be reimbursed in accordance with the contracted per diem rate if the Member is inpatient in excess of the following predetermined length-of-stay days:

- Bone Marrow/Stem Cell: 50 days
- Lung: 38 days
- Liver: 39 days
- Heart: 38 days
- Combination Heart-Bilateral Lung: 43 days
- Simultaneous Pancreas-Kidney: 34 days

Transitional Care/Discharge
Facilities must notify BlueCross BlueShield of Tennessee (or the Referring BlueCross BlueShield Plan) of a transplant Member's proposed transition/discharge from care in writing, and obtain BlueCross BlueShield of Tennessee's (or the Referring Plan's) agreement to the proposed Member transition/discharge plan and follow-up recommendation. If facility is a BQCT Practitioner, refer to BQCT Practitioner Procedures for the appropriate form(s) and instructions.

Claims
Claims should be submitted to BlueCross BlueShield of Tennessee according to the facility's contract and participation in the BlueCross BlueShield of Tennessee In-Transplant Network or other Networks as described previously in this section.

Blue Quality Centers for Transplant (BQCT) Facilities –
The Participating BQCT Facility must submit the global transplant claim to the Member's Home Plan as outlined in the BQCT Practitioner Procedures Manual when:

- Facility is contracted with BQCT for the transplant type;
- Member's BlueCross BlueShield Home Plan is a Referring Plan in BQCT; and
- Transplant has been authorized.

The Participating* BQCT *Facility must follow these steps when submitting a global transplant claim:

1. Collect all itemized bills for transplant services included in the BQCT global rate (hospital, professional, ancillary, and procurement/harvesting charges). These bills are to be submitted in paper copy, using CMS-1450 and/or CMS-1500 claim forms. All eligible transplant services and applicable global rates are listed in the Hospital Participation Agreement (BQCT Contract).

2. Attach the completed Institutional Billing Summary Form (found in the BQCT Procedures Manual) to the bundled claims.

3. Attach a completed copy of the BQCT Referral Authorization Form (blank form available in the BQCT Procedures Manual) so that the Referring Plan's Transplant Coordinator can identify the bundled claims as BQCT global claims.

4. Mail bundled claims and attachments, in one envelope, to the Member's Home Plan Transplant Coordinator, designated in the Billing Section of the BQCT Referral Authorization Form submitted by the Referring Plan.

   Mail BlueCross BlueShield of Tennessee Member claims to:
   Transplant Benefits Specialist
   BlueCross and BlueShield of Tennessee
   801 Pine St., Building 1G
   Chattanooga, TN 37402

5. Collect any applicable deductibles, coinsurance, and co-payments from the Member.

Note: *See BQCT Procedures Manual for a complete listing of BQCT Referring BlueCross BlueShield Plans and all referenced forms. Participating BQCT Practitioners may obtain additional copies of the BQCT Procedures Manual from BQCT.*

Out-of-Transplant Network Facilities (In Tennessee)
Participating BlueCross BlueShield of Tennessee facilities, not participating in BQCT for the transplant type or otherwise included in the BlueCross BlueShield of Tennessee In-Transplant Network, must submit transplant claims to BlueCross BlueShield of Tennessee as outlined in the Participating Practitioner's Institutional Agreement between the facility and BlueCross BlueShield of Tennessee. These claims should be mailed to:

Transplant Benefits Specialist
BlueCross and BlueShield of Tennessee
801 Pine Street, Building 1G
Chattanooga, TN 37402

If the Member's BlueCross BlueShield Home Plan is NOT a Referring Plan in BQCT, and the Member is NOT a BlueCross BlueShield of Tennessee Member, contact the Member's BlueCross BlueShield Home Plan for billing and claims instructions.

Note: *Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be Covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member's health care benefits plan). If the Member does have access to Out-of-Transplant Network Benefits, those Benefits are subject to the Transplant Maximum Allowable Charge (TMAC). BlueCross BlueShield of Tennessee will pay all associated transplant-related claims during the global period on a claim-by-claim basis according to when claims are filed until the benefit is exhausted.*

Transplant Maximum Allowable Charge (TMAC) – The global TMAC is calculated based on data provided by Blue Quality Centers for Transplant (BQCT). The TMAC amount is the lowest contracted BQCT global rate charged by any In-Transplant Network Facility for the specified organ type at the time of transplant. For example, contracted global rates may range from $100,000.00 at one facility to $175,000.00 for the same transplant type at another facility. In this example, the global TMAC is the lowest global rate of $100,000.00. It is important to remember that billed charges for the transplant type in this example may be over $200,000.00. The Member's Out-of-Pocket Maximum does not apply to charges beyond the TMAC. Practitioners may determine the current TMAC by contacting Transplant Case Management at 1-888-207-2421. However, the reimbursement amount will be based on the TMAC as calculated at the time of the transplant. **Member's liability beyond the TMAC may be substantial. The hospital and Practitioner's will be at risk for these charges if the Member is unwilling or unable to pay.**

Coordination of Benefits – When BlueCross BlueShield of Tennessee will be paying secondary to other commercial insurance or other insurance will be paying secondary to BlueCross BlueShield of Tennessee, Transplant Case Management should be notified.

- If Secondary to Medicare, Transplant Case Management will not review Member's coverage. Payment will be handled according to Medicare Guidelines.

- If Secondary to Commercial Carrier, Transplant Case Management will review for medical appropriateness. Approved transplants will be paid according to the Member's health care benefits plan. If other (primary) Commercial Insurance denies benefits, Transplant Case Management will coordinate benefits and handle as if BlueCross BlueShield of Tennessee were primary.

Single Patient Agreements – Single Patient Agreements are case-by-case contracts between the facility and BlueCross BlueShield of Tennessee. They are negotiated **prior to** transplant on behalf of BlueCross BlueShield of Tennessee Members in the following situations:

- Network Inadequacy – No network contracts exist for the transplant type (e.g., small bowel transplants)

- Urgent/Emergent Care – Unanticipated emergency services where transfer to an In-Transplant facility is not possible (e.g., medication induced liver failure)

- Continuity of Care – Determined on a case-by-case basis by Transplant Case Management. Must meet policy guidelines.

Claims should be submitted to BlueCross BlueShield of Tennessee according to the instructions outlined in the Single Patient Agreement Contract (if applicable).

Small Bowel Transplants
When referring Members for Small Bowel, Kidney/Small Bowel or Small Bowel/Liver transplants, please contact Transplant Case Management. These are contracted on a case-by-case basis using a Single Patient Agreement. Claims for these transplants should be filed as previously outlined under the *Single Patient Agreement*.

Travel, Meals and Lodging
Some Members have Travel Benefits. If the Member has Travel Benefits (as defined in the Member's health care benefits plan), these benefits are paid to the Member, not the Practitioner. Examples of travel expenses include: travel expenses for evaluation of a Member prior to a covered procedure; transportation to and from the site of a covered procedure, meals, and lodging expenses for the Member and one caregiver. Travel benefits may vary.

Transitional Care
Should the facility or Member contract change after the transplant has been medically approved, but before the transplant has occurred, Transplant Case Management will notify the Member and Practitioner of the change and how benefits and reimbursement will be affected.

Kidney Transplants
Kidney transplants are handled slightly differently than transplants contracted by BQCT. BlueCross BlueShield of Tennessee Members may access any Kidney Transplant facility identified as participating in the Member's Network of Acute Care Hospitals contracted to provide kidney transplants (e.g., Blue Networks P, C, S, K, or BlueCard®/BlueCard® PPO). BQCT does not contract with hospitals to provide Kidney Transplants (kidney alone).

Facilities will be reimbursed according to surgical Per Diems and/or Diagnosis Related Group (DRG) Rates and/or case rates outlined in the Institutional Agreement between the facility and BlueCross BlueShield of Tennessee.

Covered Health Services
Medically Necessary and Appropriate services and supplies are covered under the Member's health care benefits plan and provided to the Member, when he or she is the recipient of one of the following organ transplants if covered under the Member's health care benefits:

- Bone Marrow/Stem Cell
- Heart
- Heart/Lung
- Kidney
- Lung
- Liver
- Pancreas
- Pancreas/Kidney
- Kidney/Small Bowel
- Small Bowel/Liver

Benefits may be available for other organ transplant procedures, which, in BlueCross Blue Shield of Tennessee's sole discretion, are not Investigational and which are Medically Necessary and Medically Appropriate. Requests for authorization for other, non-organ transplants (e.g., cornea, skin) should be directed to BlueCross BlueShield of Tennessee Utilization Management.

The transplant and transplant related services will not be covered or will be reduced (depending on the Member's benefits) if the transplant and transplant related services are not approved by Transplant Case Management.

The transplant and transplant related services will not be covered or will be reduced (depending on the Member's health care benefits plan) if the Member does not accept Transplant Case Management.

Additional benefits, such as travel, may be available to the Member, if the In-Transplant Network is utilized. Transplant Case Management will review the Member's health care benefits plan to determine if this or other benefits exist. If available, these benefits are reimbursed to the Member, not the Practitioner.

Donor Organ Procurement
The cost of Donor Organ Procurement is included in the total cost of the Member's organ transplant. It is included in the global TMAC calculation or any contracted global or case rate. Donor services are covered only to the extent not covered by the health coverage of the Donor.

- Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself:
  - Testing for the donor's compatibility;
  - Removal of the organ from the donor's body;
  - Preservation of the organ; and
  - Transportation of the organ to the site of transplant.
- Services not Covered for the donor include:
  - Complications of donor organ procurement.
  - Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ; and
  - Donor services including screening and assessment procedures not prior authorized by the Member's health care benefits plan.

Conditions/Limitations
- Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation.
- If Transplant Case Management is not notified, the transplant and related procedures will not be covered.
- Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member's health care benefits plan).
- If the Member does have access to Out-of-Transplant Network Benefits, those benefits are subject to the global Transplant Maximum Allowable Charge (TMAC). Not all BlueCross BlueShield of Tennessee participating network Practitioners and hospitals (Blue Networks, P, S, C, K or BlueCard®/BlueCard® PPO) are in the BlueCross BlueShield of Tennessee In-Transplant Network. **Member's liability beyond the TMAC may be substantial. The hospital and Practitioners will be at risk for these charges if the Member is unwilling or unable to pay.**

Exclusions
- If the Member does not receive prior authorization, the transplant and related services will not be covered or reimbursement will be reduced substantially;
- Any service specifically excluded under the Member's health care benefits plan, except as otherwise provided in this section;
- Services or supplies not specified as Covered Services under this section;
- If the Member receives prior authorization through Transplant Case Management, but does not obtain services through the In-Transplant Network, he/she will be responsible for payment to the Practitioner and/or hospital for any additional charges not covered under the Member's health care benefits plan. These charges may be substantial;
- Any attempted covered procedure that was not performed, except where such failure is beyond the Member's control;
- Any non-Covered Services;
- Services which are covered under any private or public research fund, regardless of whether the Member applied for or received amounts from such fund;
- Any non-human, artificial or mechanical organ;

- Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- Donor services including screening and assessment procedures which have not received prior authorization from BlueCross BlueShield of Tennessee;
- Removal of an organ from a Member for the purposes of transplantation into another person, except as covered by the Donor Organ Procurement provision;
- For bone marrow transplants, any registry charges other than the one from which the bone marrow is received are not covered. All charges incurred as a result of the testing/typing are considered to be expenses of the Member to the extent that the donor has no other coverage;
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled; and
- Other non-organ transplants (e.g. cornea, skin) are not covered under this section, but may be covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

Reimbursement examples follow:

Example A – Organ Transplant (non-kidney) In-Transplant Network:

Member Benefits are:
In-Transplant Network Practitioners – 80%, after In-Network Deductibles, In-Network Out-of-Pocket Maximum applies. Once the In-Network Out-of-Pocket Maximum is met, benefits are at 100%.

Transplant Total Billed Charges (global):	$ 206,000.00
Practitioner Write-Off Due to BQCT Agreement	- 76,000.00
BQCT Rate with this Facility is (global):	$ 130,000.00
Member's In-Network deductible and Out-of-Pocket Maximum:	- 2,000.00
BlueCross BlueShield of Tennessee Pays Facility:	$ 128,000.00
Total Member Liability:	$2,000.00

In addition to the previously mentioned benefits the Member may have travel benefits.

Example B – Organ Transplant (non-kidney) Out-of-Transplant Network, but in BlueCross BlueShield of Tennessee Network (e.g., Blue Networks C, P, S, K or BlueCard/BlueCard PPO):

PPO Member Benefits are:
In-Network, but not In-Transplant Network – 80% of Transplant Maximum Allowable Charge (TMAC), after In-Network Deductible, In-Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of Pocket and are not covered. Once the In-Network Out-of-Pocket Maximum is met, the facility is eligible for 100% of the global TMAC. (see following grid)

Transplant Total Billed Charges (global):	$ 206,000.00
Practitioner Write Off Due to Network/BlueCard PPO Practitioner Agreements:	- 36,000.00
Normal Network Priced Amount Using any Applicable Fee Schedules (e.g., Blue Network P, BlueCard PPO*):	$ 170,000.00
Allowed/Covered Amount Calculation:	
Normal Network Priced Amount (global):	$ 170,000.00
Transplant Maximum Allowable Charge:	- 100,000.00
Amount in excess of the TMAC, but less than Network Pricing (non-covered):	$70,000.00
Reimbursement/Member Benefit Calculation:	
Transplant Maximum Allowable Charge:	$100,000.00
Member's Deductible and Out-of-Pocket Maximum:	- 2,000.00
* If host plan allows use of network pricing in addition to TMAC. Insurance Benefit Covers 80% of TMAC. However, once the Out-of-Pocket Maximum is met, the facility and associated Practitioners are eligible for 100% of the remaining TMAC**:	$ 98,000.00
Member owes Hospital or other Transplant Practitioners: Deductible and Out-of-Pocket Maximum:	$ 2,000.00
Amount in excess of the TMAC, but less than Network Pricing (non-covered):	$ 70,000.00
TOTAL MEMBER LIABILITY TO TRANSPLANT PRACTITIONERS	$ 72,000.00

- **Example C – Organ Transplant (non-kidney) Out-of-Transplant Network and not participating in the Member's BlueCross BlueShield of Tennessee Network:**

Member Benefits are:
Out-of-Network Practitioners – 60% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of Pocket and are not covered. Once the Out-of-Network Out-of-Pocket Maximum is met, the facility is eligible for 100% of the global TMAC. (see following grid)

Transplant Total Billed Charges are (global):	$ 206,000.00
Practitioner Write Off:	0
Transplant Maximum Allowable Charge:	100,000.00
Member Benefit Calculation:	
Transplant Total Billed Charges (global):	$ 206,000.00
Transplant Maximum Allowable Charge:	- 100,000.00
Amount in excess of the TMAC (non-covered):	$ 106,000.00
Reimbursement Calculation:	
Allowed/Covered Amount (TMAC):	$100,000.00
Member's Out-of-Network Deductible and Out-of-Pocket Maximum:	- 6,000.00
Insurance Benefit Covers 60% of TMAC. However, once the Out-of-Network, Out-of-Pocket Maximum is met, the facility and associated Practitioners are eligible for 100% of the remaining TMAC**:	$ 94,000.00
Member owes Hospital or other Transplant Practitioners:	$ 6,000.00
Out-of-Network Deductible and Out-of- Pocket Maximum:	
Amount in excess of the TMAC (non-covered):	$ 106,000.00
TOTAL MEMBER LIABILITY TO TRANSPLANT PRACTITIONERS	$ 112,000.00

No Travel Benefits are available. Travel, meals and lodging are at the expense of the Member.

**BlueCross BlueShield of Tennessee pays for all associated claims during the transplant global period on a claim-by-claim basis according to when claims are filed until the benefit is exhausted.

F. Ancillary Care Management

1. Precious Cargo® (PC) Maternity Management Program
(There is an eligibility requirement for this program.)
BlueCross Blue Shield of Tennessee's PC Program is a maternity-specific program offered to its Administrative Services Only (ASO) accounts. The PC Program is a prenatal education program armed with valuable information that complements a Practitioner's care. PC links mothers-to-be with important pregnancy-related health care information needed to make healthy choices during pregnancy. This program also helps identify certain health conditions and risk factors early in the pregnancy. If the pregnancy is high risk, the PC nurse refers the Member to BlueCross BlueShield of Tennessee's Catastrophic Case Management Program where a nurse will work with the Member and the Practitioners to develop a specific plan of

care, coordinate services, and monitor the Member throughout the pregnancy. The Precious Cargo® Maternity Management Program is designed to increase the number of healthy births, while reducing Neonatal Care Unit stays and their associated high costs.

When Members enroll in the Precious Cargo® Program, they receive:

- Two confidential pregnancy health assessments performed by obstetrical nurses;
- A copy of *Trimester*, a reference book containing information on all nine months of pregnancy; and
- Access to BabyLine, a toll-free, 24-hour information service staffed by registered obstetrical nurses.

BlueCross BlueShield of Tennessee requests that Practitioners encourage their Members to enroll in the Precious Cargo® Maternity Management program as soon as pregnancy is diagnosed. Members may self-refer into the program by calling 1-800-395-BABY or 1-800-395-2229. (A sample copy Global Authorization Enrollment Form is located at the end of this section.)

2. Behavioral Health Care Management

(There is an eligibility requirement for this program.)
Behavioral Health Care Management involves trained behavioral health clinicians working with medical case managers to determine the most appropriate care settings and the Practitioners best suited to treat each unique situation.

For health plans that require prior authorization of inpatient care only, this type of Behavioral Health Care Management helps identify Members while they are in facility-based levels of care in order to access opportunities for coordination and management of care during treatment. This program does not include outpatient visits.

For health plans that require authorization for both inpatient and outpatient visits, this Behavioral Health Care Management program helps identify high-risk Members in all levels of care, including facility-based and outpatient visits in order to assess opportunities to manage a Member's total behavioral health care while they remain in treatment.

3. Healthy Focus Disease Management Program

(There is an eligibility requirement for this program.)
Comprehensive disease management services are available as an optional product to the BlueCross BlueShield of Tennessee Administrative Services Only (ASO) accounts. Healthy Focus helps those with chronic illnesses - such as congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and asthma - lead more productive lives.

Administered by LifeMasters® Supported SelfCare, Inc., Healthy Focus combines state-of-the-art technology with personalized nursing. The program provides Members with the medical equipment and support necessary to properly monitor and manage their condition on a daily basis.

Healthy Focus provides:

- Medical equipment such as blood pressure cuffs, peak flow meters, glucose meters and digital scales where indicated.
- Tools necessary to record and transmit vital health information directly to a nurse.
- Regularly scheduled phone calls for a nurse.
- Free information on chronic illness and more.

Healthy Focus not only provides Practitioners with the information necessary to maintain individualized treatment programs, but also helps get Members more involved in their care.

Disease Management Options:

- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Asthma

G. Evaluation of Care Management Programs

The Care Management programs are evaluated on an annual basis and revised as needed. The programs are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members. Member satisfaction data is collected and reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.

BlueCare®/TennCare*Select*/Commercial
OB Global Notification Form

801 Pine Street
Chattanooga, TN 37402-2555
Fax: 1-800-292-5311

BlueCross BlueShield of Tennessee

Practitioner/Clinician _____ Phone _____ Fax _____

Provider# _____ Date _____

BlueCare Member Name	Member's I.D.#	Date of Birth (DOB)	Phone #	Date 1st Visit	Estimated Date of Confinement (EDC)	At-Risk Yes / No	Reference #
1							
2							
3							
4							
TennCare*Select* Member Name	Member's I.D.#	Date of Birth (DOB)	Phone #	Date 1st Visit	Estimated Date of Confinement (EDC)	At-Risk Yes / No	Reference #
1							
2							
3							
4							
Commercial Member Name/Facility	Member's I.D.#	Date of Birth (DOB)	Phone #	Date 1st Visit	Estimated Date of Confinement (EDC)	At-Risk Yes / No	Reference #
1							
Facility							
2							
Facility							
3							
Facility							
4							
Facility							

BlueCare/TennCare*Select*/Commercial

BlueCross BlueShield of Tennessee

The goal of this program is to help pregnant women have healthy babies by decreasing preterm births and low-birth-weight infants. Achievement of this goal is planned through the identification of risk factors which will guide prenatal education and case management. Case management will partner with the obstetric provider to facilitate and coordinate services, assist in the identification of community resources, and provide education and assessment. Please use the following sample lists of diagnoses and secondary diagnoses to identify the at-risk status for your obstetrical patient.

Current Medical Condition

- Cancer, carcinoma, malignancy
- DIC, ITP, Sickle Cell or other Hemoglobinopathies
  Pulmonary HTN, COPD, Cystic Fibrosis, or Asthma with frequent medications
- Unspecified disorder of kidney and ureter
- Hypertension
- Hyperemesis Gravidarum with metabolic changes
- Unspecified renal disease in pregnancy, without mention of hypertension
- Unspecified renal disease in pregnancy
- Liver disorders in pregnancy
- HIV, Rubella, Parvovirus, Varicella, Herpes, Hep B, Syphilis, Gonorrhea or other STD, Toxoplasmosis, TB or other viral disease or infection
- Diabetes: GDM or IDDM
- Addison's, Thyroid, or Parathyroid Disease
- Anemia of mother, complicating pregnancy, childbirth, or the puerperium
- Congenital CV Disorders of mother, complicating pregnancy
- Other CVD of mother, complicating pregnancy
- Poor fetal growth
- Poly / Oligohydraminos
- Thrombophlebitis or PE
- Systemic Lupus Erythematosis
- Seizure Disorder, Myasthenia Gravis, or Multiple Sclerosis
- Non-specific abnormal Pap

Obstetric History

- Missed Abortion (early fetal death before completion of 22 weeks gestation)
- Spontaneous Abortion
- Hx of elective abortion
- Hemorrhage in early pregnancy, before completion of 22 weeks gestation
- Threatened Abortion
- Antepartum hemorrhage, abruptio placenta, placenta previa
- Hx of severe pre-eclampsia
- Hx of eclampsia
- Habitual aborter
- Fibroid uterus (tumors of body of uterus)
- Uterine Anomaly
- Incompetent Cervix
- Pregnancy with history of abortion (includes miscarriage, spontaneous abortion)
- Pregnancy with other poor obstetric Hx (hemorrhage in early pregnancy, placenta previa, hypertension, infectious conditions, Diabetes, CV Disease, Mental Disorders)
- Pregnancy with other poor reproductive history (previous stillbirth, infant death)

Social / Demographic

- Tobacco use disorder
- Eating disorders
- Hx or current mental disorders (includes psychoses, organic psychotic conditions, alcoholic or drug psychoses, anxiety syndrome, schizophrenic disorders, affective psychoses such as major depression and bipolar, sexual deviations and disorders, mental retardation)
- Drug dependence
- Multiple Gestation
- Hx of parenting problems (child maltreatment syndrome)
- Other personal Hx presenting hazards to health (non-compliance with medical Tx, Hx tobacco use, exposure to asbestos, lead)
- Unspecified personal Hx presenting hazards to health
- Other high-risk pregnancy (elderly primigravida or multigravida $\geq$ 35 yo, young primigravida or multigravida $<$ 16 yo)
- Language barrier
- Inadequate material resources (economic problems, transportation barrier, no phone in home)
- Counseling for victim of spousal and partner abuse
- Counseling for perpetrator of spousal and partner abuse
- Multiparity
- Other unwanted pregnancy (Significantly ambivalent or negative feelings toward pregnancy)
- Other specified family circumstances (Inadequate support system)

Note: This list is intended only as a guideline. You may identity other conditions that put your patient at-risk for poor pregnancy outcome. Please use the space provided on the form to indicate risk factors. For questions regarding our program, please call **1-800-225-8698**.

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XI. PREVENTIVE CARE

Preventive care benefits vary according to the Member's health care benefits plan. Providers can verify Member benefits by calling the Provider Service at 1-800-924-7141, the BlueCross BlueShield of Tennessee Customer Service number listed on the front of the Member's ID card, or accessing e-Health Services® on the company Web site at www.bcbst.com.

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XII. QUALITY IMPROVEMENT PROGRAM (QIP)

A. Introduction

BlueCross BlueShield of Tennessee, Inc. is committed to improving the quality and safety of care and service to its Members. BlueCross BlueShield of Tennessee demonstrates this commitment through the implementation of a comprehensive Quality Improvement Program QIP, which provides the structure that supports quality improvement activities.

The purpose of the Quality Improvement Program is to assess and improve the quality and safety of clinical care and service of our Members. This is achieved by planning and implementing quality improvement activities that are integrated and coordinated across departmental lines. This purpose is accomplished by creating an infrastructure and a set of business processes that support the achievement of high quality outcomes in care and service as an integral part of the way we do business.

The QIP includes a written program description, work plan, program evaluation and a committee structure that supports the program. The QIP reflects goals that support the mission and objectives of BlueCross BlueShield of Tennessee. The QIP is integrated throughout the organization with each department sharing the responsibility for improving care or service to Members. Additionally, the QIP reflects all relevant federal and state regulations and complies with accrediting agency standards. Continuous Quality Improvement (CQI) processes are incorporated into the entire health care delivery system of BlueCross BlueShield of Tennessee.

B. Scope

The QIP is reflected throughout the entire delivery system. The scope of the populations served by the QIP includes all members. Participation/activities include, but are not limited to:

- Primary care practitioners, behavioral health providers, and specialty providers
- Institutional settings (hospital, skilled nursing facilities, home health agencies, pharmacies, rehabilitation and behavioral health)
- Non-institutional settings (free-standing surgical centers, urgent care centers, emergency departments and physical therapy)
- Internal operations
- The quality of clinical and non-clinical aspects of care and service, including the availability, accessibility, coordination and continuity of care
- Risk, health and disease management activities that identify and evaluate medical risks and implementation of actions to control or eliminate those risks

C. Authority and Structure

Authority and Responsibility

The BlueCross BlueShield of Tennessee Board of Directors (BOD) has the ultimate responsibility and accountability for the quality and safety of care and services rendered, and for the QIP. The BOD reviews and approves the QIP annually. The BOD has formally delegated oversight of the QIP and associated quality improvement activities to the Delivery Systems Committee. This Committee meets at least quarterly and is responsible for, but not limited to, the review and approval of the QIP. A complete committee structure is in place to support the QIP. The Chief Medical Officer (CMO) of Commercial Business and Established Markets is the designated

senior executive responsible for the QIP. The Senior Medical Director of Quality Improvement is accountable for clinical and service quality activities and oversees the development and implementation of the QIP. Additionally designated regional physicians are also involved in QI activities and responsibility for the implementation of the QIP. Network Practitioners are actively involved in the QIP through their participation in appropriate committees, development of clinical policies, adoption of clinical practice guidelines, peer review, review of Utilization Management (UM) criteria modifications and medical policy review.

Confidentiality
Any employee or participating Practitioner engaging in CQI activities must uphold the established principles of Member and Practitioner confidentiality and individual privacy. Each employee signs a statement of confidentiality and Practitioners sign an affidavit of confidentiality. CQI data and reports are only accessible to those individuals participating in the QIP and those agencies responsible for ascertaining the existence of an ongoing and effective program. Summary results may be released through marketing requests for information. Any request for information from attorneys or consumers must be submitted in writing to the Legal Department indicating the purpose of the request.

Conflict of Interest
No person may participate in the review and evaluation of any case or issue in which he or she has been personally or professionally involved or where a conflict of interest may exist, which potentially compromises objective evaluation. A Practitioner serving on any committee or subcommittee, acting as a Physician advisor, or serving as peer reviewer will disqualify themselves from evaluating or reviewing a case in which they or their immediate associates have been personally or professionally involved, or if a direct personal or economic interest exists.

Quality Improvement Activities
A defined methodology ensures a systematic approach to the collection of objective, statistically valid data, in order to evaluate and improve quality of care and the services offered to Members and Practitioners. Data are collected to measure structure, process, and outcome, and the following dimensions of quality: efficacy, adequacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency and satisfaction reflecting the full continuum of care.

BlueCross BlueShield of Tennessee focuses on clinical and service objectives and issues that are relevant for a significant portion of our Members. Reviewing the results of population assessments identifies important aspects of clinical care that significantly impact Members and Providers.

Important aspects of service are identified by evaluating complaints, appeals, and grievances, and by monitoring the organization's key performance measures, as well as conducting satisfaction surveys. The criteria for selecting important aspects of care and service topics include but are not limited to:

- Are the health care concerns or conditions reflective of the BlueCross BlueShield of Tennessee population?
- Is there an opportunity to improve service and/or care?
- Is this topic high-volume, high-risk, high-cost, or problem prone?
- Is this topic an issue of Member, Practitioner or Provider satisfaction?

Program Evaluation and Workplan
The overall effectiveness of the QIP is evaluated at least annually and documented in a written QI Program Evaluation. The evaluation addresses:

- Progress and status of annual goals
- Completed and ongoing QI activities
- Trending of clinical, service and other performance measurements
- Analysis of results for demonstrated improvements in quality
- Opportunities for improvement
- Overall effectiveness of the QIP
- Goals and recommendation for the workplan for the following year

Based on the annual program evaluation, the QIP is revised and a QI work plan is developed. The purpose of the annual workplan is to focus on the QIP goals, objectives and planned projects/activities for the forthcoming year. The annual workplan also identifies person(s) responsible for different portions of the workplan and timeframes for achievement of activities and committee reporting. The workplan is utilized as an action plan to document the status of activities and achievement of goals throughout the year.

D. Medical Management Corrective Action Plan

PURPOSE: This procedure statement outlines how BlueCross BlueShield of Tennessee, Inc., and its affiliated companies, ("the Plan") may initiate corrective actions if an applicant or participating Provider fails to comply with applicable medical management requirements set forth in section 1, below. The Plan's medical management programs include Provider credentialing, utilization review, quality management and Member grievance resolution activities that are overseen by professional review committees. The Plan's Board of Directors has designated the Medical Management Committee and its subcommittees (the "Committees") as the professional review committees responsible for performing peer review activities in accordance with the Federal Health Care Quality Improvement Act (the "HCQIA"), TCA section 63-6-219 and other applicable laws governing the organization and operation of professional peer review or medical review committees (the "Peer Review Laws").

The Plan's staff has been authorized to provide necessary support services to the Committees. Members of the Board, Committee Members, staff Members and anyone providing information to those Committees are intended to be protected against liability to the fullest extent permitted by the Peer Review Laws. The terms of this Procedure statement have been incorporated by reference into the Plan's Provider participation applications and agreements. As partial consideration for being permitted to apply to become a participating Provider and, if applicable, selected to participate in the Plan, participating Providers agree that they shall not seek to hold the Plan or such individuals liable for acts taken in good faith in accordance with this Procedure statement**.**

This procedure only applies to matters that involve Committee actions. Matters that do not involve Committee actions include: the non-acceptance of a participation application because the Provider fails to satisfy the Plan's pre-credentialing application standards (e.g. failure to provide evidence of licensure or insurance), the termination of a Provider's participation other than by reason of that Provider's failure to comply applicable participation requirements (e.g. the participation agreement is terminated without cause); and disputes related to claims payment or authorization decisions. Such matters must be resolved in accordance with the Plan's Provider Dispute Resolution Procedure statement.

Records or information concerning the activities of the Committees shall be treated and maintained as privileged and confidential peer review records to the fullest extent permitted by the Peer Review Laws. Reports to the Committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this procedure statement shall not alter the status of such records or information as privileged and confidential information.

I. PARTICIPATION REQUIREMENTS

The Plan's Chief Medical Officer or his designee (the "Chief Medical Officer") will monitor participating Providers' performance to ensure that they comply with the Plan's participation requirements. The following is intended to provide a non-exclusive summary of those participation requirements:

A. Participating Providers shall cooperate, in good faith, to facilitate the Plan's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from the Plan, providing information and documents requested by the Plan and cooperating with Plan staff Members as they perform their medical management activities.

B. Participating Providers shall render or order Medically Necessary and Appropriate services for Member-patients.

C. Participating Providers shall obtain prior authorization of services in accordance with applicable Plan medical management program policies and procedures.

D. Participating Providers shall not make non-emergency referrals to non-participating Providers, unless asked to do so by a Member-patient who has been advised of that Provider's non-participating status.

E. Participating Providers shall fully comply with the terms of their participation agreements.

F. Participating Providers shall comply with accepted professional standards of care, conduct and competence.

G. Participating Providers shall maintain an acceptable reputation in the community (e.g., no allegations of moral turpitude).

H. Participating Providers shall continue to satisfy the Plan's credentialing requirements as set forth in the Plan's Credential Process, including, without limitation:

1. The Provider's licenses or certifications must be in good standing.

2. The Provider's liability insurance coverage must remain in full force and effect.

3. There have been no unreported material changes in the Provider's status such that the credentialing information submitted to the Plan is no longer accurate.

II. CORRECTIVE ACTIONS

A. Investigation

The Plan's staff will investigate and report any apparent non-compliance with the participation requirements to the Chief Medical Officer or his designee, after making a reasonable effort to obtain material facts concerning that matter. Providers must submit requested information and fully cooperate with those staff members as a condition of their continued participation in the Plan. Staff members or the Chief Medical Officer may, at their discretion:

1. Consult with the Provider;

2. Review material documents, including Members' medical records; or

3. Contact other Providers or persons who have knowledge concerning the matter being investigated.

B. Bases of Actions

The Chief Medical Officer or a Committee may initiate a corrective action if a participating Provider does not comply with applicable participation requirements, and:

1. There is a reasonable belief that the action will promote the objectives of the Plan's medical management program.

2. There has been a reasonable effort to obtain the facts concerning the Provider's alleged non-compliance.

3. The proposed action is reasonably warranted by the facts known after the investigation has been completed.

4. The Provider has been notified and given an opportunity to request an appeal concerning the imposition of the corrective action in accordance with this procedure statement.

C. Actions by the Chief Medical Officer

Upon determining that a participating Provider has not complied with the Plan's participation requirements, the Chief Medical Officer may initiate corrective actions including, without limitation:

1. Counseling the Provider concerning specific actions that should be taken to address identified problems. A summary of the counseling session and the plan of corrective action will be included in the Provider's credentialing file.

2. Submitting information regarding the Provider's conduct to the appropriate Committee for further consideration and action.

3. Imposing corrective actions, following the issuance of a "notice of corrective action" including without limitation:

    a. Imposing practice restrictions, such as, focused review, mandatory prior authorizations for specified treatments or services, mandatory consultation, preceptorship, continuing medical education, and/or closure of the Provider's practice to new Members.

    b. Terminating the Provider's participation.

    c. Imposing financial penalties such as an increased withhold, a one-time financial penalty (e.g. the cost of services incurred as a consequence of the Provider’s non-compliance) or the denial of fees for inappropriate or unauthorized services.

4. Imposing a summary suspension. The Chief Medical Officer shall notify the Provider, by certified mail, of the summary suspension of the Provider's participation, if such action is necessary to protect Members' health and welfare or to protect the Plan's reputation or operations.

    a. If the Chief Medical Officer or a Committee requires additional time to investigate allegations concerning a Provider's conduct, competence, practices or reputation, the summary suspension shall remain in effect pending the completion of that investigation. Such investigation must be

completed within fourteen (14) days after the imposition of the summary suspension.

b. If, after such investigation, it is determined that the Provider's conduct, competence, practices or reputation may result in an imminent danger to Members' health or welfare, or impair the Plan's reputation or operations, the suspension shall continue in effect unless the Provider's participation is reinstated following a hearing conducted in accordance with section III, below.

c. The Chief Medical Officer shall make appropriate arrangements to have other Providers render services to Members who are under the care of the suspended Provider. The suspended Provider shall cooperate in referring Members to such other Providers in accordance with this Corrective Action Plan and the terms of his or participation agreement.

5. If a Provider is a Member of a medical group or IPA, the Medical Director of that group or IPA shall be notified, in writing, of the imposition of corrective actions pursuant to this section.

6. Denying or revoking the Provider's credentials.

D. Actions by a Committee

1. Committee Meetings

If the Chief Medical Officer refers the matter to a Committee, that Committee shall consider information submitted to it concerning a Provider's non-compliance with the Plan's participation requirements during its next regularly scheduled meeting or at a special meeting called by the Chief Medical Officer to consider that matter. Members of the Committee may participate in such meetings in person or by telephone conference call and may take actions by consent. Any meeting of a Committee concerning a Provider's alleged non-compliance shall be conducted in confidence and any information concerning such meetings shall be maintained as privileged and confidential information to the fullest extent permitted by applicable Peer Review Laws.

2. Committee Investigations

A Committee may direct the Chief Medical Officer or his designee to further investigate and submit additional information concerning a Provider's alleged non-compliance. The Committee may also request that the Provider submit specified information or attend a meeting to respond to questions concerning such alleged non-compliance. The Provider otherwise has no right to participate in Committee proceedings.

3. Corrective Actions

The Committee may take or direct the Chief Medical Officer to take any of the corrective actions described in section C, above.

E. Notice of Corrective Action

The Chief Medical Officer or the Chairperson of the Committee shall immediately notify the Provider, by certified or overnight mail, of the imposition of a corrective action. If the Provider is a member of an IPA or medical group, a copy of that notice shall also be sent to the Medical Director of that IPA or medical group. That corrective action shall become effective as of the

date of that letter, unless the Chief Medical Officer or Committee elect to defer the effective date of that action. The notice letter shall include:

1. A description of the corrective action,

2. A general description of the basis of that action,

3. A statement explaining how to request an appeal to the imposition of that action, specifying that such a appeal must be requested within thirty (30) days after the date of that notice letter.

4. If applicable, a statement that the action may be reported to the State licensing board or other entities as mandated by law if the Provider doesn't request an appeal or if that action is affirmed following exhaustion of the appeal process.

III. APPEAL PROCEDURES

A. Appeal of Non-Reportable Action by a Participating Provider

1. Written Appeal

a. The Provider may initiate an appeal by submitting a written statement of his or her position within 30 days after receipt of the notice of the imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer. A written response will be sent to the Provider within sixty (60) days after the Plan receives that written appeal.

b. The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Chief Medical Officer.

2. Informal Subcommittee Meeting

a. If not satisfied with the Plan's response to the written appeal, the Provider may request an informal meeting with the subcommittee designated to consider such appeals within ten (10) days of the date of the response letter sent pursuant to 1 (a), above.

b. The Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.

c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

3. Binding Arbitration

a. If still not satisfied with the Plan's decision, the next and final step is binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan's response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

b. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then claimant forfeits its filing fee and it may not be assessed against BCBST.

c. Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees.

d. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

e. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document . This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

B. Appeal of Non-Reportable Action by an Applicant

1. Written Appeal

a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer

b. imposing the corrective action. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

b. The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Committee or Chief Medical Officer.

2. Binding Arbitration

If the Provider is still not satisfied with the Committee's decision, he may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in paragraph III.A.3 above.

C. Appeal of a Potentially Reportable Action by Participating Providers or Applicants

1. Written Appeal

a. The Provider may appeal by submitting a written statement of his or her position within thirty (30) days of receipt of the notice of imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer. A written response will be sent to the Provider within sixty (60) days after the Plan receives that written appeal.

The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Committee or Chief Medical Officer.

2. Informal Subcommittee Meeting

a. If not satisfied with the Plan's response to the written appeal, the Provider may request an informal meeting with the subcommittee designated to consider such appeals, within ten (10) days after the date of the response letter sent pursuant to subsection 1(a), above.

b. The Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.

c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

3. Hearing

a. Appointment of the Hearing Officer

If still dissatisfied with the Committee's decision, the Provider may request a hearing. In that event, the Chief Medical Officer shall appoint a qualified

designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:

1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.

2. May not be in direct economic competition with the Provider requesting the hearing.

3. Must be qualified to evaluate the issues likely to be presented during the hearing.

4. Shall be acting as member of the Committee while performing his or her duties.

b. Notice of Hearing

The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a detailed description of the basis of the corrective action, including any acts or omissions which the Provider is alleged to have committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law in accordance with applicable Peer Review Laws.

c. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing, however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.

2. The hearing will be recorded by a court reporter.

3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.

4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.

5. During the hearing, each party has the right to:

   i. call witnesses,

   ii. cross-examine opposing witnesses, and

   iii. submit a written statement at the close of the hearings

6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer's report and recommendation.

d. Hearing Officers' Report

The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer's recommendation concerning the imposition of the corrective action, if any, and the basis for that recommendation.

e. Action by the Committee

The Hearing Officer's report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the Hearing Officer's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the Hearing Officer's report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

f. Appeal of Decision

Any action based upon or related to the Committee's decision must be submitted to binding arbitration in accordance with paragraph III.A.3 above.

IV. REPORTING CORRECTIVE ACTIONS

A. Reporting to Regulatory Agencies

Certain actions must be reported to State licensing agencies pursuant to the Peer Review Laws or other entities as mandated by law. The Chief Medical Officer will consult with the Plan's General Counsel prior to initiating any corrective action, if there is a question concerning whether it will be a reportable action.

1. The following actions must generally be reported:

   a. All professional review actions adversely affecting a Provider's participation in the Plan for longer than thirty (30) days based upon the Provider's professional conduct or competence.

   b. Acceptance of a voluntary termination of the Provider's participation while the Plan is investigation the Provider's conduct or competence, if that termination is intended to avoid the imposition of reportable sanctions.

c. A summary suspension that remains in effect for longer than fourteen (14) days.

2. Such actions must be reported to the licensing board within fifteen (15) days after the final effective date of that action. The report must include:

a. the name of the Provider,

b. a description of the facts and circumstances that form the basis for that action, and

c. any other relevant information requested by that licensing board.

3. The following actions are generally not reportable:

a. Actions that do not adversely affect the Provider's participation for longer than thirty (30) days.

b. Actions based upon the Provider's failure to comply with participation requirements that are not directly related to the Provider's professional conduct or competence.

B. INTERNAL REPORTING REQUIREMENTS

All corrective actions, whether reportable to a licensing board or not, must be reported to the following persons:

1. The involved Provider.

2. The Plan's General Counsel.

3. The Plan's Provider Networks and Contracting Department.

4. The Medical Director of each participating Medical Group or IPA if the Provider is a member of that entity.

XIII. PROVIDER DISPUTE RESOLUTION PROCEDURE

PURPOSE: To address and resolve any and all matters causing participating providers ("Providers") or BlueCross BlueShield of Tennessee or its affiliated companies ("BCBST") to be dissatisfied with any aspect of their relationship with the other party (a "Dispute"). Providers are encouraged to contact a representative of BCBST's Provider Networks and Contracting Division if they have any questions about this procedure statement or concerns related to their network participation.

I. INTRODUCTION.

A. This Procedure describes the exclusive method of resolving any Disputes related to a Provider's participation in BCBST's network(s). It is incorporated by reference into the participation agreement between the parties (the "Participation Agreement") and shall survive the termination of that Agreement.

B. This Procedure shall only be applicable to resolve Disputes that are subject to BCBST's or the Provider's control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party's control (e.g. determinations made by a customer purchasing administrative services only ("ASO Customers") from BCBST).

C. This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. As an example, the decision to not accept an applicant as a participating provider for failure to submit required information (e.g. proof of licensure), may be subject to resolution in accordance with this procedure. Matters involving peer review evaluation of an applicant's professional qualifications, conduct or competence must be resolved pursuant to BCBST's "Medical Management Corrective Action Plan" (Section XII. G).

D. The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.

E. This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it is not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.

F. The parties may agree to skip one or more steps of this procedure (e.g. mediation), to expedite the resolution of a Dispute. The parties will mediate a Dispute only if both parties agree to mediation.

G. A party must commence an action to resolve a Dispute pursuant to this procedure statement within two (2) years from the end of the year in which the event causing

that Dispute occurred (e.g. the date of the letter informing the Provider of a determination) or, with respect to Provider requests for reimbursement of unpaid or underpaid claims, within two (2) years from the end of the year in which the claim was originally submitted. This provision shall not extend the period during which a Participating Provider must submit a claim to BCBST pursuant to applicable provisions of the provider's agreement(s) with BCBST, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within two years after receiving notice of the denial of that claim. If BCBST discovers a matter creating a Dispute with a Participating Provider during an audit, which is in progress at the end of the two (2) year period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

H. **ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES' SATISFACTION PURSUANT TO SECTIONS II (A-C) OF THIS PROCEDURE STATEMENT.**

II. DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.

A. INQUIRY/RECONSIDERATION

Providers should contact a representative of the BCBST division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g. the Claims Service Department if there is a question concerning a claims related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Networks and Contracting Division for assistance in directing their inquiries to the appropriate BCBST representative. BCBST may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g. an office manager). If a party cannot respond immediately to the other party's inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

B. APPEAL.

If not satisfied, a party may submit a written appeal within 30 days after receiving the other party's response to its inquiry/reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

C. MEDIATION.

If not satisfied with the response to its appeal, a party may request mediation (or some other non-binding alternative dispute resolution process) by submitting a written request within thirty (30) days of receipt of the other party's appeal response. Both parties must agree to the mediation. Upon agreement, the parties shall cooperate, in good faith, to designate a mutually acceptable mediation procedure or agency (e.g. the American Arbitration Association ("AAA")) and a mediator, who is qualified to consider the issues likely to be raised during the hearing, within thirty (30) days after a party requests such mediation.

The parties shall equally share the mediator's fee and the costs of conducting that hearing, although each party shall be solely responsible for its costs of participating in that hearing (e.g. its attorney's fees). The mediator may terminate any mediation if either party fails to comply with applicable rules or deadlines or if the parties are unable to voluntarily resolve their Dispute.

D. BINDING ARBITRATION.

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives a response to its appeal or the conclusion of the mediation of that Dispute. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees.

The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BCBST.

The arbitrators: shall consider each claimant's demand individually and shall not certify or consider multiple claimants' demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

E. EFFECTIVE DATE.

This procedure statement was adopted by BCBST on June 1, 1997.

Last date of revision, November 1, 2003.

BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402-2555
www.bcbstn.com

Provider Dispute Form

-- Confidential --

I wish to submit the following dispute in accordance with the Provider Dispute Resolution Procedure:

☐ Level 1 Inquiry (Reconsideration) - Attention: Customer Service

☐ Level 2 Appeal - I have submitted this dispute through the Inquiry Level of the procedure and am dissatisfied with the response. ***(Please attach a copy of the response received from the Customer Service Inquiry if applicable.)***

Date	Provider Name
Provider No.	Patient Name
Provider Contact	Member ID No.
Provider Fax No.	Date of Service
Provider Telephone No.	Claim No./Decision/Issue Disputed

When submitting your dispute in accordance with the Inquiry or Appeal level of the procedure, please indicate a detailed reason for your dispute. If applicable, please include all pertinent information including prior correspondence, medical records and all documentation you wish to have considered in the final determination of your dispute. (You may also use the back of this form if necessary.) Please return this completed form along with the requested documentation to:

For Commercial Members
Mail Level 1 Inquiry (Reconsideration) to:
Attn: Customer Service
BlueCross BlueShield of TN
P. O. Box 180150
Chattanooga, TN 37401

For BlueAdvantage or BlueAdvantage*Plus* Members
Mail Level 1 Inquiry (Reconsideration) to:
Attn: BlueAdvantage Customer Service
BlueCross BlueShield of TN
P.O. Box 180205
Chattanooga, TN 37402-7205

For BlueCare® or TennCare*Select* Members
Mail Level 1 Inquiry (Reconsideration) to:
Attn: Customer Service
BlueCare
P.O. Box 182277
Chattanooga, TN 37422

For All BlueCross BlueShield of TN Members
Mail Level 2 Provider Appeal to:
Attn: Provider Appeals Coordinator
Provider Networks and
Contracting Division
801 Pine Street
Chattanooga, TN 37402-2555

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Rev 03/06

Provider Dispute Form

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XIV. CREDENTIALING

A. Introduction

The BlueCross BlueShield of Tennessee Credentialing Program was established August 1, 1995. The Credentialing Program is designed around goals that reflect the BlueCross BlueShield of Tennessee mission, as well as regulatory and accrediting requirements.

In order to establish consistent standards for network participation, and to meet regulatory requirements, BlueCross BlueShield of Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete a one page pre-application form. Utilizing the pre-application, BlueCross BlueShield of Tennessee conducts a preliminary evaluation for network participation. Practitioners must complete both the pre-application and the credential process, prior to network participation. **Note**: *The Credentialing process does not apply to Practitioners participating in BlueCross BlueShield of Tennessee's Blue Network C; however, completion of the pre-application form does apply*.

Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BlueCross BlueShield of Tennessee network. Major components of the credentialing program include:

- Credentialing Committee
- Policies and Procedures
- Initial Credentialing Process
- Recredentialing Process
- Delegated Credential Activities
- Software Implementation and Maintenance

Practitioners have the right to review information submitted with their application; correct erroneous information; or be informed of the status of their credentialing application upon request.

Inquiries regarding the Credentialing process should be addressed to the following:

Mailing Address:

Attn: Credentialing Department – 4TC
BlueCross BlueShield of Tennessee
P O Box 180176
Chattanooga, TN 37401

Telephone Inquiries:

(Toll Free) 1-800-357-0395
(Fax) 1-423-535-8357
(Fax) 1-423-535-6711

B. Credentialing Application

Credentialing applications are used to uniformly identify and gather specific information for all Practitioners and Organizational Providers that wish to participate with BlueCross BlueShield of Tennessee. The BlueCross BlueShield of Tennessee Credentialing Program determines whether Practitioners and other Health Care Professionals, licensed by the State and under contract to BlueCross BlueShield of Tennessee, are qualified to perform their services and meet the minimum requirements defined by the American Accreditation Healthcare Commission (AAHC/URAC), the Centers for Medicare and Medicaid Services (CMS), and the TennCare Risk Agreement. Verification of all required credentials is imperative.

Once Practitioners and Organizational Providers have completed the credentialing process, they will receive written notification from BlueCross BlueShield of Tennessee's Credentialing Department. Note: ***This notification does not guarantee acceptance in BlueCross BlueShield of Tennessee networks; Practitioners and Organizational Providers are not considered participating in BlueCross BlueShield of Tennessee networks until they receive an acceptance letter from BlueCross BlueShield of Tennessee's Contracting Department*****.**

Applications are considered complete under the following circumstances:

- The application is filled out in its entirety;
- The statement of the applicant page and/or the attestation page is signed and dated;
- The application is received within 90 days from the date of the statement of the applicant and/or the attestation page; and
- The following documentation is enclosed with the application submission:
  * Explanations to any questions requiring additional information;
  * Copy of the current medical license;
  * Copy of the current Drug Enforcement Administration (DEA) / Controlled Dangerous
  * Substance (CDS) certificate, if applicable;
  * Copy of the Clinical Laboratory Information Amendments (CLIA) Certificate, if applicable;
  * Copy of board certification; if applicable;
  * Copy of current business liability certification for (Organizational Providers only).
  * Copy of the current malpractice liability insurance certificate showing $1,000,000 per occurrence and $3,000,000 aggregate coverage to meet BlueCross BlueShield of Tennessee criteria.

Note: *The expiration dates for all documents must not be within 60 days of the application's receipt in the Credentialing Department.*

C. Credentialing Policies

BlueCross BlueShield of Tennessee has written policies and procedures for both the initial and recredentialing process of Practitioners and Organizational Providers. The following policies are subject to change and should only be referenced as a guideline. Final determination of credentialing status is a decision of the BlueCross BlueShield of Tennessee Corporate Credentialing Committee. For specific assistance, please contact your Regional Provider Relations Representative (see Section I for region-specific telephone number) or call the BlueCross BlueShield of Tennessee Credentialing Department at 1-800-357-0395.

Note: ***Primary Care Practitioner and OB/GYN office site visits are performed by BlueCross BlueShield of Tennessee prior to completion of the initial*** **credentialing** ***process.***

1. Credentialing Process for Practitioners:

The following information is required and/or must be verified for Practitioners:

- A current, valid, unrestricted license to practice in the state of jurisdiction.
- History of, or current license probation will be subject to peer review.
- Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law) within the scope of the Practitioner's practice, if applicable.
- Work history for the last five years with documented gaps in employment over 90 days.
- Malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate. (Exceptions made for State Employees).
- Clinical privileges in good standing at a licensed facility designated by the Practitioner as the primary admitting facility. If the Practitioner does not have clinical privileges, the Practitioner must have a coverage arrangement with a BlueCross BlueShield of Tennessee credentialed Practitioner.

- Surgical specialties must have clinical privileges or will be subject to peer review.
- National Practitioner Data Bank (NPDB) report
- Healthcare Integrity and Protection Data Bank (HIPDB) report
- Board certification verification if the practitioner indicates certified on application
- BlueCross BlueShield of Tennessee recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), American Dental Association (ADA), and the American Board of Podiatric Surgery (ABPS) for recognized specialty designation.
- Absence of history of federal and/or state sanctions (Medicare, Medicaid, or TennCare).
- Verification of a current, valid, unrestricted state license is sufficient for a Practitioner's degree. Verification of board certification or highest level of education is necessary for specialty designation.
- History of, or criminal conviction or indictment will be subject to peer review.
- Current Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable.
- Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements with a BlueCross BlueShield of Tennessee credentialed Practitioner.
- Statement from applicant regarding:
  * Current physical or mental health problems that may affect ability to provide health care;
  * Current chemical dependency/substance abuse;
  * History of loss of license and or felony convictions;
  * History of loss or limitation of privileges or disciplinary activity; and
  * An attestation to correctness/completeness of the application.
- Office site visit to each potential Primary Care Practitioner and OB/GYN's office including documentation of a structured review of the site and medical record maintenance process. This visit must occur within a two-year period prior to the Credentialing Committee's review and recommendation.
- Verification that Practitioner is at office where treatment is rendered and interacts with Nurse Practitioner/Physician Assistance conforming to state regulations.
- Verification that protocol exists and is located at the premises where Nurse Practitioner/Physician Assistant practices as required by state law.

Specific requirements for specialties listed:

Audiologist/Speech Therapist/Physical Therapist/Occupational Therapist:

- Current Licensure in State of Tennessee in Specialty will verify education.
- If not practicing in Tennessee, education may be verified by certificate from:
  * American Occupational Therapy Certification Board;
  * American Speech-Language-Hearing Association;
  * Physical Therapist Certificate of Fitness, if applicable; **or**
  * Verification of highest level of education in specialty requested.
- No call coverage required.
- Clinical privileges not required.
- DEA not required.

Chiropractors:

- Clinical privileges not required.
- DEA not required.

Hospital Based (if practicing outside the hospital setting):

- Must be credentialed and all Minimum and Exception Criteria applies.
- Any hospital-based Practitioner with additional practice sites are then evaluated and credentialed to that site's highest standard according to the type of practice (i.e., Primary Care).

Neuropsychologist (Ph.D):

Minimum and Exception criteria apply in addition to:

- Clinical privileges not required.
- License must specify "Health Services Provider".
- Ph. D. degree required.

Nurse Practitioners or Nurse Mid-Wife:

Minimum and Exception criteria apply in addition to:

- Certificate of Fitness required for Nurse Practitioners (NP).
- If Prescriptive Authority includes a DEA, all schedules must be verified.
- Certification most applicable to the nurse specialty from one of the following bodies:
  * American Nurses Credentialing Center;
  * American Academy of Nurse Practitioners;
  * American College of Nurse-Midwives Certification Council;
  * National Certification Corporation of Obstetric and Neonatal Nursing Specialties; or
  * National Certification Board of Pediatric Nurse Practitioners and Nurses.
- Written statement from the BlueCross BlueShield of Tennessee credentialed Practitioner that has a valid oversight specialty who supervises the health care professional. Such statement must include:
  * The name and address of the supervising Practitioner;
  * Verification the Practitioner is responsible for the care and treatment rendered by the NP;
  * Verification once a month the Practitioner is physically at the offices where treatment is being rendered and is interacting and overseeing the NP; and
  * Verification that a protocol exists and is located at the premises where the NP practices as required by state law.

Exclusion:

- Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA not required, however if applicant has DEA it must be verified.

Optometrist:

Minimum and Exception criteria apply in addition to:

- State license must contain Therapeutic Certification.

Physician Assistants:

Minimum and Exception criteria apply in addition to:

- Certificate from the National Commission on Certification of Physician Assistants (NCCPA), if applicable.
- Written Statement from the BlueCross BlueShield of Tennessee credentialed Practitioner that has a valid PCP specialty who supervises the health care professional. Such statement shall include:
  * The name and address of the supervising Practitioner;
  * Verification that the Practitioner is responsible for the care and treatment rendered by Physician Assistant (PA);
  * Verification that once a week the Practitioner is physically practicing at the office where treatment is being rendered and is interacting and overseeing the PA; and
  * Verification that a protocol exists and is located at the premises where the PA practices as required by state law.

Exclusion:

- Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA not required, however, if applicant has DEA, all schedules must be verified.

Physician Assistants-Surgical Assist:

- PA must be licensed, meet all other general provider requirements
- Supervising Surgeon must be credentialed with BCBST in a surgical specialty. (General, Urology, Neurology, Orthopedic, etc)
- PA must meet all State practice protocol requirements as verified with attestation.
- PA's Hospital and ASF privilege criteria must be verified.
- PA must provide proof of graduation from an accredited PA program.

PA must maintain ongoing certification by the NCCPA (which will include satisfactory completion of the NCCPA examination and all other ongoing certification requirements) and completion of NCCPA examination/certification.

Pharmacist
Minimum and Exception criteria apply in addition to:
- Copy of certification for successful completion of accredited disease specific management program(s), if applicable.
- Clinical privileges not required.
- Call coverage not required.

Podiatrist
Minimum and Exception criteria apply in addition to:
- Clinical privileges not required unless, current privileges are indicated, they will be verified.

Urgent Care Physicians
All Minimum and Exception Criteria apply unless, acting as PCP, with exception of:
- Clinical privileges.
- Call Coverage.
- Site Visit.

2. Recredentialing Process

All Practitioners will be recredentialed at a minimum of every **three** years. The date of recredentialing will be based on the date of initial credentialing.

In addition to the information that will be verified by primary or secondary sources, BlueCross BlueShield of Tennessee will include and consider collected information regarding the participating Practitioner's performance within the health plan, including information collected through the health plan's quality management program.

3. BlueCross BlueShield of Tennessee Approved Specialties

BlueCross BlueShield of Tennessee recognizes and maintains the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Practitioners must designate a specialty on the credentialing application. To be listed in any BlueCross BlueShield of Tennessee Provider directory in the specialty requested, the Practitioner must meet one of the following requirements:
- Recognized Board Certification, or
- **Practitioners**: Successful completion of residency or fellowship in the applied specialty.
- **Other Health Care Professionals**: Licensure and additional certification, if applicable in the field of specialty.

American Board of Medical Specialties (ABMS)

I. American Board of Allergy and Immunology
- A. Allergy and Immunology
- B. Clinical and Laboratory Immunology

II. American Board of Anesthesiology
- A. Anesthesiology
- B. Critical Care Medicine
- C. Pain Management

III. American Board of Colon and Rectal Surgery
- A. Colon and Rectal Surgery

IV. American Board of Dermatology
- A. Clinical and Laboratory Dermatological Immunology
- B. Dermatology
- C. Dermatopathology
- D. Pediatric Dermatology

V. American Board of Emergency Medicine
- A. Emergency Medicine
- B. Medical Toxicology
- C. Pediatric Emergency Medicine
- D. Sports Medicine
- E. Undersea-Hyperbaric Medicine

VI. American Board of Family Practice
- A. Family Practice
- B. Geriatric Medicine
- C. Sports Medicine

VII. American Board of Internal Medicine
- A. Internal Medicine
- B. Cardiovascular Disease
- C. Endocrinology, Diabetes, and Metabolism
- D. Gastroenterology
- E. Hematology
- F. Infectious Disease
- G. Medical Oncology
- H. Nephrology
- I. Pulmonary Disease
- J. Rheumatology
- K. Adolescent Medicine
- L. Clinical & Laboratory Immunology
- M. Clinical Cardiac Electrophysiology
- N. Critical Care Medicine
- O. Geriatric Medicine
- P. Interventional Cardiology
- Q. Sports Medicine

VIII. American Board of Medical Genetics, Inc.
- A. Clinical Biochemical Genetics
- B. Clinical Cytogenetics
- C. Clinical Genetics
- D. Clinical Molecular Genetics
- E. Molecular Genetic Pathology
- F. PHD Medical Genetics

IX. American Board of Neurological Surgery
- A. Neurological Surgery

X. American Board of Nuclear Medicine
- A. Nuclear Medicine

XI. American Board of Obstetrics and Gynecology
- A. Critical Care Medicine
- B. Gynecologic Oncology
- C. Gynecology
- D. Maternal and Fetal Medicine
- E. Obstetrics
- F. Obstetrics and Gynecology
- G. Reproductive Endocrinology

XII. American Board of Ophthalmology
- A. Ophthalmology

XIII. American Board of Orthopedic Surgery
- A. Hand Surgery
- B. Orthopedic Surgery

XIV. American Board of Otolaryngology
- A. Otolaryngology
- B. Otology/Neurotology
- C. Pediatric Otolaryngology
- D. Plastic Surgery within the head and neck

XV. American Board of Pathology
- A. Anatomic & Clinical Pathology
- B. Anatomic Pathology
- C. Blood Banking Transfusion Medicine
- D. Chemical Pathology
- E. Clinical Pathology
- F. Cytopathology
- G. Dermatopathology
- H. Forensic Pathology
- I. Hematology
- J. Medical Microbiology
- K. Molecular Genetic Pathology
- L. Neuropathology
- M. Pediatric Pathology

XVI. American Board of Pediatrics
- A. Adolescent medicine
- B. Clinical & laboratory immunology
- C. Developmental-behavioral pediatrics
- D. Medical toxicology
- E. Neonatal-Perinatal medicine
- F. Neurodevelopmental disabilities
- G. Pediatric cardiology
- H. Pediatric critical care medicine
- I. Pediatric emergency medicine
- J. Pediatric endocrinology
- K. Pediatric gastroenterology
- L. Pediatric hematology-oncology
- M. Pediatric infectious disease
- N. Pediatric nephrology
- O. Pediatric pulmonology
- P. Pediatric rheumatology
- Q. Pediatrics
- R. Sports medicine

XVII. American Board of Physical Medicine and Rehabilitation
- A. Pain Management
- B. Pediatric Rehabilitation Medicine
- C. Physical Medicine and Rehabilitation
- D. Spinal Cord Injury Medicine

XVIII. American Board of Plastic Surgery, Inc.
- A. Hand Surgery
- B. Plastic Surgery
- C. Plastic Surgery within the head and neck

XIX. American Board of Preventive Medicine
- A. Aerospace Medicine
- B. Medical Toxicology
- C. Occupational Medicine
- D. Preventive Medicine
- E. Undersea and Hyperbaric Medicine

XX. American Board of Psychiatry and Neurology
- A. Addiction Psychiatry
- B. Child And Adolescent Psychiatry
- C. Clinical Neurophysiology
- D. Forensic Psychiatry
- E. Geriatric Psychiatry
- F. Neurodevelopmental Disabilities
- G. Neurology
- H. Neurology with special qualification in Child Neurology
- I. Pain Management
- J. Pediatric Neurology
- K. Psychiatry

XXI. American Board of Radiology
- A. Diagnostic Radiology
- B. Neuroradiology
- C. Nuclear Radiology
- D. Pediatric Radiology
- E. Radiation Oncology
- F. Radiological Physics
- G. Radiology
- H. Vascular & Interventional Radiology

XXII. American Board of Surgery
- A. Hand Surgery
- B. Pediatric Surgery
- C. Surgery
- D. Surgical Critical Care
- E. Vascular Surgery

XXIII. American Board of Thoracic Surgery
- A. Thoracic Surgery

XXIV. American Board of Urology, Inc.
- A. Urology

American Osteopathic Association Boards (AOA)

I. American Osteopathic Board of Anesthesiology
- A. Addiction Medicine
- B. Anesthesiology
- C. Critical Care Medicine
- D. Pain Management

II. American Osteopathic Board of Dermatology
- A. Dermatology
- B. Dermatopathology
- C. MOHS-Micrographic Surgery

III. American Osteopathic Board of Emergency Medicine
- A. Emergency Medical Services
- B. Emergency Medicine
- C. Medical Toxicology
- D. Sports Medicine

IV. American Osteopathic Board of Family Practice
- A. Addiction Medicine
- B. Adolescent and Young Adult Medicine
- C. Family Practice
- D. Geriatric Medicine
- E. Sports Medicine

V. American Osteopathic Board of Internal Medicine
- A. Addiction Medicine
- B. Allergy/Immunology
- C. Cardiology
- D. Clinical Cardiac Electrophysiology
- E. Critical Care Medicine
- F. Endocrinology
- G. Gastroenterology
- H. Geriatric Medicine
- I. Hematology
- J. Hematology/Oncology
- K. Infectious Disease
- L. Internal Medicine
- M. Medical Oncology
- N. Nephrology
- O. Oncology
- P. Pulmonary Disease
- Q. Rheumatology
- R. Sports Medicine

VI. American Osteopathic Board of Neurology and Psychiatry
- A. Addiction Medicine
- B. Child and Adolescent Neurology
- C. Child and Adolescent Psychiatry
- D. Neurology
- E. Neurology/Psychiatry
- F. Psychiatry
- G. Sports Medicine

VII. American Osteopathic Board of Neuromusculoskeletal Medicine
- A. Neuromusculoskeletal Medicine
- B. Osteopathic Manipulative Medicine
- C. Sports Medicine

VIII. American Osteopathic Board of Nuclear Medicine
- A. In Vivo and In Vitro Nuclear Medicine
- B. Nuclear Cardiology
- C. Nuclear Imaging And Therapy
- D. Nuclear Medicine

IX. American Osteopathic Board of Obstetrics and Gynecology
- A. Gynecologic Oncology
- B. Gynecology
- C. Maternal And Fetal Medicine
- D. Obstetrics
- E. Obstetrics and Gynecologic Surgery
- F. Obstetrics and Gynecology
- G. Reproductive Endocrinology

X. American Osteopathic Board of Ophthalmology and Otorhinolaryngology
- A. Facial Plastic Surgery
- B. Ophthalmology
- C. Otorhinolaryngology
- D. Otorhinolaryngology and Facial Plastic Surgery

XI. American Osteopathic Board of Orthopedic Surgery
- A. Orthopedic Surgery

XII. American Osteopathic Board of Pathology
- A. Anatomic Pathology
- B. Anatomic Pathology and Laboratory Medicine
- C. Blood Banking Transfusion Medicine
- D. Chemical Pathology
- E. Cytopathology
- F. Dermatopathology
- G. Forensic Pathology
- H. Hematology
- I. Laboratory Medicine
- J. Medical Microbiology
- K. Neuropathology

XIII. American Osteopathic Board of Pediatrics
- A. Adolescent and Young Adult Medicine
- B. Neonatology
- C. Pediatric Allergy and Immunology
- D. Pediatric Cardiology
- E. Pediatric Endocrinology
- F. Pediatric Hematology/Oncology
- G. Pediatric Infectious Disease
- H. Pediatric Intensive Care
- I. Pediatric Nephrology
- J. Pediatric Pulmonary Medicine
- K. Pediatrics
- L. Sports Medicine

XIV. American Osteopathic Board of Preventive Medicine
- A. Occupational Medicine
- B. Preventive Medicine/Aerospace Medicine
- C. Preventive Medicine/Occupational-Environmental Medicine
- D. Public Health/General Preventive Medicine

XV. American Osteopathic Board of Proctology
- A. Proctology

XVI. American Osteopathic Board of Radiology
- A. Angioplasty and Interventional Radiology
- B. Body Imaging
- C. Diagnostic Radiology
- D. Diagnostic Ultrasound
- E. Neuroradiology
- F. Nuclear Radiology
- G. Pediatric Radiology
- H. Radiation Oncology
- I. Radiation Therapy
- J. Radiology

XVII. American Osteopathic Board of Rehabilitation Medicine
- A. Rehabilitation Medicine
- B. Sports Medicine

XVIII. American Osteopathic Board of Surgery
- A. General Vascular Surgery
- B. Neurological Surgery
- C. Plastic and Reconstructive Surgery
- D. Surgery
- E. Surgical Critical Care
- F. Thoracic Cardiovascular Surgery
- G. Urological Surgery

American Academy of Pediatrics (AAP)
- A. Pediatric Heart Surgery
- B. Pediatric Neurosurgery
- C. Pediatric Orthopedics
- D. Pediatric Urology

American Board of Oral and Maxillofacial Pathology
- A. Oral Pathology

American Board of Oral and Maxillofacial Surgery

American Board of Orthodontics
- A. Orthodontics

American Board of Pain Management
- A. Pain Management

American Board of Pediatric Dentistry
- A. Pediatric Dentistry

American Board of Periodontology
- A. Periodontology

American Board of Podiatric Orthopedics & Primary Podiatric
- A. Podiatry (DPM)

American Board of Podiatric Surgery (ABPS)
- A. Podiatry (DPM)

American Board of Prosthodontics
- A. Prosthodontics

American Chiropractic Neurology Board, Inc.
- A. Chiropractic neurology

Other Health Care Professionals:

I. Audiology
II. Certified Registered Nurse Anesthetist (CRNA)
III. Chiropractor (DC)
IV. Chiropractor Neurologist
V. Dietitian
VI. Endodontist
VII. Family Practice with Obstetrical Fellowship
VIII. General Dentistry
IX. General Practice
X. Licensed Clinical social Worker (LCSW)
XI. Licensed Professional Counselor
XII. Licensed Psychological Examiner (LPE)
XIII. Marriage and Family Therapist
XIV. Midwife (CRNM)
XV. Neurophychology (Ph.D.)
XVI. Nurse (RN)
XVII. Nurse Clinician
XVIII. Nurse Practitioner
XIX. Nurse Practitioner, Acute Care
XX. Nurse Practitioner, Adult Health
XXI. Nurse Practitioner, Family Practice
XXII. Nurse Practitioner, Gerontology and Adult Health
XXIII. Nurse Practitioner, Neonatal
XXIV. Nurse Practitioner, Oncology
XXV. Nurse Practitioner, Pediatrics
XXVI. Nurse Practitioner, Psychological/Mental Health
XXVII. Nurse Practitioner, Women's Health
XXVIII. Nutrition
XXIX. Occupational Therapy (OT)
XXX. Optometry
XXXI. Pastoral Counselor
XXXII. Pediatric Anesthesiology
XXXIII. Pediatric Genetics
XXXIV. Pediatric Ophthalmology
XXXV. Pediatric Plastic Surgery
XXXVI. Pharmacist
XXXVII. Pharmacist – Asthma Disease Management
XXXVIII. Pharmacist – Diabetes Disease Management
XXXIX. Pharmacist – Immunization Disease Management
XL. Physical Therapy (PT)
XLI. Physician Assistant – Surgical Assist
XLII. Physician Assistant (PA)
XLIII. Prosthetist/Orthotist
XLIV. Psychology (Ph.D.)
XLV. Speech Pathology/Speech Therapy (ST)
XLVI. Therapeutic Optometry
XLVII. Urgent Care Practitioner

4. Credentialing Process for Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application, is essential to ensure that decisions are based on the most accurate, current information available.

The following types of Organizational Providers require verification of specific requirements to be considered by the Credentialing Committee. The following lists these requirements:

Organizational Type	Requirements
Acute Care Facility	***1) TN: Licensed as Acute Care Facility*** Other States: Licensed in accordance with that state's licensing laws 2) $1 million/$3 million Malpractice 3) DEA, if applicable 4) CLIA, if applicable 5) Medicare Part A (new facilities which have not obtained subject to Committee exception) 6) JCAHO or AOA or CHAP or AAAHC, (lack of accreditation subject to Committee exception). 7) Leapfrog Compliance, if available 8) General Liability Insurance 9) History of Federal and/or State sanctions (Medicare, Medicaid, or TennCare) 10) An attestation to the correctness and completeness of the application
Ambulatory Surgery Facility	***1) TN: Licensed as Ambulatory Surgery Facility*** Other States: Licensed in accordance with that state's licensing laws 2) $1 million/$3 million Malpractice 3) CLIA, if applicable 4) JCAHO or AOA or CHAP or AAAHC or Medicare Part B 5) General Liability Insurance 6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 7) An attestation to the correctness and completeness of the application 8) If not accredited, a copy of Medicare Part B certification and a copy of the most recent site survey.
Birthing Centers	***1) TN: Licensed as Birthing Center*** Other States: Licensed in accordance with that state's licensing laws 2) $1 million/$3 million Malpractice 3) CLIA, if applicable 4) JCAHO or AOA or CHAP or AAAHC or Medicare Part B 5) General Liability Insurance 6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 7) An attestation to the correctness and completeness of the application
Dialysis Facility	***1) State of Tennessee End Stage Renal Disease (ESRD) Facility License*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part A Certification 5) CLIA certificate 6) General Liability Insurance 7) An attestation to the correctness and completeness of the application
DME Providers	***1) TN: Licensed as a DME Provider*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part B 5) DEA, if applicable 6) Pharmacy License, if applicable 7) JCAHO or CHAP or AAAHC, collect but not required 8) General Liability Insurance 9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 10) An attestation to the correctness and completeness of the application

Organizational Type	Requirements
Home Infusion Therapy Providers	***1) TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License)*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part B 5) DEA, if applicable 6) JCAHO or CHAP or AAAHC, collect but not required 7) General Liability Insurance 8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 9) An attestation to the correctness and completeness of the application
Home Health Providers:	***1) TN: Licensed as a Home Health Provider*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part A 5) CLIA, if applicable 6) JCAHO or CHAP or AAAHC, collect but not required 7) General Liability Insurance 8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 9) An attestation to the correctness and completeness of the application
Hospice Provider	***1) TN: Licensed as a Hospice Provider*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part A 5) CLIA, if applicable 6) JCAHO or AOA or CHAP or AAAHC, collect but not required 7) General Liability Insurance 8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 9) An attestation to the correctness and completeness of the application
Independent Lab	***1) TN: Licensed as a Laboratory*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) History of Professional liability claims that resulted in settlements or judgments 5) Medicare Part B 6) JCAHO or CAP, collect if applicable but not required 7) CLIA Certificate 8) General Liability Insurance 9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 10) An attestation to the correctness and completeness of the application

Organizational Type	Requirements
Inpatient Rehabilitation Facility	***1) TN: Licensed as a Inpatient Rehabilitation Facility*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part A 5) CLIA, if applicable 6) DEA, if applicable 7) JCAHO or CARF or AOA accreditation (no exception) 8) General Liability Insurance 9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 10) An attestation to the correctness and completeness of the application
Non-Licensed DME Providers (Non-motorized equipment only e.g. walker; canes; crutches)	1) Not currently sanctioned by Medicare/Medicaid 2) $1 million/$3 million Malpractice 3) History of Professional liability claims that resulted in settlements or judgments 4) Medicare Part B 5) JCAHO or CHAP or AAAHC, if applicable but not required 6) General Liability Insurance 7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 8) An attestation to the correctness and completeness of the application
Orthotic/ Prosthetic Supplier	***1) American Board for Certification in Orthotics and Prosthetics Accreditation OR Medicare B Certification*** 2) General Liability Insurance 3) $1 million/$3 million Malpractice (exception for Breast Prosthetic suppliers ONLY to have product liability coverage $500 thousand) 4) History of Professional liability claims that resulted in settlements or judgments 5) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) 6) An attestation to the correctness and completeness of the application
Outpatient Diagnostic	1) $1 million/$3 million Malpractice 2) History of Professional liability claims that resulted in settlements or judgments 3) Medicare Part A Certification 4) General Liability Insurance 5) An attestation to the correctness and completeness of the application
Outpatient Mental Health Providers	1) Licensed by the State of Tennessee Department of Health and Retardation. 2) $1 million/$3 million Malpractice 3) General Liability Insurance 4) History of Federal and/or State sanctions (Medicare, Medicaid, or TennCare) Medicare Certification, not required 5) An attestation to the correctness and completeness of the application
Outpatient Rehabilitation Facility	1) Not currently sanctioned by Medicare/Medicaid 2) $1 million/$3 million Malpractice 3) History of Professional liability claims that resulted in settlements or judgments 4) Medicare Part A *(If Provider is licensed under the Tennessee Department of Mental Health and Developmental Disabilities and provides services to pediatric patients, evidence of the State License site audit)* 5) JCAHO or CORF, collect but not required. 6) CLIA required if onsite laboratory. 7) General Liability Insurance 8) History of Federal and/or State sanctions (Medicare, Medicaid, or TennCare) 9) An attestation to the correctness and completeness of the application

Organizational Type	Requirements
Skilled Nursing Facility (No Swing Beds)	***1) TN: Licensed as a Skilled Nursing Facility*** Other States: Licensed in accordance with that state's licensing laws 2) Not currently sanctioned by Medicare/Medicaid 3) $1 million/$3 million Malpractice 4) Medicare Part A 5) CLIA, if applicable 6) DEA, if applicable 7) JCAHO or CHAP or AAAHC or AOA, collect but not required 8) General Liability Insurance 9) History of Federal and/or State sanctions (Medicare, Medicaid, or TennCare) 10) An attestation to the correctness and completeness of the application

Organizational Providers must be recredentialed every 3 years to meet federal and state regulatory guidelines. During the recredentialing process the initial credentialing information must be resubmitted.

5. BlueCross BlueShield of Tennessee Recognized Accrediting Bodies

BlueCross BlueShield of Tennessee recognizes the following accrediting bodies:

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Board of Medical Specialties (ABMS)
- American Board for Certification in Orthotics & Prosthetics Accreditation
- American College of Nurse – Midwives Certification Council
- American College of Radiology (ACR)
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Speech-Language-Hearing Association (ASHA)
- College of American Pathologist (CAP)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)
- Community Health Accreditation Program (CHAP)
- Commission on Office Laboratory Accreditation (COLA)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Food and Drug Administration (FDA)
- Health Care Financing Agency (HCFA) or Centers for Medicare and Medicaid Services (CMS)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- National Certification Corporation of Obstetric and Neonatal Nursing Specialties
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- Pediatric Nursing Certification Board
- The Medical Quality Commission (TMQC)

D. Practice Site Evaluation/Medical Record Practices

Practice Site Evaluations

These accepted standards ensure appropriate and adequate clinical practice sites for all Practitioners. BlueCross BlueShield of Tennessee maintains a process for accessing the quality of practice sites among its network Practitioners. All Primary Care Practitioner (PCP) and OB/GYN practice sites will be evaluated prior to initial credentialing and upon notification of any new site not previously reviewed. Practice site reviews shall also be performed for any credentialed Practitioner at the request of the Clinical Risk Management Department. All information will be utilized in the credentialing/recredentialing process, as applicable. All Practitioners will receive a score and suggestions for improvement where applicable at the conclusion of the audit. Practitioners scoring less than 80 percent on the site review shall have this information forwarded to the Clinical Risk Management Committee for review.

Current established site review standards are listed below and are based on BlueCross BlueShield of Tennessee adopted policy, and Bureau of TennCare contract requirements. All elements identified by an asterisk (*) are required and an overall score of 80 percent achieved for compliance with BlueCross BlueShield of Tennessee practice site standards. These standards are subject to change and revisions will be posted in quarterly updates.

1. The office is to be handicap accessible.
2. The office is to be clean, and organized, with adequate workspace in the treatment rooms to conduct patient exams effectively.
3. The office should have appropriate lighting.
4. Examining rooms should be designed for patient privacy.
5. There should be evidence of compliance with BlueCross BlueShield of Tennessee appointment availability standards

*6. Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the Practitioner on call.

7. There should be an individual medical record for each patient.
8. Current medical records should be available at the site where services are provided and readily accessible.
9. Medical records should be kept in a secure location.
10. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
11. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates follow up treatment.
12. There should be evidence that BlueCross BlueShield of Tennessee medical record documentation standards are met, or the Practitioner/staff has been advised both verbally and in writing of these standards at the time of the review.

*13. There should be a fire safety/emergency action plan with evidence of staff education. Pathways to doors should be clear and well marked.

*14. Emergency Supplies and procedures should be available for scope of practice.

*15. The office should have infection control procedures that include appropriate disposal of bio-hazardous material.

*16. There should be a process for the appropriate disposal of needles and other sharps.

*17. There should be a process for inventory control of all stock and sample medications.

*18. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.

*19. Controlled substances must be maintained in a locked area.

*12. Evidence of CLIA registration is required if lab is performed in the office.

*21. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.

22. Radiology technique should be posted near the radiology equipment.

*23. For Physician Extenders, there should be a protocol on site and evidence of supervising Physician oversight, as required by practice type and state regulations.
24. There should be a sign posted that Physician Extenders may provide care, where applicable.
25. Professional staff should be licensed appropriately with evidence of licensure on file.
26. Member rights and responsibilities should be posted.

Comprehensive Medical Record Standards

These accepted standards facilitate appropriate and adequate medical record documentation for all network Practitioners. Medical Records of credentialed Practitioners will be reviewed by clinical personnel upon request of the Clinical Risk Management Department. All Practitioners will receive results with suggestions for improvement where applicable at the conclusion of the review. The results of these reviews will be forwarded to the Credentialing Department for use in the recredentialing process.

Current established medical record standards utilized in this process are listed below and include elements required by BlueCross BlueShield of Tennessee and Bureau of TennCare contract requirements. Standards identified by an (*) are **required**. Failure to meet either of the asterisked items, or failure to achieve a minimum score of 80 percent on identified essential elements (E), will result in a non-compliant review. Practitioners not meeting these standards will be referred to the Clinical Risk Management Committee for immediate review. Revisions will be forwarded for placement as indicated quarterly.

*1. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates follow up treatment.
2. Patient identification is to be on each page of the record.
3. Each patient record is to contain a pertinent biographical record with the minimum information of home address, employer, and home and work phone numbers, as applicable.
4. Each recorded chart entry is to be identified by the author.
5. Each chart entry is to be dated.
6. There must be one medical record for each patient.
7. The medical records should be readily accessible to the Practitioner during normal office hours.
E 8. All medical records are to contain a patient problem list, which addresses chronic and significant recurrent/acute conditions.
E 9. All medication allergies, absence of allergies, and/or adverse reactions are to be prominently and consistently documented in all medical records.
E 10. A patient history addressing past hospitalizations, illnesses, accidents, and surgeries are to be documented for all patients seen 3 or more times.
E 11. Each medical record is to contain an updated list of medications the patient is taking, or documentation that the patient is presently not taking any medications.
12. Each medical record is to contain tobacco, alcohol, and/or substance abuse history (for patients 12 years and over and seen three (3) or more times).
13. The medical record of all patients age 18 years and over should contain documentation of whether a medical advance directive has been executed, as required by state/federal regulations.
14. If the patient has executed an advance directive, a copy should be on file within the office.
E 15. The patient diagnosis is to be consistent with documented clinical findings.
E 16. Patient treatment plans are to be consistent with the working diagnosis.
E 17. The medical record should not give evidence that a patient was placed at inappropriate risk by a diagnostic or therapeutic procedure.
* 18. Each patient visit is documented with appropriate subjective and objective information pertinent to the presenting complaints.
E 19. Documentation of laboratory and other studies ordered which address the diagnosis and/or the patient's presenting complaint.

E 20. There should be a treatment plan, which includes prescription drugs and diagnostic tests.
E 21. Each medical record is to contain documentation of appropriate and timely follow-up care, phone calls, or patient visits.
E 22. Documentation that unresolved problems from past visits being addressed on return office visits.
23. Documentation of appropriate use of consultants.
24. Documentation of medical services performed by a referral specialist/Practitioner.
25. Each medical record is to contain documentation that the Practitioner reviewed radiology, laboratory, and/or consultation records.
26. If diagnostic and/or therapeutic ancillary services were performed, there must be a copy of the written report of the service in the record.
E 27. There should be documentation of follow-up plans regarding significant abnormal consults, lab and/or diagnostic test results specific to the noted abnormality.
28. The medical record should contain a hospital discharge summary if the patient has been hospitalized.
29. There should be documentation in the medical record if the patient has been treated in an emergency department.
E 30. Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with *The Guide to Clinical Preventive Services 2005* or the American Academy of Pediatrics, as applicable.
E 31. Care for high-risk conditions should be documented in accordance with BlueCross BlueShield of Tennessee's *Health Care Practice Recommendations.*
E 32. There should be documentation of patient education/instructions.

Facility Site Standards

Non-accredited facilities applying for Initial Credentialing with BlueCross BlueShield of Tennessee networks must meet and maintain compliance with the site standards listed below.

Non-compliant sites for currently credentialed Providers will be referred to the BlueCross BlueShield of Tennessee Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed Providers until BlueCross BlueShield of Tennessee facility site standards are met.

Physical Assessment

1. The facility is to be handicap accessible.
2. The facility should be clean and organized with adequate lighting and work space in treatment rooms to conduct patient exams effectively.

After Hours Coverage

3. Appropriate procedures should be in place for after-hours coverage, where applicable.

Medical Record Keeping

4. There should be an individual medical record for each member.
5. Medical records should be kept in a secure location.
6. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
7. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitate follow-up treatment.

Safety

8. Emergency supplies and procedures should be available for the scope of practice.
9. Policy and procedures should be available and reviewed annually regarding administrative, operational, safety, disaster management and infection control.
10. There should be evidence of staff education to include safety, disaster management and infection control.
11. There should be infection control measures consistent with OSHA guidelines.

12. There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
13. Evidence of CLIA registration is required if lab is performed in the facility.
14. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
15. Radiological technique should be posted near the radiology equipment.
16. There should be a process for inventory control of all stock and sample medications and medical supplies.
17. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
18. Controlled substances must be maintained in a locked area.
19. The facility should maintain equipment in a safe manner consistent with the manufacturer's recommendations.
20. Professional staff should be licensed appropriately with evidence of licensure on file.
21. Member Rights and Responsibilities should be posted.

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XV. Provider Networks

Participation in BlueCross BlueShield of Tennessee Provider Networks requires satisfaction of applicable network participation credentialing requirements.

Providers interested in expanding their participation in BlueCross BlueShield of Tennessee Provider Networks, or needing to communicate any changes in their practice may call their local Provider Relations Representative. (See Section I. Introduction, for specific contact numbers.)

A. Network Participation Criteria

BlueCross BlueShield of Tennessee has established Network Participation Criteria detailing the terms and conditions for participation in BlueCross BlueShield of Tennessee Networks. These Terms and Conditions will be consistently applied. These Terms and Conditions will apply to any Provider who:

- is recruited by the Plan;
- requests participation or re-applies for participation;
- re-applies following voluntary or involuntary termination of Provider's participation;
- has a significant change in practice, which initiates a re-application and/or reconsideration of the Provider's current participation status.

B. Changes in Practice

The following changes in practice may require reconsideration and/or re-application for participation in a BlueCross BlueShield of Tennessee Network:

Practitioner

- Change in practice locations;
- Change in practice specialty;
- Change in ownership;
- Entering into a group practice;
- Exit from a group practice;
- Change in hospital privileges;
- Change in insurance coverage;
- Disciplinary action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Malpractice judgment;
- Indictment, arrest or moral turpitude allegation;
- Adverse or adversarial relationship with BlueCross BlueShield of Tennessee;
- Any material change, which affects the Practitioner's ability to perform its obligations to Member and/or BlueCross BlueShield of Tennessee;
- Any material change in the information submitted on the pre-application or application.

Institutional or Medical Service Supplier Organization

- Change in ownership;
- Malpractice judgment;
- Change in insurance coverage;
- Disciplinary action by licensing agency or federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Adverse or adversarial relationship with BlueCross BlueShield of Tennessee;
- Any material change which affects the organization's ability to perform its obligations to Member and/or BlueCross BlueShield of Tennessee;
- Any material change in the information submitted on the pre-application or application.

C. Providers Denied Participation

Providers denied participation in a BlueCross BlueShield of Tennessee Network for other than network need, must wait at least one (1) year from the date of denial before submitting a new Pre-application.

This requirement will be waived when changes are made to the Network Participation Criteria. Any Provider affected by the change(s) is eligible to re-apply immediately.

D. Participation in BCBST BlueNetworks C, S, P, and K

BlueCross BlueShield of Tennessee Provider Networks and Contracting participation criterion for 1) Practitioners; 2) Institutional Providers; and 3) Ancillary Providers in Blue Networks C, S, P, and K follow:

1. Practitioner Network Participation Criteria

Satisfaction of any minimum participation standard set forth below does not guarantee network participation. BlueCross BlueShield of Tennessee and its affiliates ("BCBST") will consider Provider for credentialing at its sole discretion.

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
I.	**Tennessee/Contiguous Counties**	Required	Required	Required	Required	Required
II.	**State License**					
	1. License to practice is Current and Valid	Required	Required	Required	Required	Required
	2. License to practice is Unrestricted as to services performed	No	Required	Required	Required	Required
	3. If the Provider's medical license has been revoked or not renewed (a license "revocation") by any jurisdiction, for cause, or surrendered his or her license to avoid such a revocation, Provider shall not be considered for participation until not less then 2 years after the date that Provider's license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains his or her license.	No	Required	Required	Required	Required
III.	**Malpractice Insurance**	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	Required unless State employee
IV.	**Accept Terms of Contract**	Required	Required	Required	Required	Required
V.	**Board Certified/Eligible**	No	Recorded	Recorded	Recorded	N/A

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
VI.	**Meet Credentialing and Recredentialing Requirements**	No	Required	Required	Required	No
VII.	**Successful Site Evaluation**	N/A	Required for Primary Care and High Volume Specialists	Required for Primary Care and High Volume Specialists	Required for Primary Care and High Volume Specialists	N/A
	Factors reviewed at site visit are: Accessibility/appearance, Risk Management Polices/Procedures, access/availability of medical services, medical records administration, and valid certification for regulated services and personnel.					
VIII.	**Admitting Privileges**					
	Maintain admitting privileges (*or provision for coverage* by a BCBST participating Provider) with a BCBST network hospital*	No	Required	Required	Required *(May admit to Acute Care or ASF)*	Required if hospital services are performed
	Any exceptions must be approved by BCBST Corporate Medical Director					
IX.	**Availability Standards** Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee and its affiliates					
	1. Primary Care	No limits to size. Must meet Network Availability Standards	No limits to size. Must meet Network Availability Standards	Limited Network. Must meet Network Availability Standards	Limited Network. Must meet Network Availability Standards	N/A
	2. Hospital Based	Affiliated with Participating Hospital	Affiliated with Participating Hospital	Affiliated with Participating Hospital	Affiliated with Participating Hospital	N/A
	Anesthesiology (*includes CRNAs)*	Fee Schedule	Fee Schedule	Fee Schedule	Fee Schedule	N/A
	Pathology	Fee Schedule	Fee Schedule	Fee Schedule	Fee Schedule	N/A
	Radiology	Fee Schedule	Fee Schedule	Fee Schedule	Fee Schedule	N/A
	Emergency Room	Fee Schedule	Fee Schedule	Fee Schedule	Fee Schedule	N/A
	Hospital required to deliver	Yes	Yes	Yes	Yes	N/A

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
	3. Specialists	No limits to size. Must meet Network Availability Standards	No limits to size. Must meet Network Availability Standards	Limited Network. Must meet Network Availability Standards	Limited Network. Must meet Network Availability Standards	No limits to size. Must meet Network Availability Standards
X.	**Member Access Standards**					
	1. Agrees to provide care to members within BCBST standards	Required	Required	Required	Required	Required
	2. Demonstrates a practice history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards.	Required	Required	Required	Required	Required
	2.1 <u>Regular</u>: Routine Examination, TENNderCARE, Preventive Care, Physical Exam	**Adult** - Annual; Within a year of the last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months. **Children** - According to the American Academy of Pediatrics periodicity schedule	**Adult** - Annual; Within a year of the last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months. **Children** - According to the American Academy of Pediatrics periodicity schedule	**Adult** - Annual; Within a year of the last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months. **Children** - According to the American Academy of Pediatrics periodicity schedule	**Adult** - Annual; Within a year of the last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months. **Children** - According to the American Academy of Pediatrics periodicity schedule	N/A
	2.2 Prenatal Care:					
	First Trimester	To be seen in the first trimester, $\leq$ 6 weeks of woman's questioning pregnancy	To be seen in the first trimester, $\leq$ 6 weeks of woman's questioning pregnancy	To be seen in the first trimester, $\leq$ 6 weeks of woman's questioning pregnancy	To be seen in the first trimester, $\leq$ 6 weeks of woman's questioning pregnancy	N/A

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
	Second Trimester	If the first appointment is beyond the 1st trimester, < 15 days	If the first appointment is beyond the 1st trimester, ≤ 15 days	If the first appointment is beyond the 1st trimester, ≤ 15 days	If the first appointment is beyond the 1st trimester, ≤ 15 days	N/A
	2.3 Urgent Care (Adult & Child)	≤ 48 hours	≤ 48 hours	≤ 48 hours	≤ 48 hours	N/A
	2.4 Emergency Care (Adult & Child)	Immediate - refer to facility-based providers	Immediate - refer to facility-based providers	Immediate - refer to facility-based providers	Immediate - refer to facility-based providers	N/A
	2.5 Specialty Care (Adult & Child)	As practitioner deems appropriate for condition or follow-up	As practitioner deems appropriate for condition or follow-up	As practitioner deems appropriate for condition or follow-up	As practitioner deems appropriate for condition or follow-up	N/A
	2.6 Wait Times					N/A
	1) Office Wait Time (including lab and X-ray)	≤ 45 minutes	≤ 45 minutes	≤ 45 minutes	≤ 45 minutes	N/A
	2) Member Telephone Call (during office hours):					N/A
	Urgent	≤ 15 minutes	≤ 15 minutes	≤ 15 minutes	≤ 15 minutes	N/A
	Routine	24 hours	24 hours	24 hours	24 hours	N/A
	3) Member Telephone Call (after office hours):					N/A
	Urgent	≤ 30 minutes	≤ 30 minutes	≤ 30 minutes	≤ 30 minutes	N/A
	Routine	≤ 90 minutes	≤ 90 minutes	≤ 90 minutes	≤ 90 minutes	N/A
	2.7 7Day/24 Hour Coverage through Par Providers	Required	Required	Required	Required	N/A
	3. Open Practice	No	No	No	No	N/A
	4. Service Area Definition	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
XI.	**Reimbursement**					
	1. Agrees to the price and reimbursement schedule for the Network	Required	Required	Required	Required	Required
	2. Agrees to the reimbursement methodology:	Required	Required	Required	Required	Required
	3. Agrees not to balance bill member	Required	Required	Required	Required	Required
	4. Delegation	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee
	5. ASO Available	Yes	Yes	Yes	Yes	Yes
XII.	**Quality Improvement/Utilization Review/Medical Management Program**					
	1. Cooperate with BCBST QI & UM Programs	UR Only	Required	Required	Required	Required
	2. Maintain a QI/UM Plan	UR Only	Required	Required	Required	N/A
	3. Demonstrate practice style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.	No	Required	Required	Required	Required
	4. Meet BCBST acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.	Reported	Reported	Reported	Required	N/A

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
XIII.	**General Provisions**					
	1. Meet member satisfaction standards - Based on member complaints, grievances, and satisfaction survey	No	Required	Required	Required	Required
	2. Demonstrate willingness to cooperate with other Providers, hospitals and healthcare facilities	No	Required	Required	Required	Required
	3. Agree to participate in exclusive arrangements	N/A	N/A	Required/Negotiated	Required/Negotiated	N/A
	4. Satisfactory record on fraud and abuse and billing practices	Required	Required	Required	Required	Required
	5. Practice style which is consistent with current standards of medical delivery	No	Required	Required	Required	Required
	6. Prescribing pattern, which is consistent with BCBST's quality management program.	No	Required	Required	Required	Required
	7. If the Provider's Drug Enforcement Administration Certificate or Controlled Dangerous Substances Certificate has been revoked, or not renewed (a "revocation") by any jurisdiction, for cause, or surrendered to avoid imposition of such revocation Provider shall not be considered for participation until not less than 2 years after the date that Provider was re-issued a certificate, except as otherwise provided by applicable laws. If such a certificate revocation action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains such certification.	No	Required	Required	Required	Required

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
	8. If the Provider has been convicted of a felony, fraud, or any offense involving moral turpitude by any jurisdiction, Provider shall not be considered for participation until not less than 2 years after the date of that conviction, except as otherwise provided by applicable laws. If such action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved in the Provider's favor.	No	Required	Required	Required	Required
	9. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s).	Required	Required	Required	Required	Required
	10. Term of Contract	90 day clause	Minimum 180 Day Termination	Minimum 1 year; 180 Day Termination; Maximum 3 years	Annual; 120 Day Termination	30 day clause
	11. Abide by Terms of BCBST Provider Dispute Resolution Procedure	Required	Required	Required	Required	Required
	12. Exclusivity Allowed	No	No	Yes	Yes	No
	13. Defined Service Area	Statewide	Statewide	Statewide	Statewide	Statewide

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Practitioner Network Participation Criteria (Cont'd)

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K	Preferred Dental / FEP Dental
	14. Provider has not established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited					
	to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.	Required	Required	Required	Required	Required
	15. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process or failure to maintain hospital privileges at a network hospital. For administrative terminations, Provider may reapply upon cure of the deficiency.	Required	Required	Required	Required	Required

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2. Institutional Provider Network Participation Criteria

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation and Skilled Nursing Facilities Satisfaction of any minimum participation standard set forth below does not guarantee network participation. BCBST and its affiliates ("BCBST") will consider Provider for credentialing at its sole discretion.

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
I.	**Tennessee/Contiguous Counties**	Required	Required	Required	Required
II.	**State License**				
	1. License to practice is Current and Valid.	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)
	2. License to practice is Unrestricted as to services performed.	No	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)
	3. If the Provider's license has been revoked or not renewed (a license "revocation") by any jurisdiction, for cause, or surrendered license to avoid such a revocation, the Provider shall not be considered for participation until not less than 2 years after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license. *If a Provider satisfies this minimum participation standard, the Provider may be considered for credentialing at BlueCross BlueShield of Tennessee's sole discretion. **Any exceptions must be approved by the BlueCross BlueShield of Tennessee Corporate Medical Director and VP Provider Networks.	No	Required	Required	Required
III.	**Malpractice Insurance**	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee
IV.	**Medicare Certification Requirements**	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)

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Institutional Provider Network Participation Criteria (Cont'd)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation and Skilled Nursing Facilities

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
V.	**Accreditation Requirements**	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)
VI.	**Accept Terms of Contract**	Required	Required	Required	Required
VII.	**Meet Credentialing and Recredentialing Requirements**	No	Required	Required	Required
VIII.	**Availability Standards** Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee and its affiliates				
	1. Institutional Providers	No limits to size. Must meet Network Availability Standards.	No limits to size. Must meet Network Availability Standards.	Limited Network. Must meet Network Availability Standards.	Limited Network. Must meet Network Availability Standards
IX.	**Member Access Standards**				
	1. Agrees to provide care to members within BCBST standards	Required	Required	Required	Required
	2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers ability to comply with these standards.	Required	Required	Required	Required
	3. Service Area Definition	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties
	4. Hospitals that are contracted in out-of-state counties which are contiguous to Tennessee must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis	Required	Required	Required	Required

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Institutional Provider Network Participation Criteria (Cont'd)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation and Skilled Nursing Facilities

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
X.	**Reimbursement**				
	1. Agrees to the price and reimbursement schedule for the Network	Required	Required	Required	Required
	2. Agrees to the reimbursement methodology:	Required	Required	Required	Required
	3. Agrees not to balance bill member	Required	Required	Required	Required
	4. Delegation	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee
	5. ASO Available	Yes	Yes	Yes	Yes
XI.	**Quality Improvement/Utilization Review/Medical Management Program**				
	1. Cooperate with BCBST QI & UM Programs	UR Only	Required	Required	Required
	2. Maintain a QI/UM Plan	UR Only	Required	Required	Required
	3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.	No	Required	Required	Required
XII.	**General Provisions**				
	1. Meet Member satisfaction standards - Based on member complaints, grievances, and satisfaction survey	No	Required	Required	Required
	2. Demonstrate willingness to cooperate with other Providers, hospitals and healthcare facilities	No	Required	Required	Required
	3. Agree to participate in exclusive arrangements	N/A	N/A	Required/Negotiated	Required/Negotiated
	4. Satisfactory record on fraud and abuse and billing practices	Required	Required	Required	Required

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Institutional Provider Network Participation Criteria (Cont'd)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation and Skilled Nursing Facilities

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
	5. Medical Delivery style which is consistent with current standards of medical delivery	No	Required	Required	Required
	6. Claims filing method	CMS-1450	CMS-1450	CMS-1450	CMS-1450
	7. If the Provider has been convicted of a felony, fraud, or any offense involving moral turpitude by any jurisdiction, the Provider shall not be considered for participation until not less than 2 years after the date of that conviction, except as otherwise provided by applicable laws. If such action is pending or initiated against Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved in the Provider's favor.	No	Required	Required	Required
	8. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s).	Required	Required	Required	Required
	9. Term of Contract	See Exhibit B-1	See Exhibit B-1	See Exhibit B-1	See Exhibit B-1
	10. Abide by Terms of BCBST Provider Dispute Resolution Procedure	Required	Required	Required	Required
	11. Exclusivity Allowed	No	No	Yes	Yes
	12. Defined Service Area	Statewide	Statewide	Statewide	Statewide

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Institutional Provider Network Participation Criteria (Cont'd)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation and Skilled Nursing Facilities

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
	13. Provider has not established an adversarial relationship with BCBST or its affiliates, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: creditable evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent				
	the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.	Required	Required	Required	Required
	14. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process. For administrative terminations, Provider may reapply upon cure of the deficiency.	Required	Required	Required	Required

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Exhibit B-1
Institutional Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
State License Requirements				
Acute Care Hospitals	**TN**: Licensed as an Acute Care Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Acute Care Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Acute Care Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Acute Care Facility **Contiguous**: Licensed in accordance with that state's licensing laws
Ambulatory Surgical Facility (ASF)	**TN**: Licensed as an Ambulatory Surgery Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Ambulatory Surgery Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Ambulatory Surgery Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Ambulatory Surgery Facility **Contiguous**: Licensed in accordance with that state's licensing laws
Ambulatory Surgical Facility, Birthing Center	**TN**: Licensed as a Birthing Center **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Birthing Center **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Birthing Center **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Birthing Center **Contiguous**: Licensed in accordance with that state's licensing laws
Dialysis Center	**TN**: Licensed as a Dialysis Center **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Dialysis Center **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Dialysis Center **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Dialysis Center **Contiguous**: Licensed in accordance with that state's licensing laws
Inpatient Rehabilitation	**TN**: Licensed as an Inpatient Rehabilitation Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Inpatient Rehabilitation Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Inpatient Rehabilitation Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as an Inpatient Rehabilitation Facility **Contiguous**: Licensed in accordance with that state's licensing laws
Outpatient Rehabilitation	**TN**: Does not license Outpatient Rehabilitation Facilities **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Does not license Outpatient Rehabilitation Facilities **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Does not license Outpatient Rehabilitation Facilities **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Does not license Outpatient Rehabilitation Facilities **Contiguous**: Licensed in accordance with that state's licensing laws
Skilled Nursing Facility (SNF)	**TN**: Licensed as a Skilled Nursing Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Skilled Nursing Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Skilled Nursing Facility **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Skilled Nursing Facility **Contiguous**: Licensed in accordance with that state's licensing laws

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Exhibit B-1 (Cont'd)
Institutional Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
Accreditation and/or Certification Requirements				
Acute Care Hospital	JCAHO, AOA, CHAP or ACHC **and** Medicare A	JCAHO, AOA, CHAP or ACHC **and** Medicare A	JCAHO, AOA, CHAP or ACHC **and** Medicare A	JCAHO, AOA, CHAP or ACHC **and** Medicare A
Ambulatory Surgical Facility (ASF)	JCAHO, AOA, CHAP, ACHC **or** Medicare B	JCAHO, AOA, CHAP, ACHC **or** Medicare B	JCAHO, AOA, CHAP, ACHC **or** Medicare B	JCAHO, AOA, CHAP, ACHC **or** Medicare B
Ambulatory Surgical Facility, Birthing Center	JCAHO, AOA, CHAP, ACHC **or** Medicare B	JCAHO, AOA, CHAP, ACHC **or** Medicare B	JCAHO, AOA, CHAP, ACHC **or** Medicare B	JCAHO, AOA, CHAP, ACHC **or** Medicare B
Dialysis Center	Medicare A	Medicare A	Medicare A	Medicare A
Inpatient Rehabilitation	JCAHO, CARF or AOA **and** Medicare A	JCAHO, CARF or AOA **and** Medicare A	JCAHO, CARF or AOA **and** Medicare A	JCAHO, CARF or AOA **and** Medicare A
Outpatient Rehabilitation	Medicare A or Mental Health License	Medicare A or Mental Health License	Medicare A or Mental Health License	Medicare A or Mental Health License
Skilled Nursing Facility	Medicare A	Medicare A	Medicare A	Medicare A
Term of Contract				
Acute Care Hospital	3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term	3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term	3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term	3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term
Ambulatory Surgical Facility (ASF)	Annual; 120 days prior to anniversary of effective date	Annual; 120 days prior to anniversary of effective date	Annual; 120 days prior to anniversary of effective date	Annual; 120 days prior to anniversary of effective date
Ambulatory Surgical Facility, Birthing Center	Annual; 120 days prior to anniversary of effective date	Annual; 120 days prior to anniversary of effective date	Annual; 120 days prior to anniversary of effective date	Annual; 120 days prior to anniversary of effective date
Dialysis Center	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause
Inpatient Rehabilitation	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause
Outpatient Rehabilitation	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause
Skilled Nursing Facility (SNF)	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause	Annual; 180 day clause

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3. Ancillary Provider Network Participation Criteria

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory
Satisfaction of any minimum participation standard set forth below does not guarantee network participation. BlueCross BlueShield of Tennessee and its affiliates ("BCBST") will consider Provider for credentialing at its sole discretion.

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
I.	**Tennessee/Contiguous Counties**	Required	Required	Required	Required
II.	**State License**				
	1. License to practice is Current and Valid	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)
	2. License to practice is Unrestricted as to services performed.	No	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)
	3. If the Provider's license has been revoked or not renewed (a license "revocation") by any jurisdiction, for cause, or surrendered license to avoid such a revocation, Provider shall not be considered for participation until not less than 2 years after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license. *If a Provider satisfies this minimum participation standard, the Provider may be considered for credentialing at BlueCross BlueShield of Tennessee's sole discretion. **Any exceptions must be approved by the BlueCross BlueShield of Tennessee Corporate Medical Director and VP Provider Networks.	No	Required	Required	Required
III.	**Minimum Insurance Requirements**	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)
IV.	**Medicare Certification Requirements**	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)	Required, as applicable (see Exhibit B-1)

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Ancillary Provider Network Participation Criteria (Cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
V.	**Accreditation Requirements**	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)
VI.	**Accept Terms of Contract**	Required	Required	Required	Required
VII.	**Meet Credentialing and Recredentialing Requirements**	No	Required	Required	Required
VIII.	**Availability Standards** Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee and its affiliates				
	1. Ancillary Providers	No limits to size. Must meet Network Availability Standards.	No limits to size. Must meet Network Availability Standards.	Limited Network. Must meet Network Availability Standards.	Limited Network. Must meet Network Availability Standards.
IX.	**Member Access Standards**				
	1. Agrees to provide care to members within BCBST standards	Required	Required	Required	Required
	2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards.	Required	Required	Required	Required
	3. Service Area Definition	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties	TN & Contiguous Counties

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Ancillary Provider Network Participation Criteria (Cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
X.	**Reimbursement**				
	1. Agrees to the price and reimbursement schedule for the Network	Required	Required	Required	Required
	2. Agrees to the reimbursement methodology:	Required	Required	Required	Required
	3. Agrees not to balance bill member	Required	Required	Required	Required
	4. Delegation	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee	Subject to minimum criteria and approval by Delegated Oversight Committee
	5. ASO Available	Yes	Yes	Yes	Yes
XI.	**Quality Improvement/Utilization Review/Medical Management Program**				
	1. Cooperate with BCBST QI & UM Programs	UR Only	Required	Required	Required
	2. Maintain a QI/UM Plan	UR Only	Required	Required	Required
	3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.	No	Required	Required	Required
	4. Agrees to Rapid Response Requirement	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)
XII.	**General Provisions**				
	1. Meet Member satisfaction standards - Based on member complaints, grievances, and satisfaction survey	No	Required	Required	Required
	2. Demonstrate willingness to cooperate with other Providers, hospitals and healthcare facilities	No	Required	Required	Required

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Ancillary Provider Network Participation Criteria (Cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
	3. Agree to participate in exclusive arrangements	N/A	N/A	Required/Negotiated	Required/Negotiated
	4. Satisfactory record on fraud and abuse and billing practices	Required	Required	Required	Required
	5. Medical Delivery style which is consistent with current standards of medical delivery	No	Required	Required	Required
	6. Claims filing method	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)	Required, as applicable (See Exhibit B-1)
	7. Must provide all services	No	No	No	Required, as applicable (See Exhibit B-1)
	8. Services must be available in all counties of a CSA (subcontracting permitted)	No	No	No	No
	9. CLIA Certificate	Required for Independent Labs only	Required for Independent Labs only	Required for Independent Labs only	Required for Independent Labs only
	10. Valid contract with CAREMARK®	Required for Home Infusion only	Required for Home Infusion only	Required for Home Infusion only	Required for Home Infusion only
	11. If the Provider has been convicted of a felony, fraud, or any offense involving moral turpitude by any jurisdiction, the Provider shall not be considered for participation until not less than 2 years after the date of that conviction, except as otherwise provided by applicable laws. If such action is pending or initiated against Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved in the Provider's favor.	No	Required	Required	Required

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Ancillary Provider Network Participation Criteria (Cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

	Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
	12. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s).	Required	Required	Required	Required
	13. Term of Contract	See Exhibit B-1	See Exhibit B-1	See Exhibit B-1	See Exhibit B-1
	14. Abide by Terms of BCBST Provider Dispute Resolution Procedure	Required	Required	Required	Required
	15. Exclusivity Allowed	No	No	Yes	Yes
	16. Defined Service Area	Statewide	Statewide	Statewide	Statewide
	17. Provider has not established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition,				
	treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.	Required	Required	Required	Required
	18. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process. For administrative terminations, Provider may reapply upon cure of the deficiency.	Required	Required	Required	Required

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Exhibit B-1
Ancillary Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
State License Requirements				
Home Health	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws
Home Infusion Therapy	**TN**: Licensed as a Home Infusion Therapy Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Infusion Therapy Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Infusion Therapy Provider **Contiguous**: Licensed in accordance with that state's licensing laws
Durable Medical Equipment	**TN**: Licensed as a Durable Medical Equipment Supplier **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Home Infusion Therapy Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Durable Medical Equipment Supplier **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Durable Medical Equipment Supplier **Contiguous**: Licensed in accordance with that state's licensing laws
Prosthetic/Orthotic Durable Medical Equipment Suppliers	**TN**: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Durable Medical Equipment Supplier **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: does not license Specialty Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws
Hospice	**TN**: Licensed as a Hospice Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Hospice Provider **Contiguous**: Licensed in accordance with that state's licensing laws licensing laws	**TN**: Licensed as a Hospice Provider **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Hospice Provider **Contiguous**: Licensed in accordance with that state's licensing laws

Exhibit B-1 (Cont'd)
Ancillary Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
State License Requirements (Cont'd)				
Independent Laboratory	**TN**: Licensed as a Medical Laboratory **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Medical Laboratory **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Medical Laboratory **Contiguous**: Licensed in accordance with that state's licensing laws	**TN**: Licensed as a Medical Laboratory **Contiguous**: Licensed in accordance with that state's licensing laws
Minimum Insurance Requirements				
Malpractice Insurance	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee
Comprehensive Insurance (DME Only)	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee	$1 million/$3 million unless State employee
Product Liability (Breast Prosthesis Only)	$500,000	$500,000	$500,000	$500,000
Medicare Certification Requirements				
Home Health	Medicare Part A	Medicare Part A	Medicare Part A	Medicare Part A
Home Infusion Therapy	Medicare Part B	Medicare Part B	Medicare Part B	Medicare Part B
Durable Medical Equipment	Medicare Part B	Medicare Part B	Medicare Part B	Medicare Part B
Prosthetic/Orthotic Durable Medical Equipment Suppliers	Medicare Part B	Medicare Part B	Medicare Part B	Medicare Part B
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	Medicare Part B	Medicare Part B	Medicare Part B	Medicare Part B
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	Medicare Part B	Medicare Part B	Medicare Part B	Medicare Part B
Hospice	Medicare Part A	Medicare Part A	Medicare Part A	Medicare Part A
Independent Laboratory	Medicare Part B	Medicare Part B	Medicare Part B	Medicare Part B
Accreditation Requirements				
Home Health	N/A	N/A	N/A	N/A
Home Infusion Therapy	N/A	N/A	N/A	N/A
Durable Medical Equipment	N/A	N/A	N/A	N/A
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A	N/A	N/A	ABC

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Exhibit B-1 (Cont'd)
Ancillary Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A	N/A	N/A	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	JCAHO or CHAP or ACHC
Independent Laboratory	N/A	N/A	N/A	JCAHO OR CAP
Agrees to Rapid Response Requirement				
Home Health	Yes	Yes	Yes	Yes
Home Infusion Therapy	Yes	Yes	Yes	Yes
Durable Medical Equipment	Yes	Yes	Yes	Yes
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A	N/A	N/A	N/A
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A	N/A	N/A	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A
Independent Laboratory	N/A	N/A	N/A	N/A
Claims Filing Method				
Home Health	CMS-1450	CMS-1450	CMS-1450	CMS-1450
Home Infusion Therapy	CMS-1500	CMS-1500	CMS-1500	CMS-1500
Durable Medical Equipment	CMS-1500	CMS-1500	CMS-1500	CMS-1500
Prosthetic/Orthotic Durable Medical Equipment Suppliers	CMS-1500	CMS-1500	CMS-1500	CMS-1500
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	CMS-1500	CMS-1500	CMS-1500	CMS-1500

Exhibit B-1 (Cont'd)
Ancillary Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	CMS-1500	CMS-1500	CMS-1500	CMS-1500
Hospice	CMS-1450	CMS-1450	CMS-1450	CMS-1450
Independent Laboratory	CMS-1500	CMS-1500	CMS-1500	CMS-1500
Must Provide all Services				
Home Health	N/A	N/A	N/A	Required
Home Infusion Therapy	N/A	N/A	N/A	Required
Durable Medical Equipment	N/A	N/A	N/A	Required
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A	N/A	N/A	N/A
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A	N/A	N/A	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A
Independent Laboratory	N/A	N/A	N/A	Required
Services must be available in all counties of a CSA (*subcontracting permitted)*				
Home Health	N/A	N/A	N/A	N/A
Home Infusion Therapy	N/A	N/A	N/A	N/A
Durable Medical Equipment	N/A	N/A	N/A	N/A
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A	N/A	N/A	N/A

Exhibit B-1 (Cont'd)
Ancillary Provider Network Participation Criteria

Network Attribute	Broad Network Network C	PPO Network P	PPO/POS Network S	PPO Network K
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A	N/A	N/A	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A
Independent Laboratory	N/A	N/A	N/A	N/A
Term of Contract				
Home Health	180 days	180 days	180 days	180 days
Home Infusion Therapy	180 days	180 days	180 days	180 days
Durable Medical Equipment	180 days	180 days	180 days	180 days
Prosthetic/Orthotic Durable Medical Equipment Suppliers	180 days	180 days	180 days	180 days
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	180 days	180 days	180 days	180 days
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	180 days	180 days	180 days	180 days
Hospice	180 days	180 days	180 days	180 days
Independent Laboratory	90 days	60 days	60 days	180 days

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E. Provider Identification Number Process

Before submitting claims to BlueCross BlueShield of Tennessee, a Provider must request and be assigned an individual provider identification number. The purpose of this number is to identify the Provider and ensure accurate distribution of payments, remittance advices (Explanation of Payments (EOPs)), and 1099 forms. **The assigned provider number in no way signifies that the Provider participates in any or all BlueCross BlueShield of Tennessee networks.**

Inquiries regarding the need for a new provider number should be directed to:

- BlueCross BlueShield of Tennessee Provider Service at 1-800-924-7141
- Your local Provider Relations Representative in the Chattanooga, Nashville, Knoxville, Johnson City, Memphis or Jackson regional office. (See Section II. for specific numbers.)

XVI. BLUECARD® PROGRAM

The BlueCard Program links participating health care providers and the independent BlueCross and/or BlueShield plans across the country and around the world through a single electronic network for claims processing and reimbursement.

The BlueCard Program also allows Members who are away from (traveling or living) their **Home Plan's*** service area to receive medical care from participating Providers wherever services may be required and in many instances, to receive the same level of benefits they would receive if the services were rendered in their Home Plan's service area.

The program allows Providers to submit claims for BlueCross and/or BlueShield plan Members from other BlueCross and BlueShield plans, including international BlueCross and BlueShield plans, directly to the Provider's local plan (**Host Plan****). That plan will be the Provider's contact for claims filing, claims payment, adjustments, inquiries, and problem resolution.

***Home Plan** is the plan that "owns" the Member's coverage
****Host Plan** is the Practitioner's local BlueCross BlueShield Plan – for Tennessee Practitioner's treating Members of other Blue Plans, it is BlueCross BlueShield of Tennessee.

A. How the Program Works

1. A BlueCross and/or BlueShield Member is outside his/her Home Plan's service area and needs health care services.
2. The Member locates a participating Provider* by calling the BlueCard Provider Finder at 1-800-810-BLUE (2583) or by accessing the BlueCard Provider Finder Web site at www.bcbs.com/healthtravel/finder.html.
3. The Member presents his/her BlueCross and/or BlueShield ID card. The Member's identification number should begin with a **three-character alpha prefix.**
4. The Provider should verify the Member's eligibility and benefits by calling BlueCard Eligibility at **1-800-676-BLUE (2583),** the customer service number on the back of the Member's ID card, or online via the secure BlueAccess link on the company Web site, www.bcbst.com. The Member is responsible for obtaining any necessary prior authorizations. However, the Provider may elect to verify any prior authorization requirements and assist the Member with this requirement. (See subsection B. "How to Identify a BlueCard Member" to determine the Member's BlueCross BlueShield of Tennessee Plan.) Note: A BlueCard Member's coverage and utilization management requirements may differ from those of BlueCross BlueShield of Tennessee.
5. The Provider should submit claims to BlueCross BlueShield of Tennessee.
6. BlueCross BlueShield of Tennessee will electronically forward the claim to the Member's Home Plan with the Provider's network participation status and the maximum allowable based on the Provider's agreement with BlueCross BlueShield of Tennessee.
7. The Member's Home Plan will determine the benefits to be provided based on the Member's eligibility, contract provisions, the Provider's network status, and the maximum allowable. The Home Plan will transmit back to BlueCross BlueShield of Tennessee the finalized adjudication information (e.g., reason for denial, amount applied to deductible, amount paid, etc.).
8. BlueCross BlueShield of Tennessee will notify the Provider via the Explanation of Payment (EOP) of the final adjudication results.
9. The Member's Home Plan will notify the Member of his/her benefits via an Explanation of Benefits (EOB).

*If the Member receives services from a non-participating Provider, the Member is responsible for:

- paying the charges at the time the services are rendered;
- submitting the claim to BlueCross BlueShield of Tennessee; and
- any amounts not paid by his/her benefit plan, including amounts exceeding the maximum allowable.

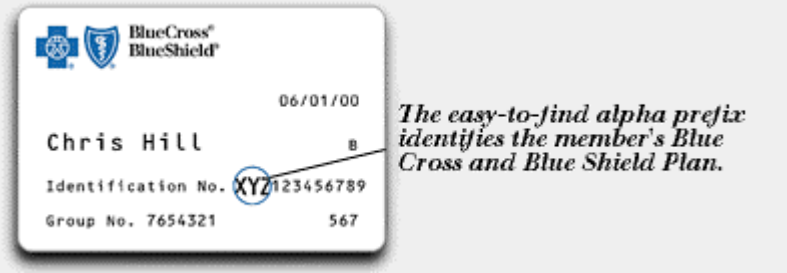
B. How to Identify a BlueCard Member

BlueCard Members will carry BlueCross and/or BlueShield identification cards that include one or more of the following identifiers:

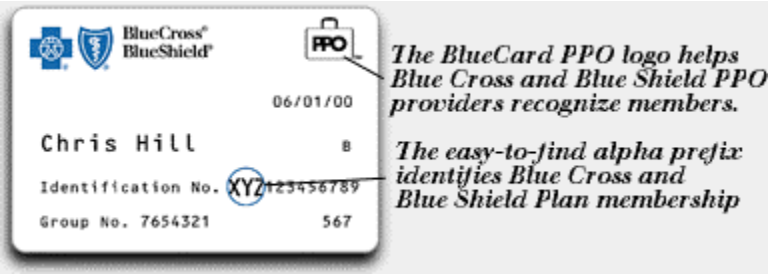
- Subscriber identification number begins with an alpha-prefix
- Suitcase logo (empty or PPO inside)
- Member's Plan name other than BlueCross BlueShield of Tennessee reflected on back of ID card

Sample copies of the BlueCard ID cards follow:

BlueCard Traditional ID Card
BlueClassic Network



BlueCard PPO ID Card
BluePreferred Network



C. BlueCard Traditional

- BlueCard Traditional Members have identification cards with either no suitcase or with an "empty" suitcase logo.
- BlueCard Traditional Members are often required to use a participating Provider within their Home Plan's service area. Therefore, Providers should verify the level of benefits (in-network vs. out-of-network) they will receive for services provided these Members.
- The maximum allowable is based on Blue Network C.

D. BlueCard PPO

- BlueCard PPO Members have identification cards with a "PPO" inside a suitcase logo.
- Benefits are provided at the in-network level if the Provider is participating in the local BlueCross and/or BlueShield plan's BlueCard PPO Network.
- The maximum allowable is based on Blue Network P.

E. BlueCard® Claim Filing

Claims for the following services should be submitted to BlueCross BlueShield of Tennessee (BCBST) unless the Provider contracts directly with the Member's Home Plan:

- Medical services (including secondary claims)
- Routine hearing
- Routine vision

Claims for the following services should be submitted directly to the Member's Home Plan:

- Stand-alone Dental
- Prescription Drugs

Claims should be filed with the identification number as it appears on the Member's ID card omitting any dashes or spaces within the identification number.

When submitting electronically, follow the guidelines found in this manual (Section VI. Billing and Reimbursement – Filing Electronic Claims). Providers needing additional information regarding electronic claims filing can call BlueCross BlueShield of Tennessee e-Commerce at 423-755-5717.

When submitting paper claims, mail to:

BlueCross BlueShield of Tennessee Claims Service Center
P.O. Box 180150
Chattanooga, TN 37401-7150

When submitting claims for secondary benefits (secondary to a commercial carrier or to Medicare), please include the primary carrier's Explanation of Payment.

F. BlueCard Program Reimbursement

BlueCross BlueShield of Tennessee will reimburse Providers for BlueCard Program claims submitted according to BlueCross BlueShield of Tennessee claims filing guidelines when:

- The Member is eligible for benefits
- The services are covered under the Member's plan*
- The Provider has not already been paid for the services

*The Home Plan determines what services are considered eligible under the Member's plan including all medical policy determinations (e.g., Medical Necessity, Investigational; routine, etc.).

G. Medical Records

BlueCross BlueShield of Tennessee will forward requests for medical information and/or copies of records as requested by the Member's Home Plan. The medical information and/or records should be returned to BlueCross BlueShield of Tennessee as quickly as possible to reduce any delays in claims processing.

Note: Medical record requests are based on the Home Plan's medical policies and may differ from those of BlueCross BlueShield of Tennessee.

H. Inquiries

The following grid lists examples of specific inquiries and provides direction to the appropriate contact:

Inquiry	Contact	Description
Verification of eligibility/benefits	Home Plan	1-800-676-BLUE or by accessing BlueCard within BlueAccess
Prior Authorizations	Home Plan	See back of Member's ID card
Electronic claims submissions	Host Plan (BCBST)	BCBST e-Commerce 423-755-5717
General questions	Host Plan (BCBST)	BlueCard Host Service 1-800-705-0391
Processed claims	Host Plan (BCBST)	BlueCard Host Service 1-800-705-0391
Status requests	Host Plan (BCBST)	BlueCard Host Service 1-800-705-0391 or by accessing BlueCard within BlueAccess
Claim rejected "Home Plan will handle direct"	Home Plan	Customer Service Number located on back of Member's ID card
Claim rejected "Additional information needed"	Host Plan (BCBST)	BlueCard Host Service 1-800-705-0391
Overpayments	Host Plan (BCBST)	BlueCard Host Service 1-800-705-0391
Appeals	Host Plan (BCBST)	Follow guidelines found in this Manual (Section XIII. Provider Dispute Resolution Procedure)

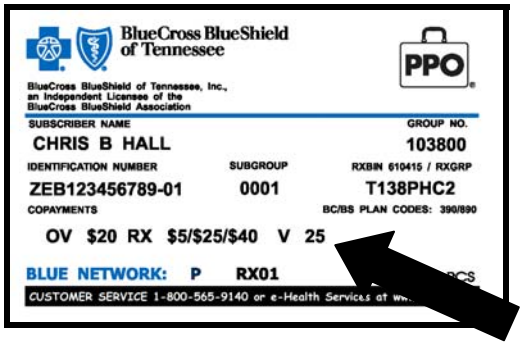
Providers interested in more information regarding the BlueCard Program can call BlueCross BlueShield of Tennessee's BlueCard Service Department at 1-800-705-0391.

XVII. OPTIONAL VISION CARE COVERAGE

This benefit is payable for routine vision care performed, ordered or furnished by a duly licensed Practitioner, Optometrist, or Ophthalmologist provided the member is covered for this benefit.

The vision care program provides benefits for BlueCross BlueShield of Tennessee Members when services are for routine eye examinations (includes follow-up care – see Sec. XVII. C. for a listing of follow-up care CPT™ Codes) and dispensing of glasses or contact lenses. Benefits for services due to illness or injury are covered under the Member's medical plan.

The following ID card identifies BlueCross BlueShield of Tennessee Members also subscribing to vision coverage:



A. Vision Plan I

Benefits

- One vision exam per calendar year and follow-up care from an Optometrist or Ophthalmologist
- $10 copayment per visit

Exclusions
Benefits will not be provided for the following services, supplies or charges:

- Charges for vision testing examinations ordered while insured but not delivered within 60 days after coverage is terminated.
- Charges for lenses or frames, or other hardware.
- Charges filed for procedures determined by the Member's vision plan to be special or unusual (e.g., orthoptics, vision training, subnormal vision aids, tonography, etc).

B. Vision Plan 2

Benefits

- One vision exam per calendar year and follow-up
- $10 copayment
- Prescription lenses including bi-focal, tri-focal, etc. – 100% up to $85 (one set per calendar year)
- Prescription contact lenses in lieu of eyeglasses every calendar year – 100% up to $150
- One set of frames – 100% up to $75 (once every two calendar years)

Restrictions

- Prescription sunglass lenses, or sunglasses, will be handled as other lenses, or eyeglasses.

Exclusions
Benefits will not be provided for the following services, supplies or charges:

- Charges for vision testing examinations, lenses and frames ordered while insured but not delivered within 60 days after coverage is terminated.
- Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for the regular lenses.
- Charges filed for procedures determined by the Member's vision plan to be special or unusual (e.g., orthoptics, vision training, subnormal vision aids, aniseikonis lenses, tonography, etc.).
- Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
- Charges in excess of the maximum allowable charge as established by the Member's vision plan.

XVIII. DENTAL PROGRAM

A. Dental Covered Services and Limitations

The standard dental program provides a wide range of benefits to Cover most services associated with dental care.

If more than one procedure or course of treatment can be used to accomplish the same treatment goal, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the patient's condition, then benefits may be based on the lowest cost procedure or treatment. This will be at our sole discretion.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service. Benefits will also not be paid for incomplete treatment.

1. Diagnostic Services

- Exams
  - Standard exams including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams). No more than one standard exam in any 6-month period. Additionally, no more than one comprehensive, detailed/extensive, or periodontal exam in any 36-month period.
  - Emergency exams, including limited oral evaluations (exams). No more than one emergency exam in any 12-month period.
  - Re-evaluations and consultations are excluded.

- X-rays
  - Full mouth series, intraoral and bitewing radiographs.
  - No more than one full mouth set of X-rays in any 36-month period. A full mouth set of X-rays is defined as either an intraoral complete series or panoramic X-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
  - No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.
  - Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey X-ray films, cephalometric films and diagnostic photographs are excluded.

  Note: Cephalometric films and diagnostic photographs may be Covered as orthodontic benefits for Members having orthodontic coverage.

2. Preventive Services

- Prophylaxis
  - Adult and child prophylaxis. No more than one of any prophylaxis or periodontal maintenance procedure in any 6-month period.
  - Periodontal maintenance procedures are subject to additional limitations (see Basic Periodontics this section).

- Fluoride Treatment
  - For dependents under age 19, fluoride treatments, performed with or without a prophylaxis.
  - No more than one fluoride treatment in any 12-month period.
  - Fluoride must be applied separately from prophylaxis paste.

- Other Preventive Services
  - Sealants, no more than one sealant per first or second molar tooth per lifetime, for Dependents under age 16.
  - Space maintainers, for dependents under age 14, no more than one recementation in any 12-month period.
  - Nutritional and tobacco counseling, oral hygiene instructions are excluded.

3. Basic Restorative Services

- Fillings and Stainless Steel Crowns

  - Amalgam restorations, resin composite restorations, stainless steel crowns. No more than one amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration. Acid etching, bases, liners, or varnishes are considered to be part of the restoration and for which benefits will not be paid separately.
  - Stainless steel crowns. Replacement of stainless steel crowns Covered only after 36 months from the date of initial restoration.
  - Gold foil restorations are excluded.

- Other Basic Restorative Services

  - Palliative (emergency) treatment for the relief of pain. This type of treatment is to enable a Member to obtain temporary relief from pain until a scheduled appointment can be made to provide a long-term resolution to the problem. No other services will be covered on the same tooth for the same dates of service. Should be submitted on claim form with code D9110, a tooth number, type of service rendered and narrative description of the clinical findings present.
  - Repair of full and partial dentures. No more than one repair per denture per 24 months.

4. Major Restorative and Prosthodontic Services

- Single Tooth Restorations
  - Crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), veneers
  - Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration.
  - For permanent teeth only. Veneers will be considered only on incisor and cuspid teeth.
  - For Members under age 12, benefits will not be provided for cast crowns or laminate veneers. Replacement of single tooth restorations Covered only after 60 months from the date of initial placement.
  - Temporary and provisional crowns are excluded.

- Multiple Tooth Restorations - Bridges

    - Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).
    - Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Members under age 16. Replacement of fixed partial dentures Covered only after 60 months from the date of initial placement.

- Removable Prosthodontics

    - Complete, immediate and partial dentures.
    - If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).
    - Benefits are not provided for Members under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.
    - Interim dentures are excluded.

- Other Major Restorative and Prosthodontic Services

    - Crown and bridge services including core buildups, post and core, recementation, and repair. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible. Post and core services are Covered only when performed in conjunction with root canal therapy and/or with a Covered crown or bridge. Crown and bridge repair and re-cementation are Covered separately only after 12 months from the date of initial placement.
    - Denture services including adjustment, relining, rebasing and tissue conditioning. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement. No more than one denture reline or rebase in any 36-month period.
    - Other major restorative services including sedative fillings and coping, are excluded.
    - Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal, are excluded.

5. Endodontics

- Basic Endodontics
    - Pulpotomy, pulpal therapy.
    - For primary teeth only, not Covered when performed in conjunction with major endodontic treatment.
    - The benefits for basic endodontic treatment include benefits for X-rays, pulp vitality tests, and sedative fillings provided in conjunction with basic endodontic treatment.
    - Pulpal debridement is excluded.

- Major Endodontics
    - Root canal treatment and re-treatment, apexification, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.
    - No more than one root canal treatment, re-treatment or apexification per tooth in 60-month period, and no more than one apicoectomy per root per lifetime.
    - The benefits for major endodontic treatment include benefits for X-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative fillings and temporary filling material provided in conjunction with major endodontic treatment.
    - Implantation, canal preparation, and incomplete endodontic therapy are excluded.

6. Periodontics

- Basic Periodontics
    - Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.
    - No more that one periodontal scaling and root planing per quadrant in any 24-month period, and no more than one full mouth debridement per lifetime.
    - No more than one of any prophylaxis or periodontal maintenance procedure in any 6-month period.
    - Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment.
    - Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.
    - Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes are excluded.

- Major Periodontics
    - Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
    - No more than one major periodontal surgical procedure in any 36-month period.
    - Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.
    - Tissue regeneration and apically positioned flap procedure are excluded.

7. Oral Surgery

- Basic Oral Surgery
    - Non-surgical or simple extractions.
    - Benefits provided for basic oral surgery include benefits for suturing and postoperative care.
    - Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery are excluded.

- Major Oral Surgery
  - Surgical extractions (including removal of impacted teeth and wisdom teeth), and other oral surgical procedures typically not Covered under a medical plan. Note that some BlueCross BlueShield of Tennessee Members may have benefits that include Major Oral Surgery, where such coverage is primary.
  - Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.
  - Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.
  - Implants and any related oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures are excluded.
  - Orthognathic surgery and treatment for congenital malformations are excluded.

8. Orthodontics

Orthodontic coverage varies based on the Member's benefits plan. Groups may elect no orthodontic coverage, child-only coverage (under age 19) or child and adult coverage. When covered, standard benefits include:

- Orthodontic services, including exams, photographic images, diagnostic casts, cephalometric X-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.
  - The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan.
  - The Plan reserves the right to review the Member's dental records, including necessary X-rays, photographs, and models to determine whether orthodontic treatment is Covered.
  - All orthodontic services shall be deemed to have been concluded on the last date treatment performed during Member's Coverage, even if a prior approved Treatment Plan has not been completed.
  - Orthodontic services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and Lifetime Maximum as defined in the Member's Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the Lifetime Maximum.
  - Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan, and surgical procedures to aid in orthodontic treatment are excluded.

B. General Exclusions

BlueCross BlueShield of Tennessee's dental plan does not provide benefits for the following services supplies or charges to include, but not limited to:

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2. Charges for services performed by the Member or Member's spouse, or Member's or Member's spouse's parent, sister, brother or child.
3. Services rendered by a Dentist beyond the scope of his/her license.
4. Dental services which are free, or for which the Member is not required or legally obligated to pay or for which no charge would be made if the Member had no dental Coverage.
5. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
6. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by Blue Cross Blue Shield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
7. Any court-ordered treatment of a Member unless benefits are otherwise payable.
8. Courses of treatment undertaken before the Member became Covered under this program.
9. Any services performed after the Member ceased to be eligible for Coverage.
10. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
11. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of Workers' Compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
12. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
13. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)
14. Replacement of tooth structure lost from wear or attrition.
15. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
16. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before the Member's Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after the Member's Coverage became effective.
17. Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.

18. Implant supported prosthetics. Alternate benefits may be provided for a standard crown, bridge or denture, at our sole discretion.
19. Diagnostic dental services such as diagnostic tests and oral pathology services.
20. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
21. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
22. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

C. Clinical Criteria Requirements

The following criteria are based on procedure codes as defined in the American Dental Association's (ADA) Current Dental Terminology CDT 2005 manual.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. They are designed as *guidelines* for consideration of payment and payment decisions and *are not intended to be all-inclusive or absolute*.

Requests for information regarding treatment using these codes, such as radiographs, periodontal charting, or descriptive narratives, are determined by generally accepted dental standards for consideration of payment. Additional narrative information is appreciated when there may be a special situation.

Unspecified codes (e.g., D0999, D2999, D3999, D4999, D5899 D5999, D6999, D7999, D8999, D9999) will be clinically reviewed and considered for payment if a narrative and/or appropriate radiographs are included with the claim.

In some instances, the State legislature will define the requirements for dental procedures.

Cast Restorations and Veneer Procedures

Radiographic documentation needed for consideration of payment:

- Preoperative radiograph of the teeth to be treated: bitewings, periapicals or panorex.

  A request for a ¾ cast crown, full cast crown or cast onlay must meet the following criteria:

  CDT Codes:

D2542	D2710	D2780
D2543	D2712	D2781
D2544	D2720	D2782
D2642	D2721	D2783
D2643	D2722	D2790
D2644	D2740	D2791
D2662	D2750	D2792
D2663	D2751	D2794
D2664	D2752	D2971

- Treatment will be limited to permanent teeth.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve three or more surfaces and at least 50% of the incisal edge. Missing incisal edge must not be due to wear.
- The patient must be free of any active periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth. If any allowance is made for a temporary crown, this will be deducted from the permanent crown allowance.
- If there is previous endodontic treatment, the root canal fill must be adequate (not poorly condensed, not excessively overfilled, not excessively underfilled).
- Teeth must exhibit a minimum of 50% bone support.

A request for core build-up, prefabricated post and core, or cast post and core procedures must meet the following criteria:

CDT Codes:

D2950	D2954
D2952	D2957
D2953	

- A core build-up will only be allowed, prior to a permanent crown restoration, on teeth that have significant breakdown of the clinical crown making the restoration necessary for support of a proposed crown.
- A cast core and dowel or pre-fabricated post and core will only be allowed on teeth having/needing endodontic treatment.
- Teeth must exhibit a minimum of 50% bone support.

A request for a porcelain or composite veneer must meet the following criteria:

CDT Codes:
D2960
D2961
D2962

- Treatment will be limited to anterior permanent teeth.
- All criteria that would qualify a tooth for a ¾ cast crown, full cast crown or onlay would apply to veneers.

Crown Repair

Written and/or photographic documentation needed for consideration of payment:

- Narrative describing treatment and/or photograph.

A request for crown repair procedures must meet the following criteria:

CDT Code:
D2980

- Tooth must be a permanent tooth.
- The crown will be serviceable once repaired.
- Narrative and/or photograph is needed to support treatment.

Endodontic Procedures – Section 1

Radiographic and written documentation needed for consideration of payment:

- Preoperative radiographs of the teeth to be treated: bitewings, periapicals or panorex.
- Narrative describing treatment required for D3332.

A request for direct pulp cap must meet at least one of the following criteria:

CDT Codes:
D3110

- Caries or fracture presents close approximation to pulpal area as supported by radiographs.
- Periapical radiolucency or widening of the periodontal ligament in the apical region as supported by radiographs.
- Extensive breakdown in coronal tooth structure as supported by radiographs.
- The presence of a large restoration that presents close approximation to pulpal area as supported by radiographs.
- Apical pathology or a draining fistula.
- The presence of lingering pain from percussion or temperature.
- Not allowable for primary teeth.
- Teeth must exhibit a minimum of 50% bone support.

A request for incomplete endodontic therapy; inoperable or fractured tooth must meet the following criteria:

CDT Code:
D3332

- Includes time necessary to diagnose and initiate treatment, prior to fracture being diagnosed and tooth determined to be untreatable.
- Narrative is needed to support treatment.
- Teeth must exhibit a minimum of 50% bone support.

A request for apexification/recalcification procedures must meet the following criteria:

CDT Codes:
D3351

- Initial visit: Proposed tooth must exhibit an open apex indicating proper apical seal cannot be attained through traditional endodontic therapy as supported by radiographs.
- Teeth must exhibit a minimum of 50% bone support.

Endodontic Procedures – Section 2

Radiographic documentation needed for consideration of payment:

- Postoperative radiographs showing adequate root canal fill (not poorly condensed, not excessively overfilled, not excessively underfilled).

A request for root canal therapy must meet at least one of the following criteria:

CDT Codes:
D3310
D3320
D3330

- Caries or fracture presents close approximation to pulpal area as supported by radiographs.
- Periapical radiolucency or widening of the periodontal ligament in the apical region as supported by radiographs.
- Extensive breakdown in coronal tooth structure as supported by radiographs.
- The presence of a large restoration that presents close approximation to pulpal area as supported by radiographs.
- Apical pathology or a draining fistula.
- The presence of lingering pain from percussion or temperature.
- Teeth must exhibit a minimum of 50% bone support.

A request for apexification/recalcification procedures must meet the following criteria:

CDT Codes:
D3353

- Initial visit: Proposed tooth must exhibit an open apex indicating proper apical seal cannot be attained through traditional endodontic therapy as supported by radiographs.

- Teeth must exhibit a minimum of 50% bone support.

Endodontic Procedures – Section 3

Radiographic and written documentation needed for consideration of payment:

- Preoperative radiographs of the teeth to be treated: bitewings, periapicals or panorex.

- Postoperative radiographs showing adequate root canal fill (not poorly condensed, not excessively overfilled, not excessively underfilled).

- Narrative describing treatment required for D3331 and D3333.

A request for treatment of root canal obstruction - non-surgical access must meet the following criteria:

CDT Code:
D3331

- The formation of a pathway to achieve an apical seal due to a non-negotiable canal or foreign body obstruction.

- Narrative is needed to support treatment.

- Teeth must exhibit a minimum of 50% bone support.

A request for internal root repair of perforation must meet the following criteria:

CDT Code:
D3333

- Must be caused by resorption or decay, not iatrogenic in nature.

- Narrative is needed to support treatment.

- Teeth must exhibit a minimum of 50% bone support.

A request for endodontic re-treatment must meet at least one of the following criteria:

CDT Codes:
D3346
D3347
D3348

- The existing root canal fill is inadequate (poorly condensed, overfilled, underfilled).

- Apical pathology or a draining fistula.

- Lingering pain from percussion or temperature.

- Teeth must exhibit a minimum of 50% bone support.

A request for apicoectomy/periradicular procedures must meet <u>at least one</u> of the following criteria:

<u>CDT Codes</u>

D3410 D3425 D3430
D3421 D3426 D3450
D3920

- The existing root canal fill is inadequate (poorly condensed, overfilled, underfilled).
- Apical pathology or a draining fistula.
- Lingering pain from percussion or temperature.
- Teeth must exhibit a minimum of 50% bone support.

Periodontal Procedures

Radiographic and written documentation needed for consideration of payment:

- Preoperative radiographs of the teeth to be treated: periapicals or bitewings preferred (not required for D4270, D4271 and D4273).
- Complete periodontal charting with American Academy of Periodontology (AAP) Case Type (not required for D4210, D4211, D4249, D4274, D4275, D4276, D4341 and D4342).
- Narrative describing treatment required for D4270, D4271 and D4273.

A request for gingivectomy or gingivoplasty must meet the following criteria:

<u>CDT Code:</u>
D4210

- A history of root planing or curettage within the last three (3) months.
- Generalized pocketing greater than 5mm.
- Limited to classification Type III and Type IV cases only. Or,
- For patients currently taking Dilantin or cyclosporin medication.

A request for clinical crown lengthening or single tooth gingivectomy must meet the following criteria:

<u>CDT Codes:</u>
D4211
D4249

- A minimum of 50% bone support after crown lengthening procedure is anticipated.
- Tooth has coronal fracture or caries below the periodontal attachment approximating the bone level prior to procedure.
- Not to be performed on the same date of service as the restorative procedure.

A request for gingival flap surgery or osseous surgery must meet the following criteria:

CDT Codes:

D4240	D4260
D4241	D4261

- Generalized pocketing greater than 5mm.
- Limited to classification Type III and Type IV cases only.

A request for bone replacement grafts must meet the following criteria:

CDT Codes:
D4263
D4264
D4265

- Radiographically verifiable vertical bone loss.
- Procedure does not involve an extraction site.

A request for soft tissue graft procedures must meet the following criteria:

CDT Codes:

D4265	D4273
D4270	D4275
D4271	D4276

- A single site is defined as one (1) tooth.
- Narrative is needed to support treatment for D4270, D4271 and D4273.

A request for a distal or proximal wedge must meet the following criteria:

CDT Code:
D4274

- Not to be performed with osseous surgery on the same date of service.

A request for periodontal scaling must meet the following criteria:

CDT Code:
D4341
D4342

- At least one of the following must be present:

    1) Radiographic evidence of root surface calculus.
    2) Radiographic evidence of noticeable loss of bone support.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e., late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing: "Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Removable Prosthodontic Procedures (Full and Partial Dentures)

Written documentation needed for consideration of payment:

- Completed missing tooth chart.

A request for a full or partial denture must meet the following criteria:

CDT Codes:

D5211	D5225
D5212	D5226
D5213	D5281
D5214	

- Prior treatment has eliminated untreated caries or active periodontal disease in the abutment teeth, and abutments must be at minimum 50% supported in bone.
- Provision has been made to instruct the patient in the proper care of the prosthesis.
- In general, the partial denture replaces one or more teeth excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full-sized teeth.

Fixed Prosthodontic Procedures (Bridges)

Radiographic documentation needed for consideration of payment:

- Preoperative radiographs of the teeth to be treated: bitewings, periapicals or panorex.

A request for a fixed bridge pontic or retainer must meet the following criteria:

CDT Codes:

D6205 - D6252
D6545 - D6548
D6600 - D6634
D6710 - D6792; D6794

- All abutment teeth must exhibit a minimum of 50% bone support.
- The patient must be free of any active periodontal disease.
- If there is previous endodontic treatment, the root canal fill must be adequate (not poorly condensed, not excessively overfilled, not excessively underfilled).

A request for crown build-up, prefabricated post and core, or cast post and core procedures must meet the following criteria:

CDT Codes:
D6970 - D6973
D6976
D6977

- A core build-up will only be allowed, prior to a permanent crown restoration, on teeth that have significant breakdown of the clinical crown making the restoration necessary for support of a proposed crown.
- A cast core and dowel or pre-fabricated post and core will only be allowed on teeth having/needing endodontic treatment.

Fixed Partial Denture Repair

Written and/or photographic documentation needed for consideration of payment:

- Narrative describing treatment and/or photograph.

A request for fixed partial denture repair procedures must meet the following criteria:

CDT Code:
D6980

- Tooth must be a permanent tooth or pontic replacing permanent tooth.
- The crown and/or pontic will be serviceable once repaired.
- Narrative and/or photograph is needed to support treatment.

The following lists CDT codes and the required documentation that should accompany claims to BlueCross BlueShield of Tennessee for review:

CDT Codes defined:

CDT Code	Description	Documentation Required with Claim
D0999	Unspecified diagnostic procedure, by report	Narrative, radiographs, if applicable
D2542	Onlay-metallic 2 surfaces	Preoperative radiographs
D2543	Onlay-metallic 3 surfaces	Preoperative radiographs
D2544	Onlay-metallic-4+ surfaces	Preoperative radiographs
D2642	Onlay-porcelain/ceramic 2 surfaces	Preoperative radiographs
D2643	Onlay-porcelain/ceramic 3 surfaces	Preoperative radiographs
D2644	Onlay-porcelain/ceramic 4+ surfaces	Preoperative radiographs
D2662	Onlay-resin-based composite 2 surfaces (laboratory processed)	Preoperative radiographs
D2663	Onlay-resin-based composite 3 surfaces (laboratory processed)	Preoperative radiographs
D2664	Onlay-resin-based composite 4+ surfaces (laboratory processed)	Preoperative radiographs
D2710	Crown-resin (indirect)	Preoperative radiographs
D2712	Crown-3/4 resin-based composite (indirect)	Preoperative radiographs
D2720	Crown-resin with high noble metal	Preoperative radiographs
D2721	Crown-resin with predominantly base metal	Preoperative radiographs
D2722	Crown-resin with noble metal	Preoperative radiographs
D2740	Crown-porcelain/ceramic substrate	Preoperative radiographs
D2750	Crown-porcelain fused to high noble metal	Preoperative radiographs
D2751	Crown-porcelain fused to predominately base metal	Preoperative radiographs
D2752	Crown-porcelain fused to noble metal	Preoperative radiographs
D2780	Crown-3/4 cast high noble metal	Preoperative radiographs
D2781	Crown-3/4 cast predominately base metal	Preoperative radiographs
D2783	Crown-3/4 porcelain/ceramic	Preoperative radiographs
D2782	Crown-3/4 cast noble metal	Preoperative radiographs
D2790	Crown-full cast high noble metal	Preoperative radiographs
D2791	Crown-full cast predominately base metal	Preoperative radiographs

CDT Code	Description	Documentation Required with Claim
D2792	Crown-full cast noble metal	Preoperative radiographs
D2794	Crown-titanium	Preoperative radiographs
D2950	Core buildup, including any pins	Preoperative radiographs
D2952	Cast post & core in addition to crown	Preoperative radiographs
D2953	Each additional cast post (same tooth)	Preoperative radiographs
D2954	Pre-fab post & core in addition to crown	Preoperative radiographs
D2957	Each additional prefabricated post (same tooth)	Preoperative radiographs
D2960	Labial veneer (laminate)-chair side	Preoperative radiographs
D2961	Labial veneer (resin laminate)-laboratory	Preoperative radiographs
D2962	Labial veneer (porcelain laminate)-laboratory	Preoperative radiographs
D2971	Additional procedures to construct new crown under existing partial denture framework	Preoperative radiographs
D2980	Crown repair, by report	Narrative and/or photograph
D2999	Unspecified major crown procedure, by report	Narrative, radiographs, if applicable
D3110	Direct pulp cap	Preoperative radiographs
D3310	Anterior root canal therapy (excluding restoration)	Postoperative radiographs
D3320	Bicuspid root canal therapy (excluding restoration)	Postoperative radiographs
D3330	Molar root canal therapy (excluding restoration)	Postoperative radiographs
D3331	Treatment of root canal obstruction non-surgical	Pre- and Postoperative radiographs, narrative
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	Preoperative radiographs, narrative
D3333	Internal root repair of perforation defects	Pre- and Postoperative radiographs, narrative
D3346	Retreatment of anterior root canal	Pre- and Postoperative radiographs
D3347	Retreatment of bicuspid root canal	Pre- and Postoperative radiographs
D3348	Retreatment of molar root canal	Pre- and Postoperative radiographs
D3351	Apexification/recalcification-initial visit	Preoperative radiographs

CDT Code	Description	Documentation Required with Claim
D3353	Apexification/recalcification-final visit	Postoperative radiographs
D3410	Apicoectomy/periradicular surgery anterior	Pre- and Postoperative radiographs
D3421	Apicoectomy/periradicular surgery-bicuspid	Pre- and Postoperative radiographs
D3425	Apicoectomy/periradicular surgery molar	Pre- and Postoperative radiographs
D3426	Apicoectomy/periradicular surgery (each additional root)	Pre- and Postoperative radiographs
D3430	Retrograde filling (per root)	Pre- and Postoperative radiographs
D3450	Root amputation (per root)	Pre- and Postoperative radiographs
D3920	Hemisection (including root removal, not including root canal	Pre- and Postoperative radiographs
D3999	Unspecified endodontic procedure, by report	Narrative, radiographs, if applicable
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quandrant	Preoperative radiographs
D4211	Gingivectomy or gingivoplasty-1 to 3 teeth per quadrant	Preoperative radiographs
D4240	Gingival flap procedure including root planing-four or more contiguous teeth or bounded teeth spaces per quadrant	Preoperative radiographs, periodontal charting
D4241	Gingival flap procedure including root planing, 1 to 3 teeth per quadrant	Preoperative radiographs, periodontal charting
D4249	Clinical crown lengthening-hard tissue	Preoperative radiographs
D4260	Osseous surgery-(including entry & closure)-four or more contiguous teeth or bounded teeth spaces per quadrant	Preoperative radiographs, periodontal charting
D4261	Osseous surgery - 1 to 3 teeth	Preoperative radiographs, periodontal charting
D4263	Bone replacement graft-1st site in quadrant	Preoperative radiographs, periodontal charting
D4264	Bone replacement graft- each additional site in quadrant	Preoperative radiographs, periodontal charting
D4265	Biological materials - regeneration	Preoperative radiographs, periodontal charting
D4270	Pedicle soft tissue graft	Periodontal charting, narrative

CDT Code	Description	Documentation Required with Claim
D4271	Free soft tissue graft (including donor site)	Periodontal charting, narrative
D4273	Subepithelial connective tissue graft procedures	Periodontal charting, narrative
D4274	Distal or proximal wedge procedure	Preoperative radiographs
D4275	Soft tissue allograft	Preoperative radiographs
D4276	Connective tissue -pedicle graft	Preoperative radiographs
D4341	Periodontal scaling and root planing -four or more teeth per quadrant	Preoperative radiographs
D4342	Scaling and root planing - 1 to 3 teeth	Preoperative radiographs
D4999	Unspecified periodontal procedure, by report	Narrative, radiographs, if applicable
D5211	Maxillary partial denture, resin base	Missing tooth chart completed
D5212	Mandibular partial denture-resin base	Missing tooth chart completed
D5213	Maxillary partial denture-cast metal framework, resin base	Missing tooth chart completed
D5214	Mandibular partial denture-cast metal framework, resin base	Missing tooth chart completed
D5225	Maxillary partial denture-flexible base (including any clasps, rests and teeth)	Missing tooth chart completed
D5226	Mandibular partial denture-flexible base (including any clasps, rests and teeth)	Missing tooth chart completed
D5281	Removable unilateral partial denture one piece cast metal	Missing tooth chart completed
D5899	Unspecified removable prosthodontic procedure	Narrative, radiographs, if applicable
D5999	Unspecified maxillofacial prosthesis, by report	Narrative, radiographs, if applicable
D6205	Pontic-indirect resin-based composite	Preoperative radiographs
D6210	Pontic-cast high noble metal	Preoperative radiographs
D6211	Pontic-cast predominately base metal	Preoperative radiographs
D6212	Pontic-cast noble metal	Preoperative radiographs
D6214	Pontic-titanium	Preoperative radiographs
D6240	Pontic-porcelain fused to high noble metal	Preoperative radiographs

CDT Code	Description	Documentation Required with Claim
D6241	Pontic-porcelain fused to predominately base metal	Preoperative radiographs
D6242	Pontic-porcelain fused to noble metal	Preoperative radiographs
D6245	Pontic-porcelain/ceramic	Preoperative radiographs
D6250	Pontic-resin with high noble metal	Preoperative radiographs
D6251	Pontic-resin with predominately base metal	Preoperative radiographs
D6252	Pontic-resin with noble metal	Preoperative radiographs
D6545	Retainer-cast metal for resin bonded fixed prosthesis	Preoperative radiographs
D6548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	Preoperative radiographs
D6600	Inlay - porcelain/ceramic 2 surfaces	Preoperative radiographs
D6601	Inlay - porcelain/ceramic 3+ surfaces	Preoperative radiographs
D6602	Inlay - metal with high noble 2 surfaces	Preoperative radiographs
D6603	Inlay - metal with high noble 3+ surfaces	Preoperative radiographs
D6604	Inlay - metal base 2 surfaces	Preoperative radiographs
D6605	Inlay - metal base 3+ surfaces	Preoperative radiographs
D6606	Inlay - metal noble 2 surfaces	Preoperative radiographs
D6607	Inlay - metal noble 3+ surfaces	Preoperative radiographs
D6608	Onlay - porcelain/ceramic 2 surfaces	Preoperative radiographs
D6609	Onlay - porcelain/ceramic 3+ surfaces	Preoperative radiographs
D6610	Onlay - metal with high noble 2 surfaces	Preoperative radiographs
D6611	Onlay - metal with high noble 3+ surfaces	Preoperative radiographs
D6612	Onlay - metal base 2 surfaces	Preoperative radiographs
D6613	Onlay - metal base 3+ surfaces	Preoperative radiographs
D6614	Onlay - metal noble 2 surfaces	Preoperative radiographs
D6615	Onlay - metal noble 3+ surfaces	Preoperative radiographs
D6624	Inlay-titanium	Preoperative radiographs
D6634	Onlay-titanium	Preoperative radiographs
D6710	Crown-indirect resin-based composite	Preoperative radiographs

CDT Code	Description	Documentation Required with Claim
D6720	Crown-resin with high noble metal	Preoperative radiographs
D6721	Crown-resin with predominately base metal	Preoperative radiographs
D6722	Crown-resin with noble metal	Preoperative radiographs
D6740	Crown-porcelain/ceramic	Preoperative radiographs
D6750	Crown-porcelain fused to high noble metal	Preoperative radiographs
D6751	Crown-porcelain fused to predominately base metal	Preoperative radiographs
D6752	Crown-porcelain fused to noble metal	Preoperative radiographs
D6780	Crown-3/4 cast high noble metal	Preoperative radiographs
D6781	Crown-3/4 cast predominately base metal	Preoperative radiographs
D6782	Crown-3/4 cast noble metal	Preoperative radiographs
D6783	Crown-3/4 porcelain/ceramic	Preoperative radiographs
D6790	Crown-full cast high noble metal	Preoperative radiographs
D6791	Crown-full cast predominately base metal	Preoperative radiographs
D6792	Crown-full cast noble metal	Preoperative radiographs
D6794	Crown-titanium	Preoperative radiographs
D6970	Cast post & core in addition to fixed partial denture retainer	Preoperative radiographs
D6971	Cast post as part of fixed partial denture retainer	Preoperative radiographs
D6972	Prefab post & core, in addition to fixed partial denture retainer	Preoperative radiographs
D6973	Core buildup for retainer, including any pins	Preoperative radiographs
D6976	Each additional cast post (same tooth)	Preoperative radiographs
D6977	Each additional prefabricated post (same tooth)	Preoperative radiographs
D6980	Fixed partial denture repair, by report	Narrative and/or photograph
D6999	Unspecified, fixed prosthodontic procedure, by report	Narrative, radiographs, if applicable
D7999	Unspecified oral surgery procedure, by report	Narrative, radiographs, if applicable
D8999	Unspecified orthodontic procedure, by report	Narrative, radiographs, if applicable
D9999	Unspecified adjunctive procedure, by report	Narrative, radiographs, if applicable

D. ADA Dental Claim Form

Dental claims should be completed on a standard American Dental Association (ADA) claim form using the most appropriate ADA *Current Dental Terminology (CDT)* codes. To help avoid processing delays, include the following information:

- Patient name
- Patient date of birth
- Member ID number
- Date of service
- Procedure code
- Individual charges
- Total charges
- Provider tax ID number
- Signature of treating dentist
- Tooth number, tooth surface and area of oral cavity, as appropriate

Note: *The Tennessee Board of Dentistry Code of Professional Conduct Section 5; 5.B.4 states the date of completion is the treatment date. The revised ADA claim form does not take into consideration individual state laws or specific contracting agreements.*

A sample copy and description of an ADA Dental Claim Form follows:

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Address Line 1
Address Line 2
City ST Zip

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number

10. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code
Other Carrier Name
Other Carrier Address
City ST Zip

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Name
Address Line 1
ST

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Name
Address Line 1
Address Line 2
City ST Zip

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	0.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99)
Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis?
☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Name
Address Line 1
Address Line 2
City ST Zip

49. Provider ID

50. License Number

51. SSN or TIN

52. Phone Number

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID

55. License Number

56. Address, City, State, Zip Code
Address
City ST Zip

57. Phone Number

58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Rev 06/03

1. ADA Claim Form Locator Field Description:

Header Information

Field 1 Type of Transaction
Field 2 Predetermination/Prior authorization Number

Primary Payer Information

Field 3 Primary Payer Name and Address

Other Coverage Information

Field 4 Other Dental or Medical Coverage
Field 5 Subscriber Name
Field 6 Subscriber Date of Birth
Field 7 Gender M/F
Field 8 Subscriber SSN or ID Number
Field 9 Plan/Group Number
Field 10 Relationship to Primary Subscriber
Field 11 Other Carrier Name

Primary Subscriber Information

Field 12 Name and Address
Field 13 Date of Birth
Field 14 Gender
Field 15 Subscriber SSN or ID Number
Field 16 Plan/Group Number
Field 17 Employer Name

Patient Information

Field 18 Relationship to Primary Subscriber
Field 19 Student Status
Field 20 Name and Address
Field 21 Date of Birth
Field 22 Gender
Field 23 Patient ID/Account # (Assigned by Dentist)

Record of Services Provided

Field 24 Procedure Date
Field 25 Area of Oral Cavity
Field 26 Tooth System
Field 27 Tooth Number(s) or Letter (s)
Field 28 Tooth Surface
Field 29 Procedure Code
Field 30 Description
Field 31 Fee
Field 32 Other Fee(s)
Field 33 Total Fee

Missing Teeth Information

Field 34 Identify missing tooth with an “x”
Field 35 Remarks

Authorizations

Filed 36 Patient/Guardian Signature
Field 37 Subscriber Signature
Field 38 Place of Treatment
Field 39 Number of Enclosures (00-99)
Field 40 Is treatment for Orthodontics?
Field 41 Date Appliance Placed
Field 42 Months of Treatment Remaining
Field 43 Replacement of Prosthesis?
Field 44 Date Prior Placement
Field 45 Treatment Resulting from (Check Applicable Box)
Field 46 Date of Accident
Field 47 Auto Accident State

Billing Dentist or Dental Entity

Field 48 Name and Address
Field 49 Provider ID Number
Field 50 License Number
Field 51 SSN or TIN
Field 52 Phone Number

Treating Dentist and Treatment Location Information

Field 53 Signature (Treating Dentist)/Date
Field 54 Provider ID
Field 55 License Number
Field 56 Address, City, State, Zip Code
Field 57 Phone Number
Field 58 Treating Provider Specialty

Note*: When submitting charges on an ADA Dental Claim Form to BlueCross BlueShield of Tennessee, please include the assigned BlueCross BlueShield of Tennessee Individual Provider Identification Number. This provider-specific number is located in the upper right hand corner of the assigned BlueCross BlueShield of Tennessee Dental Remittance Advice and may be listed on the dental claim form in Field 49 and 54. Some dental practices choose to obtain a group provider number for payment purposes. In these cases the remittance advice will reflect the group provider number. This group number is used to report payments and should* ***not*** *be used when submitting claims. If there is a question on the individual provider number, dentists may contact Dental Customer Service at 1-800-523-1478.*

2. Tips for Completing a Dental Claim Form

Listed below are some tips that will help ensure claims are processed timely and accurately:

- Type all letters in Upper Case (capital letters)
- Use black ink (if typed) or block letters (if hand written) to reflect a clear impression.
- Enter insured's ID number as shown on ID Card
- BlueCross BlueShield of Tennessee requests that providers use an eight-digit format for all dates (MM_DD_CCYY) Example: January 1, 2005 would be written out as 01/01/2005.
  Some paper dental forms will only allow a 2-digit year in the date of service. In these cases, use the format MMDDYY (01/01/05).
- Review each claim to ensure all required fields have been provided.
- Send only original claims and supporting documentation.
- Securely staple any attachments, receipts, etc.
- Be sure to include the BlueCross BlueShield of Tennessee designated Individual Provider Identification Number in Fields 49 and 54.
- File corrected claims hardcopy and clearly mark **"Corrected Billing"** in the Remarks section of the claim form**;** Do Not use correction tape or white out. Draw a line through the original information and list the new information above, below or beside the original information. (The original information MUST be visible).

E. Filing a Dental Claim Form

To help avoid processing delays, submit claims to (excludes Personal Dental Coverage):

- DentalBlue/Preferred Dental Care claims should be filed to:
  BlueCross BlueShield of Tennessee
  Dental Service
  P.O. Box 180150
  Chattanooga, TN 37401

- Personal Dental Coverage claims **only** should be filed to:
  Dental Network of America
  P.O. Box 23120
  Belleville, IL 62223

F. Predeterminations

The Predetermination of Benefits program allows the Dentist and the Member to know exactly what kinds of treatment are covered. If a course of treatment will exceed $200.00, the treatment plan and estimated charges should be submitted to BlueCross BlueShield of Tennessee for review before the work starts. In order to review, the predetermination must be on an ADA dental claim form and "Dentist's Pre-Treatment Estimate" box should be checked and a description of each service and charge should be submitted along with all supporting aids such as preoperative X-rays and/or photographs. **Do not include the date(s) that the work will be started**.

BlueCross BlueShield of Tennessee will review the claim and other information submitted and notify the Member and the Provider via the Dental Pre-Determination of Benefits form of its decision and estimated dental benefits available.

G. Dental Professional Remittance Advice

The Dental Professional Remittance Advice is an explanation of payments and deductions. It is necessary for the Provider's office staff to understand the Remittance Advice thoroughly in order to make all billing adjustments accurately. A sample copy of the Dental Professional Remittance Advice can be found on Blue*Source*, BlueCross BlueShield of Tennessee's quarterly provider reference CD.

The following instructs Providers how to read a BlueCross BlueShield of Tennessee dental remittance advice when overpayment recovery activity is reflected.

Credit Balance Activity

BlueCross BlueShield of Tennessee utilizes the Credit Balance Process (Automatic Payment Recovery) to recover overpayment of charges. Credit balances are the result of a credit (amount to be taken back) which exceeds actual payments on a given Dental Remittance Advice (RA). A credit balance will carry forward and be applied against **future** Remittance Advices. Depending on the amount of the credit balance, it may take more than one future RA to deplete the entire balance.

A credit balance carried forward and applied against a subsequent RA **should be applied to the Member's account where the original overpayment occurred.** The following steps should be taken to resolve a credit balance:

Step 1
Locate the prior Remittance Advice and identify where the credit balance originally occurred.

Step 2
Determine whether this credit balance is the result of an Online Adjustment or a Manual Credit Adjustment.

- ***Online Adjustment***
  This type of adjustment occurs when a Provider or Eligible Member initiates an adjustment request. The adjustment will appear on Page one (1) of the Remittance Advice in the claim detail section and is identified by a negative (-) indicator in the "Amount Paid" column. Page two (2) of the Remittance Advice reflects the credit balance due to BlueCross BlueShield of Tennessee, the Remittance total amount, the credit amount applied to this check, and, the check amount (the final dollar amount printed on the check). At the bottom of this page, the Adjustment Reference No., the current balance due to BlueCross BlueShield of Tennessee and the specific claim numbers involved in the Online Adjustment are listed.

- ***Manual Adjustment***
  This type of adjustment is initiated by BlueCross BlueShield of Tennessee via a Refund Request letter to the Provider outlining specific claims-overpayment information. Once the Provider returns the overpaid amount to BlueCross BlueShield of Tennessee, the amount returned by the provider will be entered manually and the overpaid claim adjusted.

Step 3
Post Claim Payment and/or Credit Adjustment (amount BlueCross BlueShield of Tennessee took back) to the individual Member's account.

H. Personal Dental Coverage

BlueCross BlueShield of Tennessee offers a **non-network** dental product called Personal Dental Coverage to Members with **Individual** coverage plans not covered by the Preferred Dental Network.

Covered dental services under Personal Dental Coverage include diagnostic, preventive, restorative, major restorative including crowns, inlays and onlays*, endodontic, periodontic*, removable and fixed prosthetics* and oral surgical services. Orthodontic services are **not** covered.

Personal Dental Coverage covers two (2) examinations and two (2) prophylaxis (cleaning) per Member per twelve (12) months.

Benefits for radiographs are provided for one (1) complete intraoral series and one (1) panoramic per eligible Member per thirty-six (36) month period. Two (2) bitewings are allowed every twelve (12) months.

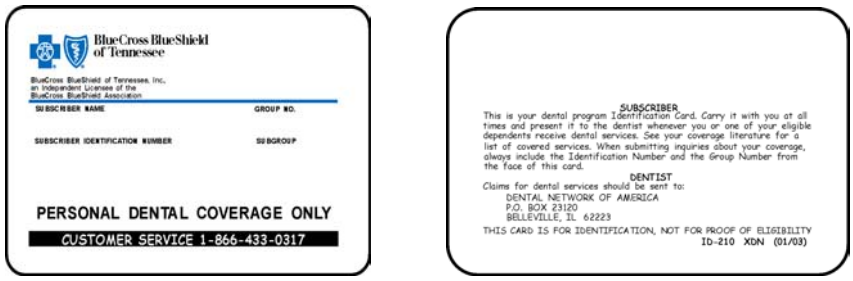
Other Covered Services include:

- Fluoride treatments - one (1) treatment in a twelve (12)-month period for eligible Members up to age 19
- Sealants - for 1st and 2nd permanent molars for eligible Members up to age 19
- Periodontal maintenance - two (2) in a twelve (12)-month period following active therapy

Members with Personal Dental Coverage have a separate BlueCross BlueShield of Tennessee ID card for dental services. "Personal Dental Coverage Only" is reflected on the front of the ID card.

* 12-month waiting period applies.

A sample copy of a Personal Dental Coverage ID card is shown below:



Dental Network of America (DNOA) is contracted with BlueCross BlueShield of Tennessee to perform the following services related to Personal Dental Coverage:

- claims processing;
- payment; and
- customer service.

Personal Dental Coverage claims should be filed on an American Dental Association (ADA) claim form and mailed to:

Dental Network of America
P.O. Box 23120
Belleville, IL 62223

Timely filing guidelines for Personal Dental Coverage claims is one (1) year and ninety (90) days from the date a Covered Service was received. If the claim is not submitted within the 1-year and 90-day time period, it may not be paid.

Customer service at DNOA can be contacted at 1-866-433-0317.

Personal Dental Members are not limited to a specific network of dentists for their care. Covered dental services may be provided by a licensed dentist, a licensed hygienist under the supervision and direction of a licensed dentist, or practitioner acting within the scope of his/her license.

As a schedule plan, reimbursement for Personal Dental Coverage eligible services is based on defined amounts in the *Member's* contract. Servicing Providers may balance bill Personal Dental Coverage Members all additional amounts.

Note: *The Personal Dental $50 individual deductible and $150 family deductible does not apply to diagnostic or preventive services*.

I. Disclaimer

Each BlueCross BlueShield of Tennessee Member has his/her own group-specific benefits. To ensure correct benefits, please contact BlueCross BlueShield of Tennessee Customer Service at 1-800-523-1478 to determine specific Member benefits prior to performing services. Or visit us on the company Web site, www.bcbst.com.

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XIX. PHARMACY

A. Pharmacy Programs

Formulary/Prescribing Guidelines

BlueCross BlueShield of Tennessee commercial pharmacy benefits currently cover most legend drugs for The Food and Drug Administration (FDA) indicated use. Non-FDA approved drugs are considered experimental and are not covered. "Off-label" uses of drugs follow state law requiring the drug to be a FDA-approved drug as listed in standard compendia and its off-label use documented in a nationally circulated, peer-reviewed journal.

Practitioners prescribing controlled substances to BlueCross BlueShield of Tennessee Members are expected to comply with all existing federal and state laws governing this activity. The "Controlled Substance Prescribing Documentation Standards" may be monitored through Practitioner site reviews and medical record audits of Members receiving controlled substances upon request from the Clinical Risk Management Department. These adopted standards can be viewed on the company Web site at http://www.bcbst.com/providers/docs/ControlledSubstancePrescribingStandards.shtm. Paper copies can be obtained by faxing requests to 423-752-8357.

Practitioners non-compliant with these documentation standards are monitored by the Pharmacy and Therapeutics Committee and may be referred to the Clinical Risk Management Committee (CRMC) for further review and action.

B. Member's Health Care Benefits Plan Exclusion

A Member's particular health care benefits plan may exclude certain drug classes or individual drugs (e.g., oral contraceptives, products for hair loss, drugs considered for cosmetic purposes, et al.). A Provider or Member may check with that Member's Customer Service Representative for assistance in determining covered benefits. The Customer Service phone number is listed on the front of the Member's identification card.

C. Member's Drug Co-Pay

There are many varieties of co-pay structures for BlueCross BlueShield of Tennessee Members. These may range from a 10% or 20% co-pay to a two-tiered drug card co-pay of $10/$20 (or other variation) to a three-tiered co-pay of perhaps $10/$20/$35. Generic drugs are in the first co-pay; brand name products are in the top co-pay; and for the three-tiered plan, "preferred" brands are in the second tier.

D. Pharmacy Network

Currently, approximately 96% of Tennessee pharmacies are in the pharmacy network. Members can locate their plan's pharmacy network letter distinction (RX01, RX03, RX04), if applicable, in the lower middle of their health care insurance ID card. These pharmacies are listed in the BlueCross BlueShield of Tennessee Referral Directory of Network Providers or can be accessed on the company Web site at www.bcbst.com. Additionally, BlueCross BlueShield of Tennessee uses a national network, which allows Members to obtain prescriptions outside of Tennessee.

E. Claims Submission

Claims for injectable drugs administered in a Practitioner's office should be submitted on a CMS-1500 claim form using the most appropriate CPT® or HCPCS code. If there is no specific code for an item, the miscellaneous code may be used along with the specific drug's National Drug Code (NDC) number, which is printed on the drug container. The strength of the drug and the number of units administered also should be submitted. Claims for oral, self-administered injectable, or topical medications should be electronically submitted through a network pharmacy to the Member's pharmacy benefits manager.

F. Preferred Drug List (PDL)

The PDL is a list of the top therapeutic classes of drugs, including many of the more popular products within those classes, and which are therapeutically sound and offer a cost advantage for the Member or the Member's sponsoring plan. The PDL is updated annually and can be accessed on the company Web site at www.bcbst.com.

G. Prior Authorization

Certain drugs with special indications require authorization by the pharmacy benefits manager (PBM) prior to dispensing by a pharmacy. The prescribing Practitioner is responsible for obtaining the necessary authorization from the PBM. A list of drugs requiring prior authorization and the criteria for authorizations are listed on the company Web site, www.bcbst.com, and are available through your Provider Relations Representative. For BlueCross BlueShield of Tennessee's commercial health care benefits plans, CAREMARK® serves as the pharmacy benefits manager. Requests for prior authorization can be made by calling CAREMARK® at 1-877-916-2271 or by faxing the request to 1-888-836-0730.

Reconsideration for denied requests should be faxed directly to BlueCross BlueShield of Tennessee Regional Pharmacy Director toll-free at 1-888-343-4232. Often, additional supportive clinical information is necessary for approval of a request for a PA drug.

H. Appeals

If the denial is upheld following the reconsideration, an appeal may be sent to BlueCross BlueShield of Tennessee's Healthcare Assessment/Pharmacy Programs. A brief written statement giving medical justification supporting the appeal may be faxed 1-888-343-4232. If, after reconsideration and appeal a drug request is still denied, the Member may pursue the request through the normal grievance process.

I. Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. All specialty drugs are limited to a one-month supply. A list of these products is available on the company Web site www.bcbst.com, and from your Provider Relations Representative. Requests for exceptions to these limits may be faxed to 1-888-343-4232.

J. Maintenance List

Many BlueCross BlueShield of Tennessee health care benefits plans allow for up to 100-day supply of those medications that have been determined by the Pharmacy and Therapeutics Committee to be indicated for disease states which are long term, chronic, and stable. The Practitioner must write the prescription for the 100-day supply. In keeping with good medical practice, some therapeutic categories are not available in 100-day supply (e.g., antibiotics, pain medications, antidepressants, certain gastrointestinal drugs, Class II controlled drugs, et al.). It is anticipated that the prescribing Practitioner will stabilize a Member on a medication before ordering a maintenance supply.

Note: Drugs that require prior authorization, quantity limits, or that are available on the Maintenance List are subject to change without notice, although announcements of these changes are made through normal BlueCross BlueShield of Tennessee communications and can be accessed on the company Web site at www.bcbst.com.

K. Pharmacy and Therapeutics Committee

All policies and procedures affecting the Pharmacy Programs are reviewed and approved by the Pharmacy and Therapeutics Committee, which is a panel of Pharmacists and Practitioners, some of whom are community Practitioners. Any comments or suggestions regarding the commercial Pharmacy Program may be directed to:

Pharmacy Programs – 1E
BlueCross BlueShield of Tennessee
801 Pine St.
Chattanooga, TN 37402

L. Specialty Pharmacy Program

Effective January 1, 2004, BlueCross BlueShield of Tennessee introduced a Specialty Pharmacy Program for commercial Members who utilize certain high-cost/high-risk drugs for serious, chronic conditions. Specialty pharmacy medications are injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring.

BlueCross BlueShield of Tennessee has a network of preferred Specialty Pharmacy vendors for Members and Providers to call to obtain specialty medications. These preferred vendors are:

- CAREMARK Specialty Pharmacy Services
  Phone 1-866-295-2779
  Fax 1-866-295-2778
- CuraScript Pharmacy
  Phone 1-888-773-7376
  Fax 1-888-773-7386
- Priority Healthcare
  Phone 1-866-225-5670
  Fax 1-866-225-5671

The specialty pharmacy vendor will call the Member to collect the required copayment or coinsurance. This amount is typically paid by credit card. The medication will then be shipped directly to the Member's home or other designated location. After shipping, the specialty pharmacy vendor will call the Member to verify the medication was received and to answer any questions the Member may have concerning the medication or its administration.

With the added pharmacy support services available through each vendor, Members have access to:

- Patient care coordinators;
- Pharmacists and nurses, available 24-hours-a-day, 7-days-a-week;
- Compliance management programs to help optimize drugs usage, and
- Disease management programs to proactively monitor and manage complex drug regimens.

Certain specialty pharmacy medications administered in any setting other than inpatient hospital require prior authorization by either the Member's medical benefits plan or his/her pharmacy benefits plan.

A complete listing of specialty pharmacy medications can be viewed online at http://www.bcbst.com/pharmacy/SpecialtyProgram/SpecialtyPharmacyDrugList.pdf. Those requiring prior authorization under the Member's medical benefits plan are identified by an (*). See Section VIII. Utilization Management Program in this Manual for prior authorization requirements for specialty pharmacy medications covered under the Member's medical benefits plan.

To obtain prior authorization of specialty pharmacy medications covered under the Member's pharmacy benefits plan, the network Practitioner should call Caremark Prior Authorization Desk at 1-877-916-2271. Preferred specialty pharmacy vendors may also call this number to obtain prior authorization.

Note: *Claims for self-administered injectables must be electronically submitted through a network pharmacy to the Member's pharmacy benefits manager*.

The following patient prescription form can be used for any of the three vendors listed above. This form and additional program information can also be accessed from the Provider page of the company Web site, www.bcbst.com.

A sample copy of the Patient Prescription Form follows:

BlueCross BlueShield of Tennessee
www.bcbst.com

Patient Prescription Form
Specialty Pharmacy Program
- CONFIDENTIAL -

Please complete and fax to one of the following dispensing pharmacies.

Caremark Specialty Pharmacy Services	CuraScript Pharmacy	Priority Healthcare
Phone: 1-866-295-2779	Phone: 1-888-773-7376	Phone: 1-866-225-5670
Fax: 1-866-295-2778	Fax: 1-888-773-7386	Fax: 1-866-225-5671

Physician Information

Physician's Name:
Address:
City:
State: Zip:
Office Contact:
Telephone:
Fax:
UPIN #:
State License #:
DEA #:

Patient Information

Patient's Name:
Address:
City:
State: Zip:
Date of Birth: / / Sex: ❑ M ❑ F
Social Security #:
Daytime Telephone #:
Evening Telephone #:
Height: Weight:
Allergies:

Primary Insurance Information

Insured's Name:
Relationship:
ID #:
Policy #:
Carrier/Group #:

Other Insurance Information

Insurance Company:
Policy #:
Group #:
Insured's Name:
Relationship:
Social Security #:
Date of Birth: / /

Clinical Information

Diagnosis Code: _____ Primary Diagnosis: _____

Prescription Medications	Strength	Directions (Dose/Route/Frequency)	Quantity/Length
1)			
2)			
3)			
4)			

# of Refills: _____ **Physician's Signature:** _____ **Date:** _____ **DAW:** _____

Delivery Instructions

Ship to: ❑ Physician's Office
❑ Patient's Home
❑ Other

Delivery Date: Refill Date:

If Other, please supply:
Address:
City:
State: Zip:

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XX. BEHAVIORAL HEALTH SERVICES

A. Introduction

BlueCross BlueShield of Tennessee is committed to providing safe and effective treatment at the clinically appropriate and least restrictive level of care necessary in order to meet a Member's biopsychosocial needs, and to providing a credentialed network of behavioral health Providers to meet the access requirements of its Members.

B. Behavioral Health Networks

BlueCross BlueShield of Tennessee has four networks offering behavioral health services:

- Blue Network C
- Blue Network K
- Blue Network P
- Blue Network S

C. Prior Authorization Guidelines

Prior authorization is required for all inpatient behavioral health levels of care and may be required for outpatient professional visits**.** Inpatient levels of care include acute care, residential, partial hospitalization, intensive outpatient programs and inpatient and outpatient Electroconvulsive Therapy (ECT). Outpatient treatment means outpatient office visits and may require prior authorization in some Member health benefits plans. Depending on the specific Member health benefits plan, benefits for non-prior authorized care may be reduced or may not be available. Emergency behavioral health services do not require prior authorization; however, emergency services should be authorized at the time of admission or the next business day if the admission was in the evening or during the weekend.

Note: *Inpatient Review Only Programs do* ***not*** *require prior authorization or referral for outpatient professional visits or behavioral health testing. These programs require prior authorization for acute care, residential care, partial hospital programs, intensive outpatient programs and inpatient and outpatient electroconvulsive therapy.*

Note*: Comprehensive Care Management Programs require prior authorization of <u>all inpatient levels of care, outpatient professional visits and testing</u>. This includes acute care, residential care, partial hospital programs, intensive outpatient programs, inpatient and outpatient electroconvulsive therapy, professional office visits and behavioral health testing.*

D. Access to Services

Telephone Access for Referral and Authorization:

Members can directly access behavioral health services 24-hours-a-day, 7-days-a-week. Licensed Clinical Care Managers with at least 5 years clinical experience are available to assist Members and Providers with their questions.

BlueCross BlueShield of Tennessee Members can call **1-800-888-3773** to arrange behavioral health services. Medical or Behavioral Health Providers or their office staff can also use this number to assist Members in setting up appointments for required behavioral health evaluations or treatment.

Treatment Access to Facilities and Professionals:

BlueCross BlueShield of Tennessee maintains standards to provide access to licensed and approved psychiatric and substance abuse facilities and treatment programs, as well as licensed behavioral health care Providers.

Facilities must be licensed by the State and should be approved by the Joint Commission on Accreditation of Hospital Organizations (JCAHO) or by the Commission Accreditation of Rehabilitation Facilities (CARF) to be approved BlueCross BlueShield of Tennessee behavioral health facilities.

Professional Providers must be state-licensed Psychiatrists, Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Psychological Examiners, Licensed Senior Psychological Examiners, Licensed Marriage and Family Therapists, Registered Nurses with a CNS designation, or a Psychiatric Advanced Practice Nurse to be approved BlueCross BlueShield of Tennessee Providers.

E. Behavioral Health Specific Billing Guidelines

The following information is intended to assist you when billing behavioral health professional and facility claims. For general claims filing instructions, please refer to Section VI. Billing and Reimbursement in this Manual.

1. Inpatient Professional Services

Inpatient professional behavioral health services must be filed on a CMS-1500 claim form using the most appropriate Current Procedural Terminology (CPT®) code. When submitting ANSI 837 electronic claims, the Professional format must be used (ANSI 837P).

The following billable services list represents the most frequently utilized CPT® codes for inpatient professional services:

CPT® Code
9922X
9923X
9925X
99281
99282
99283
99284
99285

2. Outpatient Professional Services

Outpatient professional behavioral health services must be filed on a CMS-1500 (HCFA-1500) claim form using the most appropriate Current Procedural Terminology (CPT®) code. When submitting ANSI 837 electronic claims, the Professional format must be used (ANSI 837P).

Behavioral health professionals may only provide services and bill for CPT® codes that fall within the scope of practice allowed by their professional training and state licensure. The following billable services list represents the most frequently utilized CPT® codes for outpatient professional services:

CPT® Code			
90801	90813	90826	90880
90802	90814	90827	90901
90804	90815	90828	96101
90805	90816	90829	96103
90806	90817	90846	99058
90807	90818	90847	99212
90808	90819	90849	99241
90809	90821	90853	99242
90810	90822	90857	99243
90811	90823	90862	99244
90812	90824	90870	99245

3. Health and Behavior Assessment/Intervention

Performance of a health and behavior assessment may include a health-focused clinical interview, behavioral observations, psychophysiological monitoring, use of health-oriented questionnaires, and assessment data interpretation. Elements of a health and behavior intervention may include cognitive, behavioral, social, and psychophysiological procedures that are designed to improve the patient's health, ameliorate specific disease-related problems, and improve overall well being.

Effective January 1, 2002, the following CPT® codes should be billed with a medical diagnosis: (Please refer to the current International Classification of Diseases (ICD) Codes manual for the most appropriate diagnosis code in effect for the date of service.)

CPT® Code	Description
96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient; initial assessment.
96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient; re-assessment.
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual.
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients).
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present).
96155	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present).

4. Psychiatric Consultation Guidelines in a Medical Setting

When psychiatric consultation services are required, Providers should call the Behavioral Health number on the back of the member's ID card to verify member eligibility and determine prior authorization requirements.

- ***If prior authorization IS required, the call will be transferred to a behavioral health case manager.*** Inform the case manager you are requesting prior authorization for a consultation service for a patient who is receiving medical treatment on a medical unit/floor, in an emergency room or in a nursing home.

- If prior authorization is NOT required, the following guidelines apply:

If consultation is in:	service may be:
Emergency Room	performed **only** by psychiatrist and billed according to contract fee schedule
Hospital Bed	performed by psychiatrist and/or psychologist and billed according to contract fee schedule
Nursing Home	performed by all behavioral health professionals and billed according to contract fee schedule

Psychiatric consultation services must be billed with the appropriate Place of Service code for the medical treatment setting and the CPT® code provided at the time the service was authorized. Claims must be billed on a CMS-1500 claim form or ANSI-837P transaction.

5. Facility and Program Services Revenue Codes

As a result of the code set requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), behavioral health facility claims must be filed with the appropriate Revenue Codes in accordance with your Magellan Behavioral Health Provider Participation Agreement for BlueCross BlueShield of Tennessee business. A listing and contract descriptions follow:

Revenue Code	Contract Description
0116, 0126, 0136, 0146, 0156, 0204	Acute Care, Inpatient Hospital, A&D Detox
0118, 0128, 0138, 0148, 0158	Acute Care, Inpatient Hospital, Substance Abuse Disorder
1001	➢ Non-Acute, Residential Treatment, Psychiatric ➢ Non-Acute, Residential Treatment, Eating Disorder ➢ Hospitalization 23-Hour Observation, Substance Abuse Disorder
1002	Non-Acute, Residential Treatment, Substance Abuse Disorder
1004	➢ Supervised Living, Substance Abuse Disorder, Half-Way House ➢ Supervised Living, Mental Health, Half-Way House
0901	ECT Inpatient and Outpatient
0905	➢ Intensive Outpatient, Psychiatric ➢ Intensive Outpatient, Eating Disorder
0906	Intensive Outpatient, Substance Abuse Disorder
0912, 0913	➢ Partial Hospital, Psychiatric (Day Treatment) ➢ Partial Hospital, Substance Abuse Disorder (Day Treatment) ➢ Partial Hospital, Eating Disorder
0944	Methadone Detox
0944, 0945	Ambulatory Detox
0910	Crisis Stabilization
0944. 0529	Methadone Maintenance (Not a covered service in all plans)

To avoid delays in receiving payments, behavioral health claims should be submitted to the following address:

BlueCross BlueShield of Tennessee, Inc.
P.O. Box 180150
Chattanooga, TN 37420

F. Provider/Member Complaints/Grievances

Providers and Members can register complaints or grievances by calling the behavioral health services number on the back of the Member ID card or the BlueCross BlueShield of Tennessee Customer Service number listed on the front of the Member ID card.

G. Covered Behavioral Health Services

Benefits are available for clinical assessment, diagnosis, referral, as well as inpatient and outpatient services for treatment of Behavioral Health Disorders (mental health and alcoholism and substance abuse).

Behavioral health services are covered when received from a contracting Provider or a non-contracting Provider depending upon the Member's health care benefits plan. Members should consult their health care benefits plan or call the Customer Service number listed on their ID card for prior authorization requirements and benefit coverage.

1. Inpatient Services

Inpatient services are covered when received in a behavioral health facility, program or unit for mental health disorders and for substance abuse disorders when prior authorized by the Member's health care benefits plan. In emergency situations no prior authorization is necessary; however, a call for authorization is required within 24 hours. Inpatient services include acute care, residential care, partial hospitalization, intensive outpatient programs, and inpatient and outpatient electroconvulsive therapy (ECT) defined as follows:

- **Acute Care**
  Acute care is provided in a hospital licensed by a state to provide psychiatric and/or substance abuse treatment. It should also be Joint Commission on Accreditation of Hospital Organization (JCAHO) approved. Acute care includes 24 hour psychiatric and substance abuse care for adults, adolescents and children with distinct criteria for each service. It may also include detoxification, dual diagnosis, and other services targeted to treat specific behavioral health disorders.

- **Inpatient and Outpatient Electroconvulsive Therapy (ECT)**
  ECT is covered when performed in a hospital setting. Both inpatient and outpatient ECT requires review and prior authorization by Behavioral Health Services.

- **Residential or Sub-Acute Care**
  Residential or Sub-Acute care includes psychiatric and substance abuse treatment in a JCAHO and/or CARF accredited program. Residential care is 24 hour-a-day care. Supervised residential care provided in licensed halfway houses, licensed group homes and licensed supervised apartment settings, combining outpatient treatment with assistance and supervision of day-to-day activities, may be authorized through the intensive case management process.

- **Partial Hospitalization, Intensive Outpatient and Day Treatment programs**
  Must be provided in licensed, JCAHO or CARF (or other Plan approved accrediting programs) approved facilities.

2. Outpatient Services

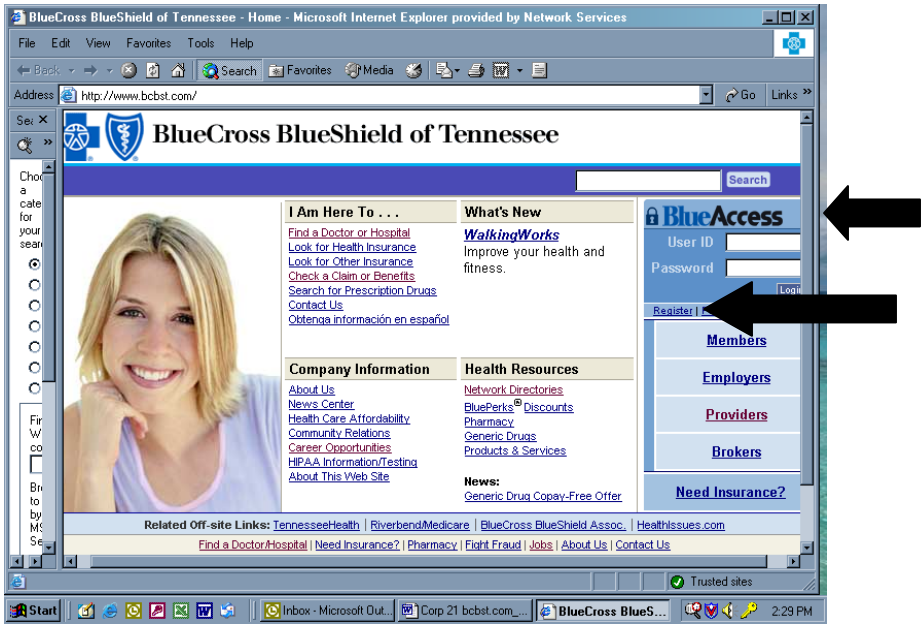
Outpatient services are covered when provided in office settings, within facility-based outpatient settings or as psychiatric home health. The Provider of the services must be licensed at the independent practice level in the state where the services are provided and meet other requirements as formulated by State of Tennessee law, BlueCross BlueShield of Tennessee, and the behavioral health services covered under the Member's health care benefits plan.

H. Licensed Professional Providers of Behavioral Health Services

- Clinical Nurse Specialist/Psychiatric (RN, CNS)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Psychological Examiner (LPE)
- Licensed Senior Psychological Examiner (LSPE)
- Psychiatrist
- Psychologist
- Licensed Marriage and Family Therapist (LMFT)
- Advanced Practice Nurse (APN)

XXI. www.bcbst.com

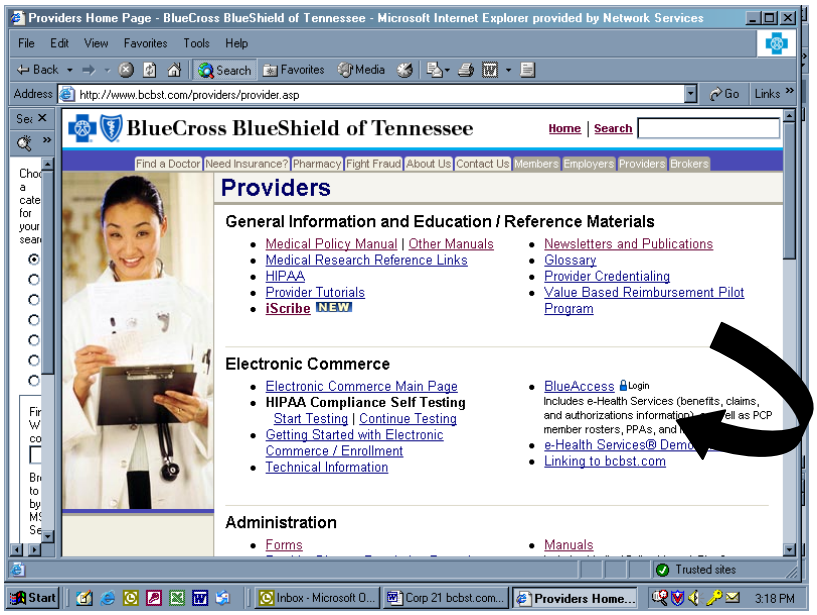
The company Web site, www.bcbst.com, is an award-winning, easy-to-use service that enables Providers and Members having Internet capabilities to link to a compilation of informative health care information.



BlueAccess

If you are already registered, look for the "BlueAccess" login box located in the top right-hand corner of the Web page. Simply enter your user ID and password to view information in a **secure environment**, just as it appears **right now** in our computer system. First time users can click on "Register" (see above), and follow registration instructions.

BlueAccess includes e-Health Services® (benefits, claims, and authorizations information), as well as access to Primary Care Practitioner member rosters, quarterly Commercial Practice Pattern Analysis (PPA) and User Guide, and commercial Providers' remittance advice.



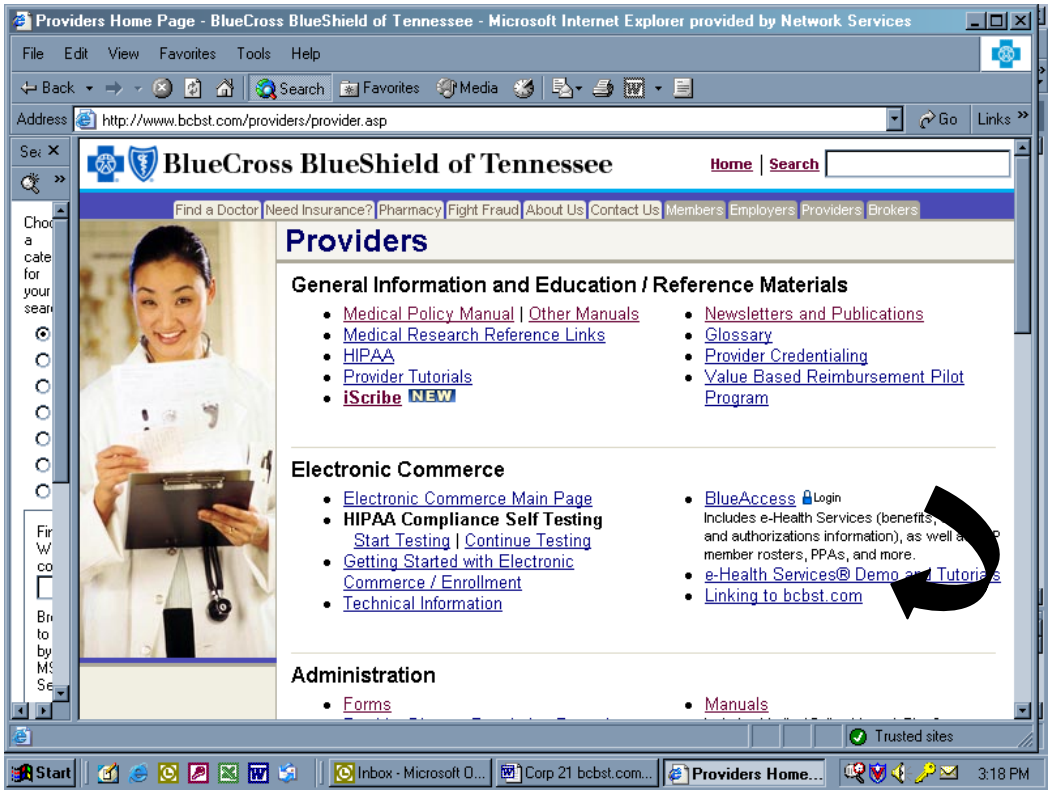
- ***Practice Pattern Analysis (PPA)***

  BlueCross BlueShield of Tennessee periodically performs a Practice Pattern Analysis (PPA), which is a quality management study designed to provide practitioners with important information about their utilization practices and quality of care.

  PPAs are not intended to prescribe what constitutes appropriate individual care. Instead they are designed to reveal patterns of care that are outside the normal range of practice for a practitioner's specialty. PPAs provide useful information to assist practitioners in evaluating the appropriateness of care and give them an opportunity to compare their overall practice patterns to those of their peers.

e-Health Services®

e-Health Services is a quick, convenient way to answer many of your health insurance questions 24-hours-a-day, 7-days-a-week.



On this site, you can:

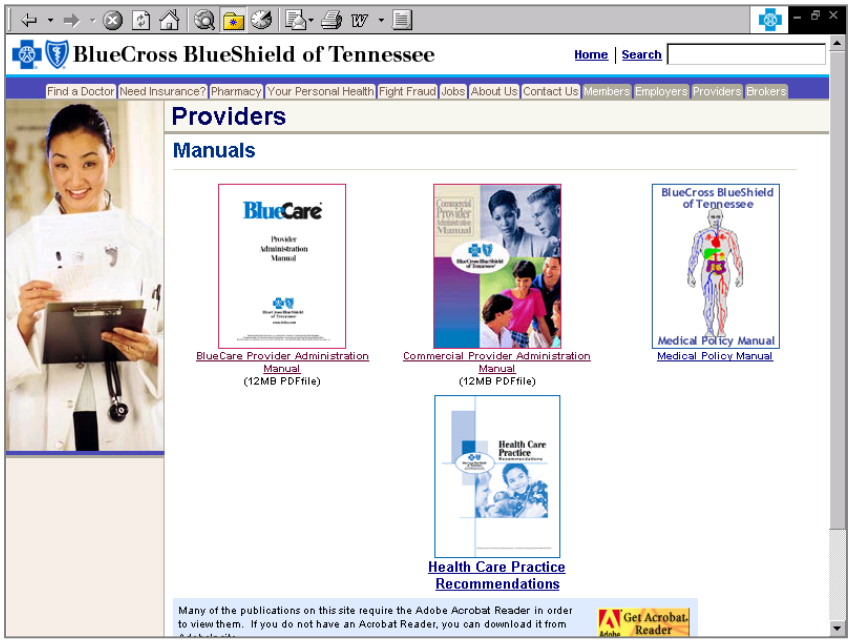
- verify benefits, including eligibility and coverage details
- check medical, behavioral health and dental claim status (excludes prescription drug claims)
- look up prior authorization status
- submit Inpatient, Outpatient and 23-Hour Observation prior authorization requests and receive online approvals if specific criteria are met; and much, much more……

Other Online Reference Materials

A number of reference materials are also available online giving you access to current administrative processes, and medical policies.

Provider administration manuals, Medical Policy Manual and Health Care Practice Recommendations

The Web site contains a "find" feature making it convenient for Providers to locate specific information, (e.g., billing requirements, UM guidelines, preventive care guidelines, upcoming medical policies and much more).



Click on the manual you wish to reference; to search for a specific topic, simply:

- click on the "find" button (little binoculars);
- type in a word or number of words that most describe the topic you wish to find; and
- hit "enter" on your keyboard.

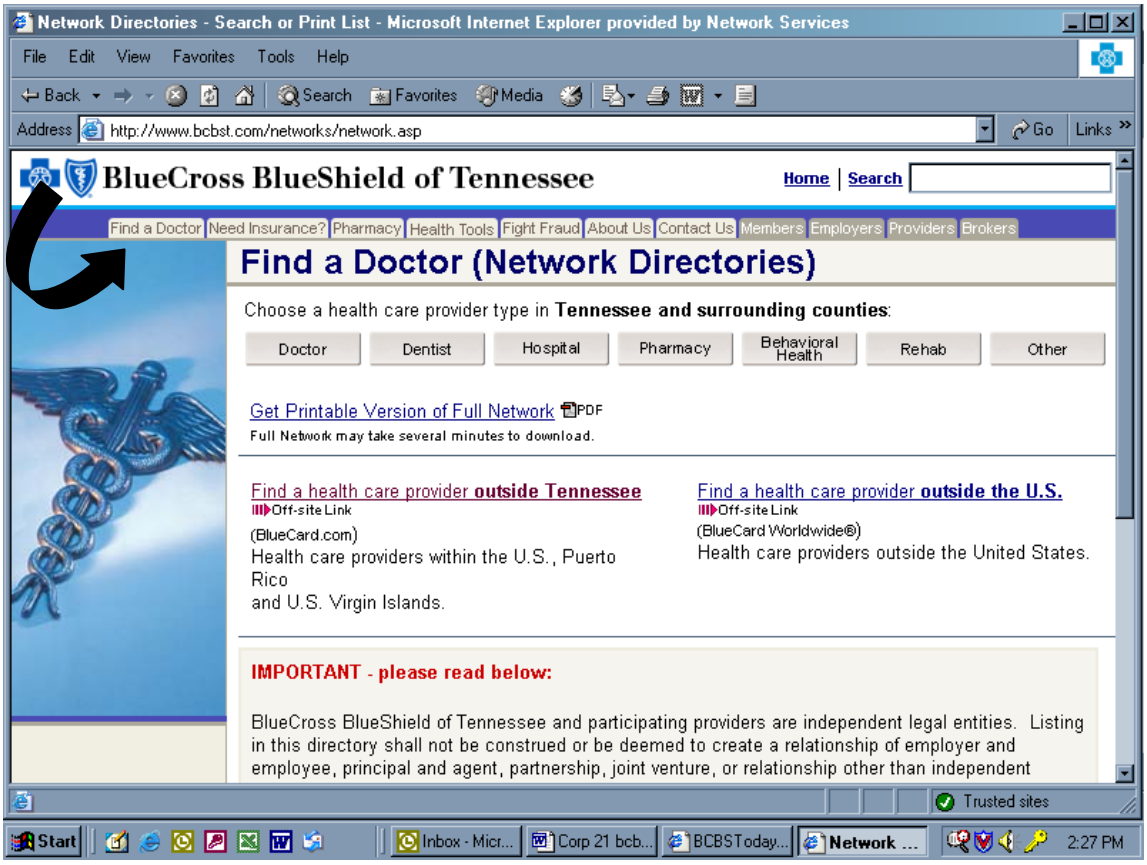
You will be taken to where the first mention of your search is located. To continue searching, just click on the "find again" button (little binoculars with forward arrow).

Utilization Management Guidelines

- ***Modified Milliman Care Guidelines***

  BlueCross BlueShield of Tennessee uses Milliman Care Guidelines® to assist in its clinical decision-making processes. There are times when BlueCross BlueShield of Tennessee must modify or redefine certain Milliman Care Guideline criteria to meet practice patterns in Tennessee (i.e., a guideline does not exist, the length of stay needs to be defined, or the decision criteria needs to be modified). Beginning Sept. 1, 2004, the Milliman Care Guidelines® that have been modified by BlueCross BlueShield of Tennessee are published on the company Web site. This allows providers the opportunity to review and be aware of any changes or variances made to Milliman Care Guidelines® by BlueCross BlueShield of Tennessee. Providers will be notified through *BlueAlert*, BlueCross BlueShield of Tennessee's Provider newsletter, 30 days in advance of subsequent changes to these guidelines.

Network Directories



Find a Doctor
Referring your patients to other participating Providers is not only contractual, but will save substantial out-of-pocket costs for your patients.

On this page, Providers can click on the “Find a Doctor” tab to access the *Network Directories* which feature a search engine for locating other participating Providers and a tool for use in creating a printable listing.

The information listed in this online directory is updated daily. As is the case with any directory, the listed Providers' participation in the network is verifiable only up to the date the directory was updated. Providers join, as well as, drop from the network. It is very important to verify health care professionals' and facilities' continued participation in the network before referring a patient.

We invite you to visit the company Web site often; information and new features are added on a regular basis.

XXII. BlueCare® Program Outline

The following pages highlight information regarding operating policies and procedures as they relate to the BlueCare Program.

The information found in this outline applies to Providers who care for BlueCare and TennCare*Select* Members.

The requirements, policies and processes defined in this outline are contractual obligations stipulated in the BlueCare Provider Contract and TennCare*Select* Provider Agreement and are covered extensibly in the *BlueCare Provider Administration Manual*.

If you have questions regarding the TennCare Program, please call your Provider Relations representative. A listing of contact telephone numbers can be found in Sections B. and D. of this outline.

A. BlueCare Health Plan

TYPE OF PLAN

Health Maintenance Organization (HMO)

NETWORK

Volunteer State Health Plan (VSHP)

COPAYMENT - Effective May 1, 2002

Poverty Levels	Copayment Amount	Individual Maximum Out-of-Pocket (OOP) Per Calendar Year	Family Maximum Out-of-Pocket (OOP) Per Calendar Year
0 – 100%	0	0	0
101% - 199%	$25.00 for hospital emergency room (waived if admitted) $5.00 for primary care practitioner (PCP) and Community Mental Health Agency services other than preventive care $15.00 for physician specialists $5.00 for prescriptions or refills $100.00 per inpatient hospital admission	$1000	$2000
200% and above	$50.00 for hospital emergency room (waived if admitted) $10.00 for primary care practitioner (PCP) and Community Mental Health Agency services other than preventive care $25.00 for physician specialists $10.00 for prescriptions or refills $200.00 per inpatient hospital admission	$2000	$4000

Note: Once the OOP copayment maximum is met, the Member will not be required to pay a co-payment.

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MEDICAL REFERRALS

Effective July 1, 2001, completion of the written referral form was eliminated for Primary Care Practitioners referring to a participating specialist or to any emergency room. PCPs are still expected to direct Members' care and make the appropriate appointments to participating specialists and to all emergency rooms. **Note*: The current written referral process is still required when referring a Member to an out-of-network Provider.*** (See the Utilization Management section of the *BlueCare Provider Administration Manual* for out-of-network written referral instructions.)

MENTAL HEALTH REFERRALS

Outpatient/Inpatient - Call Premier Behavioral Systems of Tennessee at 1-800-325-7864. Call Tennessee Behavioral Health at 1-800-447-7242 for Members residing in CSAs 2 or 11. For details, see section F. in this outline.

SELECTED SERVICES REQUIRE NOTIFICATION OR PRIOR AUTHORIZATION

See the Utilization Management section of the *BlueCare Provider Administration Manual* for a listing of select services requiring notification or prior authorization.

Notification or Prior Authorization requests should be directed to:

BlueCare East Grand Region
1-800-246-1904
1-800-622-8901
1-888-423-0131
1-800-292-5311 (Fax)

TennCare*Select* (Statewide)
1-800-711-4104
1-800-292-5311 (Fax)

B. Description of BlueCare

BlueCross BlueShield of Tennessee has a long-standing commitment to provide excellent service to the people who depend on us. The increased emphasis at both the federal and state levels for establishing National Health Care Reform resulted in the State's introduction of TennCare. TennCare was designed to provide managed health care services for current Medicaid recipients. It also provides medical services to the uninsured and the uninsurable that have previously been unable to receive adequate health care. BlueCross BlueShield of Tennessee, through Volunteer State Health Plan (VSHP), is only one of the managed care organizations (MCOs) administering the TennCare Program in the State of Tennessee.

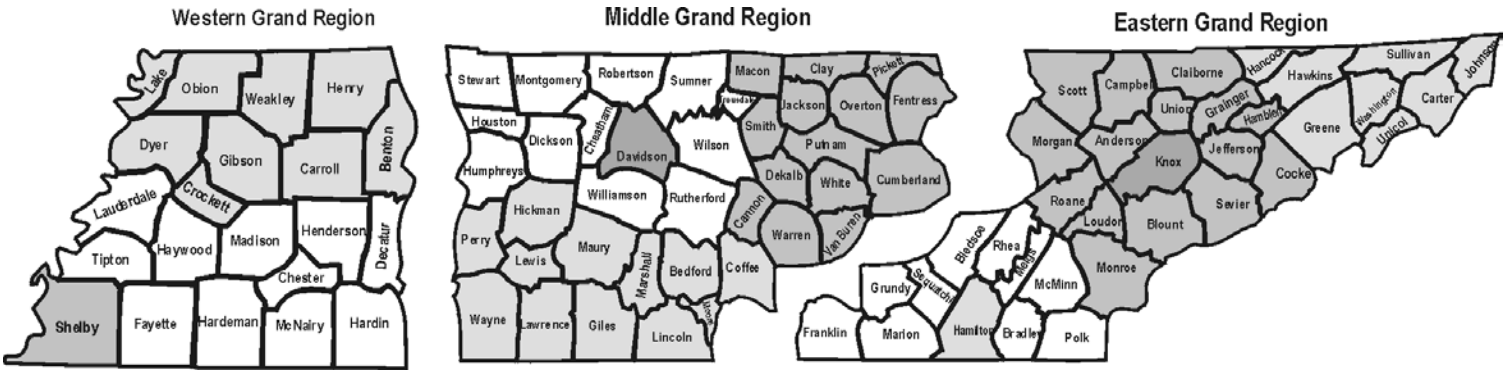
BlueCare is a product underwritten by Volunteer State Health Plan, Inc., and provides medical care for its TennCare Members. BlueCare strives to ensure Members receive the highest quality of care in the most cost-effective manner.

BlueCare is a Primary Care Practitioner (PCP)-driven HMO network. The focus is on PCPs providing appropriate care to Members in accordance with established clinical guidelines.

BlueCare offers its Members and Providers programs in medical management, quality improvement, education and development, as well as quality customer service. The customer service areas are designed to provide efficient access and assistance to our Providers and Members.

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by Volunteer State Health Plan, Inc.

A map defining BlueCare and important contact numbers follow:



BlueCare (Eastern Grand Region)

Member Service Line	**1-800-468-9698**
Provider Service Line	**1-800-468-9736**
Fax Line	**1-800-468-9692**
Notification or Prior Authorization	**1-800-246-1904**
	1-800-622-8901
	1-888-423-0131
Fax Line	**1-800-292-5311**

Mailing Address: **BlueCare**
P.O. Box 182277
Chattanooga, TN 37422-7277

TennCare*Select* (Statewide)

(See BlueCare Provider Administration Manual, Section XXI for TennCare*Select* specifics)

Member Service Line	**1-800-263-5479**
Provider Service Line	**1-800-276-1978**
Fax Line	**1-800-218-3190**
Notification or Prior Authorization	**1-800-711-4104**
Fax Line	**1-800-292-5311**

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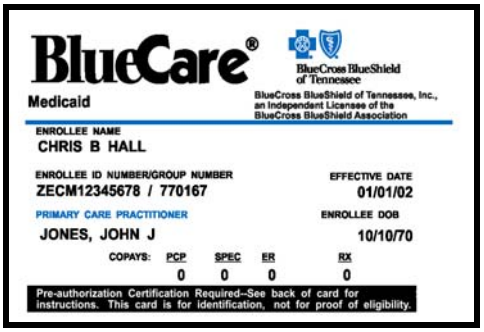
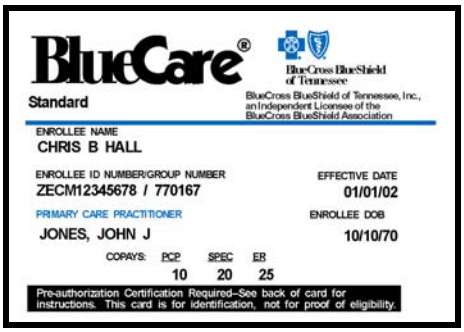
C. BlueCare ID Card

Each BlueCare Member receives a plastic BlueCare ID card reflecting the PCP's name and effective date. A new BlueCare ID card is issued each time the Member changes his or her PCP. Sample ID cards follow:





ID cards are for identification only; they do not guarantee eligibility. If the Member is Medicare/Medicaid dual eligible, the BlueCare ID card will reflect the following information:

- Medicare Part A Only - PCP's name (reflected in PCP field) and effective date
- Medicare Part B Only - "Medicare/Medicaid Dual" (reflected in PCP field)
- Medicare Part A and Part B - "Medicare/Medicaid Dual" (reflected in PCP field)

NOTE**:** *Medicare/Medicaid dual-eligible Members with Part B* ***or*** *Part A and B are not required to seek care from a BlueCare PCP for their care,* ***except*** *for non-Medicare Covered Services that are BlueCare-covered.*

If a Member presents without his or her ID card, Providers can verify eligibility by:

- Checking his or her most recent BlueCare Member Listing (if a Primary Care Practitioner);
- Calling BlueCare Provider Services line (See Section B. BlueCare Description in this outline);
- Calling the BlueCare Automated Information Line (See Section D. BlueCare Frequently Called Numbers in this outline); or
- Access Friendly Screens via e-Health Services® at www.bcbst.com.

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D. BlueCare Frequently Called Numbers

The following guide is intended to aid Providers in locating telephone numbers and addresses when seeking specific information:

Contact	Toll-Free Number	Address/Description
Bureau of TennCare	1-800-669-1851	Bureau of TennCare P.O. Box 580 Nashville, TN 37202
BlueCare Automated Information Line • Eligibility • Claims Status	1-800-543-8607	Available Monday - Friday (except between 7 p.m. and 9 p.m. when eligibility information is being updated) and Saturday and Sunday from 8 a.m. - 4 p.m. The system is not available on Thanksgiving Day or Christmas Day.
Provider Service	BlueCare 1-800-468-9736 TennCare*Select* 1-800-276-1978	Available Monday – Friday from 8 a.m. through 6 p.m. (EST)
BlueCross BlueShield of Tennessee Health Information Library	1-800-999-1658	Available 24-hours-a-day
TennCare Solutions Unit	Phone 1-800-878-3192 Fax 1-888-345-5575	TennCare Solutions Unit P.O. Box 593 Nashville, TN 37202-0593
TennCare Pharmacy Program (Prior Authorizations)	Phone 1-866-434-5524 Fax 1-866-434-5523	First Health Services Att: TennCare PA 14955 Heathrow Forest Pky Houston, TX 77032
Dental	1-888-554-5542	Doral Dental Services of TN 12121 N. Corporate Pky Mequon, WI 53092
e-Commerce Technical Enrollment	 423-755-5717 423-755-5174	BlueCross BlueShield of Tennessee e-Commerce 801 Pine Street Chattanooga, TN 37402
Fraud & Abuse Hotline	1-800-496-9600	To report suspected fraudulent activity against Volunteer State Health Plan, Inc.

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E. BlueCare Primary Care Practitioner (PCP)

Each BlueCare Member (excluding Medicare/Medicaid dual-eligible Members with Part B or Part A and B, and children in State custody) is assigned a Primary Care Practitioner (PCP) who is responsible for coordinating all the Member's medical care.

The PCP is the Practitioner who can understand each patient's health status and how it is impacted by lifestyle. The PCP is called on to exercise independent clinical judgement on a case-by-case basis to discuss options with patients; On occasion, Members request exception to the established clinical guidelines of health plans.

Primary Care Practitioners (PCPs) are responsible for the overall health care of BlueCare Members assigned to them. Responsibilities associated with the role include:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all Medically Necessary and Covered Services;
- Initiating and/or authorizing referrals* for specialty care;
- Monitoring the continuity of Member care services;
- Routine office visits for new and established Members;
- Medicaid Early and Periodic Screening, Diagnostic and Treatment programs (EPSDT);
- Hearing services including: screening test, pure tone audiology, air only audiology, pure tone audiometry and air only audiometry hearing services;
- Counseling and risk intervention, family planning;
- Immunizations;
- Administering and interpreting of health risk assessment instrument;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide Covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the access and availability standards outlined in the *BlueCare Provider Administration Manual* (Section VII. Member Policy).

*Completion of the referral form for BlueCare Members has been eliminated for Primary Care Practitioners referring to a participating specialist or to any emergency room. However, PCPs are still expected to direct the Member's care and make appropriate appointments to participating specialists and to all emergency rooms.

F. Behavioral Health Services

All inpatient/outpatient mental health facility care and inpatient psychiatric consultations require prior authorization. PCPs may treat or manage a Member's behavioral condition within their scope of practice. PCPs are encouraged, at their discretion, to contact the behavioral health organization (BHO) for consultation on any covered mental health and substance abuse condition/service.

Premier Behavioral Health Systems of Tennessee and Tennessee Behavioral Health, Inc. serve as TennCare behavioral health organizations (BHOs) for TennCare managed care organizations (MCOs).

PCPs having behavioral health questions or needing prior authorizations for outpatient/inpatient MH/SA services need to call:

- **Premier Behavioral Health** (All BlueCare, TennCare*Select*, and Best Practice Network Members **except** those residing in East Tennessee* and Knox County)
  1-800-325-7864

- **Tennessee Behavioral Health, Inc.** (BlueCare Members residing in East Tennessee* and Knox County only)
  1-800-447-7242

*East Tennessee includes Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union Counties.

G. General Information

Claims

Claims status information for claims submitted to BlueCare can be accessed via Friendly Screens or by calling BlueCare's Automated Information line. (See Section D. BlueCare Frequently Called Numbers in this outline.) For more information on user-friendly screens or authorization access, please call e-Commerce at 423-755-5717.

Appeals

BlueCare Provider and Member appeals are processed at separate locations. Using the correct address to file appeals improves handling efficiency and expedites responses. The following matrix is designed to provide direction in determining the appropriate appeal address:

APPEAL REASON	APPEAL REQUESTER	APPEAL ADDRESS
Denials due to determinations of not medically necessary, i.e., admissions, facility continuation care, and elective surgery for members residing in these community service areas: First Tennessee-Region 1; Upper Cumberland, South East Tennessee, and Hamilton County-Region 3; Mid Cumberland, South Central, and Davidson County-Region 4; North West, South West and Shelby County-Region 5 (***See BlueCare Provider Administration Manual Section VIII. L Utilization Management Provider Appeals Process***)	Provider	BlueCross BlueShield of Tennessee BlueCare Appeals Department 801 Pine Street – 2G Chattanooga, TN 37401
Issues regarding claims, accounts receivable, denials for non-covered services, denials for no referral, member benefits, member eligibility, and referral status (***See BlueCare Provider Administration Manual Section XII. D. Administrative Inquiry***)	Provider	BlueCare Claims Service Center PO Box 182277 Chattanooga, TN 37422-7277
Denials that are upheld through the above noted processes may be submitted through the Provider Dispute Resolution process. (***See BlueCare Provider Administration Manual Section XII. D. Provider Dispute Resolution Procedure***)		Provider Appeals Coordinator Provider Networks & Contracting Div. BlueCross BlueShield of Tennessee 801 Pine Street Chattanooga, TN 37402-2555
Denied, reduced, suspended, or terminated benefits of covered service for members residing in all Regions	Member (Includes provider-assisted with member signature)	BlueCare PO Box 593 Nashville, TN 37202-0593

XXIII. Provider Audit Guidelines

A. Introduction

All claims are subject to audit for the purpose of verifying that the information submitted was correct and complete and provided to BlueCross BlueShield of Tennessee with appropriate information needed to properly adjudicate the claim. If, during the course of an audit, claims are determined to be potentially fraudulent, a referral is made to the Special Investigations Unit for investigation. Additional types of audit may be necessary dependent upon the type of reimbursement used.

This section defines our audit process and provides a basic understanding of:

- BlueCross BlueShield of Tennessee audit history
- In-house Audits
- Claims linking software
- On-site Audits – Facility and Practitioner

B. BlueCross BlueShield of Tennessee Audit History

BlueCross BlueShield of Tennessee has maintained a Provider audit program for many years utilizing a method called “extrapolation”. With extrapolation, a sample of claims is audited and a percent of overpayments is determined. That percentage is then projected across all dollars paid for a specified period. In January 2002, BlueCross BlueShield of Tennessee discontinued the use of extrapolation. Claims are now audited and adjusted on a claim-by-claim basis.

C. In-House Audits/Claims Linking

In-house audits are performed using a “claims linking” software package that analyzes claims data retrospectively. The claims linking program electronically evaluates claims against industry standard edits to perform the following audits:

- Pre-admission Testing Audit (PAT)
- Correct Coding Initiative (CCI) Audit
- Duplicate Audit
- CPT® Audit
- Professional Audit
- Outpatient Surgery Audit

BlueCross BlueShield of Tennessee reserves the right to periodically evaluate and modify the audits administered via claims linking. Examples of each audit follow:

1. Pre-Admission Testing Audit (Pat)

Pre-admission Testing Audit (PAT) links inpatient admissions to outpatient claims billed for dates of service within the contracted range. It also identifies outpatient PAT that occurs on the same day as a surgical procedure. The edits pick up any service within the inpatient stay. Frequently charges are identified for blood work, X-rays, and EKG's.

2. Correct Coding Initiative (CCI) Audits

Correct Coding Initiative audits apply Medicare rebundling edits on professional and facility claims. Generally, these audits are automated. A clinical review may be required for some claims and BlueCross BlueShield of Tennessee may request medical records from the Provider.

Example:

- 93970 - Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study.
- 93971 - Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study.

Reasoning:

Based on Correct Coding Guidelines, CPT® code 93970 is for a complete study of both sides. CPT® Code 93971 is only one side or limited. Therefore, code 93970 will include 93971. A complete study includes everything.

3. Duplicate Audits

A duplicate audit links suspected duplicate claims and identifies billings that have been paid more than once for the same date of service.

4. CPT® Audits

CPT® audits summarize duplicate CPT® codes on the same claim or several outpatient claims. These require clinical review to determine if the duplicate code could reasonably be expected within the standards of medical practice. BlueCross BlueShield of Tennessee may request specific medical records in order to complete this review.

Example: CPT® code 27130 - Total hip replacement. This code would reasonably be performed one hip at a time. In extremely rare cases, both hips could be performed simultaneously. The facility can send us the pertinent medical records showing where this procedure was done bilaterally and the audit would be reversed.

Reasoning:

Both claims were filed and paid with the same procedure code.

5. Professional Audits

Professional audits link Practitioner claims for issues such as global maternity and surgical codes. In addition, this audit identifies upcoding of office visits from established patient to new patient. Correct Coding Initiative edits and claim fragmentations are also applied to professional claims.

Example #1:

Basic coding guidelines state to choose the code that most closely represents the service provided.

59400 - Routine obstetric care including antepartum care, vaginal delivery, & postpartum care
59409 - Vaginal delivery only
59410 - Vaginal delivery and postpartum care
59425 - Antepartum care only
59430 - Postpartum care only
99203 - Office visit

Practitioner provides all care (antepartum, delivery, postpartum) and bills codes 59425, 59409, & 59430. Code 59400 more closely represents the services rendered.

Example #2:

Office visit filed for a new patient. Based on previous paid claims to this Provider, the patient is not NEW. This patient would be considered as an established patient. Per the *American Medical Association* “an established patient is one who has received professional services from the Physician or another Physician of the same specialty who belongs to the same group practice, within the past three years”.

6. **Outpatient Surgery Audits**
   Outpatient surgery audits analyze outpatient surgery claims to verify correct processing. Lab & X-ray charges are included in the surgery fee schedule. If a second procedure is performed on the same day, payment is 50% of the contracted fee schedule for the additional procedure.

7. **Reconsideration Process**
   If a Provider receives a letter* indicating a claim has been audited by the BlueCross BlueShield of Tennessee Provider Audit Department, he/she has the right to request a reconsideration if he/she disagrees with the findings. The initial letter will contain instructions on what information will be required and where to send it. Once BlueCross BlueShield of Tennessee receives the requested information, a determination will be made whether to uphold or reverse its original decision. If the original decision is upheld, the Provider will receive an additional letter outlining the formal appeal process. If the original decision is overturned, the Provider will be notified and the claim will be corrected.

   **See sample copies of Provider Audit notification letters at end of section.*

D. On-Site Audit – Facility

The Facility Review Team performs claim-by-claim audits of claims paid to, but not limited to, hospitals, ambulatory surgery centers, skilled nursing facilities, dialysis centers, and rehabilitation centers. Most facilities are audited once each year but some may be audited more or less frequently depending on claims volume and audit findings. Audit rights are defined in the BlueCross BlueShield of Tennessee Provider Agreement. Provider audits are for the general purpose of determining if Blue Cross Blue Shield of Tennessee provided the appropriate reimbursement for the care rendered to its Members.

The audit consists of a sampling of claims. Claims found with errors, both overcharges and undercharges, are adjusted. Undercharges are defined as those charges supported through documentation that were not billed on the original claim. The Provider may request reconsideration on any audit determination following the procedure detailed in our closeout and adjustment notification letters. Based on audit findings a decision may be made to expand the audit sample. If the audit is expanded BlueCross BlueShield of Tennessee will focus primarily on the type of claims that were found to have errors. That focused audit will be scheduled and performed as routine audits are scheduled.

Types of audits performed are determined by the type of reimbursement:

- **Diagnostic Related Groups (DRG) Audit**
  Validation will be performed to determine if the appropriate level of care was billed and if the claim should have reached the outlier payment.

  DRG reimbursement is based on a classification system for categorizing hospital patients into groups based on:

  - Principal and secondary diagnosis and procedure codes
  - Gender
  - Age
  - Discharge status
  - Presence or absence of complications and comorbidities (CC's)

  Since DRG assignment is based on medical records, the medical records should be maintained in accordance with BlueCross BlueShield of Tennessee's Comprehensive Medical Record Standards as found in the Credentialing section of this provider administration manual.

- **Per Diem Audit**
  Claims will be reviewed to determine if the appropriate level of care was billed and the number of days billed is correct.

  Per Diem audits review:
  - Services billed on the CMS-1450 claim form/ANSI 837 Institutional Transaction
  - Medical records
  - Provider's contract
  - Amount and level of service paid

  Example:
  BlueCross BlueShield of Tennessee paid a per diem of $1443.00, which is the contracted surgical per diem. However, according to the Provider's contract the procedure code filed is not a contracted procedure code for surgery. Therefore, the claim should be reimbursed at the medical per diem.

- **Outlier Payment Audit**
  Claims will be audited to determine if all services and supplies were documented and to determine if a claim should have reached the outlier payment. Outlier payment audits consider the following when determining payment:

  - Provider's contracted outlier payment
  - Number of days approved or authorized
  - Amount non-covered or disallowed

- **Medical Records Documentation Audit**
  Claims will be audited for:
  - Documentation
  - Upcoding
  - Unbundling
  - Doctor's orders
  - Level of service
  - Correct billing of information in general

  Audits are performed for documentation that services & supplies were ordered and provided for each reimbursed rendered service.

- **Emergency Room Levels**
  Documentation is reviewed to determine if the appropriate contracted emergency room level was billed. There are seven components used in determining emergency room levels:
  - History
  - Examination
  - Medical decision making
  - Counseling
  - Coordination of care
  - Nature of presenting problem
  - Time

- **Cost Based Reimbursement** – When reimbursement is based on cost, the facility will be required to provide invoices and purchase agreements for review to determine the facility's actual cost for services or supplies. If deemed necessary BlueCross BlueShield of Tennessee may perform a 100% audit on these claims. If the facility determines the audit should be expanded they may perform internal audits on these items. If undercharges are revealed the facility may resubmit the claim for adjustment.

E. Audit Process

1. **Audit Scheduling**
   Providers are given a 6-week written notice of the dates an audit is to occur. BlueCross BlueShield of Tennessee Provider Audit staff will work with Providers to establish an audit month that will apply from year to year. Once an audit is scheduled it should not be changed or cancelled except for extenuating circumstances. If audits are cancelled indefinitely, payment for the claims that are selected for audit may be retracted until the audit is allowed. If a Provider delays an audit to the extent that the audit period expires BlueCross BlueShield of Tennessee will consider the claims to be an open audit and will reserve the right to audit retrospectively beyond the contract audit period. Providers will generally be audited once a year but more frequent audits may be necessary.

2. **Performing the Audit**
   Auditors will work during the Provider's normal business office hours. Audit discrepancies will be verified with the Provider designee prior to the exit conference. If an agreement cannot be reached between the auditor and the Provider designee, the issues will be discussed during the exit conference and the Provider will have the opportunity to request reconsideration of the audit decision through the process described in our closeout and adjustment notification letters.

3. **Exit Conference**
   If requested by the facility, auditors will meet with designated Provider staff to provide a general overview of the audit findings. All specific details should be discussed in the verification process. The exit conference should last no longer than one hour.

4. **Audit Findings**
   Providers will receive a preliminary report of audit findings within 30 days of the conclusion of the audit. The Provider will then receive a letter outlining the audit adjustment amount for each claim and will then have the number of days specified in that letter to request reconsideration of the audit findings. If no response is received from the Provider, the specified claims will be adjusted. If the Provider files for reconsideration, the normal reconsideration process will apply.

Sample copies of Provider and Facility Review notification letters follow:

Sample Provider Review Letter– *Claims Linking Recovery*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

Provider Name
Provider Address
City, State, ZIP

Dear Provider:

After a review of our records by our Provider Review Department, we have determined an overpayment has been made to you in the amount of $_____. Please reference the attached table for a breakdown of the information related to each claim and the reason for the refund request. At the end of 45 days, the overpayment will be recovered via remittance advice. However, if you prefer to send a check, please include a copy of this letter including all attachments and send to the address shown below.

If you feel our refund request is incorrect, you may request a reconsideration of this audit decision. You must request this in writing within 30 days from the date of this letter. Please include a copy of our letter in addition to all attachments and any supporting documentation that validates your review i.e., Physician Notes, Operative Reports, etc. This information should be sent to:

Provider Review Department 3-G
801 Pine Street
Chattanooga, TN 37402

We appreciate your cooperation in this matter. If you have any questions, do not hesitate to contact one of our customer service representatives at (xxx) xxx-xxxx.

Note: If the refund is not received within forty-five days of this letter, future benefits may be reduced by this dollar amount.

Sincerely,

Provider Review Department
BlueCross BlueShield of Tennessee

Sample Provider Review Letter - *Appeal Received & Original Decision Overturned*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

<PROVIDER NAME>
<PROVIDER ADDRESS>
<PROVIDER CITY, STATE, ZIP>

Patient:
Birth Date:
Certificate #:
Service Date:
Claim #:
Audit #:

Dear <PROVIDER>:

The Provider Review Department has received and reviewed your reconsideration concerning the adjustment made to the reimbursement for the above referenced service. After reconsideration of all available information, we have determined that our original decision should be overturned. Therefore, claims submitted for the above referenced service will be paid. Our coding decisions are based on nationally accepted standards of coding.

We regret any inconvenience this may have caused.

Sincerely yours,

Manager
Provider Review, 3G
BlueCross BlueShield of Tennessee

Sample Provider Review Letter - *Appeal Received with No Supporting Documentation*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

<PROVIDER NAME>
<PROVIDER ADDRESS>
<PROVIDER CITY, STATE, ZIP>

Patient:
Birth Date:
Certificate #:
Admit Date:
Claim #:
Audit #:

Dear <PROVIDER>:

Our Provider Review Department has received and reviewed your reconsideration concerning the adjustment in reimbursement for the above referenced service. Based on the information provided and after careful consideration of all available information, we have determined that our request is correct. Therefore, we are upholding our original decision.

If you would like to appeal our decision, you may submit a written request for Appeal within thirty (30) days of the date of this letter. Your Appeal should include all pertinent information, including prior correspondence, medical records and a detailed explanation of the basis for the appeal. Our decision will be based solely on the information we have previously received and the information you submit with your appeal. A formal Provider Appeal form, as well as a copy of the formal BlueCross BlueShield of Tennessee (BCBST) Provider Dispute Resolution Procedure (PDRP) are included in the Commercial Provider Administration Manual, or are available upon request.

To request a copy of the PDRP and/or a Provider appeal form, please contact the Customer Service Department or your Provider Relations Representative.
Please mail your appeal to:

Provider Appeals Coordinator
Provider Networks and Contracting Division, 4TC
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402

The Provider Appeals department will complete a comprehensive of your appeal and provide a detailed response or status within sixty (60) days of receipt of your appeal.

Sincerely yours,

Manager
Provider Review, 3G
BlueCross BlueShield of Tennessee

Sample Facility Review Letter – *Audit Setup*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

Administrator
Hospital
Address
City, State, Zip

Dear:
For many years BlueCross BlueShield of Tennessee has had an ongoing audit program to verify the accuracy of claims submitted for reimbursement. We would like to perform such an audit at your facility. Attached is a listing of cases that we plan to review. Within two weeks from the date of this letter, please send all documents as requested in each section of that list. Please include the invoices for those cases marked with an "I" or a "D" in the Special Note column. The information requested should be mailed to **Facility Review 3G, 801 Pine Street, Chattanooga, TN 37402.**

AT THE TIME OF THE AUDIT, **please make available for review at your facility**:

- Medical Record – for all listed cases. (Mother and baby records for claims marked with "M" in the Special Note column.)
- Financial Folder – (required for Commercial BCBST claims but not for BlueCare/TennCare Select) to include the patients' ledger, the final billed amounts to our members, and a copy of the claim file.
- Charge Master(s) for the dates of service included in the audit in order to allow the unbilled services and supplies. If the entire charge master cannot be provided, the minimum required is Emergency Room visit and Outpatient Observation fees.

If copies of the requested medical records are not provided at the time of the on-site audit, BlueCross BlueShield of Tennessee will recoup all monies paid to our facility for those claims. However, copies of those medical records may be mailed to the auditor within 15 days following our onsite review. The claim will then be paid according to the findings of that review and your facility will be notified of those review findings.

We will allot sufficient time during the audit to verify findings with your designated hospital representative. Those verification meetings may be held daily to review the findings on a case-by-case basis. If additional information is available that may affect the audit outcome, it may be provided to the auditor at that time. Please note that failure to verify our audit findings that are based on absent medical record documentation at the time of the audit may result in a waiver by your facility to make future adjustments based on that documentation. If you desire, an exit conference will also be conducted to review our general audit findings with administrative staff.

A letter listing our general findings will be mailed to you. A separate mailing will be sent from our financial recovery area(s) detailing the pending claims adjustments. After the period of time indicated in the letter(s) has expired the claims will be adjusted as detailed if we have not received additional information from you. For those you disagree with you may request reconsideration. That process will be outlined in one of the letters you receive following the audit.

This will be an audit of individual claims. If adjustments in paid amounts are made based on our findings, those adjustments will be made on a claim-by-claim basis. An expanded audit may be performed based on our findings. Please be aware that overcharges identified **cannot** be billed to the subscriber with the exception of those supplies and services listed as exclusions from coverage in the subscriber's contract with BlueCross BlueShield of Tennessee.

The audit has been scheduled for the week of _____. Reasonable space for equipment, and access to an electrical outlet and a telephone will be needed.

Thank you for your prompt attention to this matter. If you have questions, you may contact Audit Support Assistant at 423-XXX-XXXX

Sincerely,
Nurse Auditor, Facility Review
Provider Audit

Sample Facility Review Letter – *Audit Closeout*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

Dear Administrator:

Please express my appreciation to your staff for the courtesy and cooperation extended to me during my audit that began on (date) at your facility.

During the verification conference with_____, I reviewed each claim with discrepancies accepting and considering additional information provided. A list of all claims being referred to our claims areas for re-adjudication was left with _____. During the exit conference with _____, _____ and _____ I pointed out certain situations that need attention. Below is a list of the general audit findings:

- Emergency Room levels were billed at levels that could not be supported by the provided documentation.
- DRG claims were changed to reflect a more appropriate DRG based on documentation available.
- Implants were billed at amounts greater than the contracted rates.

The claims identified with discrepancies have been forwarded to our Financial Recovery Units for review and possible adjustments. You will be notified by the individual Financial Recovery Units as to which claims need to be adjusted and the amount of the adjustment. After you receive their letter you will have 30 days to respond and request a reconsideration of any claims included in this audit. **A copy of the medical record should be sent with each reconsideration request to the attention of XXXXXXXX at the address below.** If we do not hear from you within 30 days the claims will be adjusted.

In the mean time, if you have questions please give me a call or email.

Sincerely,

(Auditor Name and credentials), Nurse Auditor
Facility Review, 3G
801 Pine Street
Chattanooga TN 37402

Sample Facility Review Letter – *Hot and Cold Packs*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

Administrator
Hospital
Address
State

Dear _____:

Overpayments not addressed in detail in the preliminary audit closeout letter have been identified during our routine audit at your facility. During that on-site audit at your facility, which began on (Date of Audit), it was noted that CPT® 97010 was billed and paid. CPT® 97010 is a bundled services per the 10-01-99 Blue Alert publication sent from Blue Cross Blue Shield of Tennessee to all contracted providers and the March 2000 PRN Newsletter. Enclosed is a list of paid claims with that CPT® code. Re-adjudication of those claims will be requested.

The claims identified with payments for that CPT® code have been forwarded to our Financial Recovery Units for review and possible adjustments. You will be notified by the individual Financial Recovery Units as to which claims need to be adjusted and the amount of the adjustment. After you receive their letter(s) you will have the indicated number of days to respond and request a reconsideration of any claims included in this audit. Documentation supporting your reason for requesting the second review should be provided with that request. If we do not hear from you within the specified timeframe the claims will be adjusted.

In the mean time, if you have questions please give me a call or email me.

Sincerely,

Manager, Facility Review 3G
Provider Audit

Sample Facility Review Letter – *Reconsideration*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

Administrator
Hospital
Address
City, State, Zip

Dear:

Attached is a summary of our response to your request for reconsideration dated (Date of reconsideration letter). This pertains to our audit on (Date of Audit).

When any revised adjustments are made based on this review, a separate letter will be sent to you from the financial recovery area showing the amount of adjustment on each claim.

Please notify us if you are not in agreement with the findings listed on the attached summary. You may submit a written request for appeal within thirty (30) days from the date of this letter. Your appeal should include all pertinent information, including prior correspondence, medical records not sent previously to BlueCross BlueShield, and a detailed explanation of the basis for the appeal. Our decision will be based solely on the information we have previously received and the information you submit with your appeal.

A formal Provider Appeal form as well as a copy of the BlueCross BlueShield of Tennessee Provider Dispute Resolution Procedure (PDRP) are included in the Provider Administration Manual, or are available upon request.

To request a copy of the PDRP and/or a Provider Appeal form, please contact the Customer Service Department or your Provider Relations representative.

Please mail your appeal to:

Provider Appeals Coordinator
Provider Networks and Contracting Division
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga TN 37402

The Provider Appeals Department will coordinate a comprehensive review of your appeal and provide a detailed response or status of the research within sixty (60) days of the receipt of your appeal.

If you have any questions, please contact (Auditor), RN at (Include Area Code) or me.

Thank you for your attention to this matter.

Sincerely,

Manager, Facility Review 3-G
Provider Audit

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

SUMMARY OF RECONSIDERATION REVIEW

SECOND MEDICAL RECORD REVIEW

PROVIDER NAME:

PROVIDER NUMBER:

DATE OF AUDIT:

DATE OF RECONSIDERATION REVIEW:

REVIEWING AUDITOR'S NAME:

DATABASE NUMBER:

Case # And Patient Name	Detail of Requested Adjustment	Auditor Response	Difference in Billed Amount on first review and this review (or other comparison as noted below)

Sample Facility Review Letter – *Special Request Onsite*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

Administrator
Facility Name
Address
City, State, Zip

Dear _____

The claims on the attached sheet have been included in a request for review. We plan to review these claims during our routine audit scheduled at your hospital on **(audit date)**. Please forward a copy of the pertinent CMS-1450 and vendor invoices for implants. Also, please have the medical record available to our auditor on the date scheduled so that we may verify that the billing and payment are in compliance with contractual agreements. You will be notified during the onsite review and in writing of the results of our review.

To assure delivery to the requesting party, **please include a copy of this letter** with the requested information and send to the address listed below.

Please note: BlueCross BlueShield of Tennessee will recover all monies previously paid to your facility for the claim if the requested information is not received within the time frame specified.

Thank you for your prompt attention to this matter.

Sincerely,

Manager, Facility Review 3-G
Provider Audit

Sample Facility Review Letter – *Special Request Mail-In*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date

HIM or Audit Contact Name
Facility Name
Address
City, State, Zip

Dear _____

The claims on the attached page have been included in a request for review to verify that the billing and payment are in compliance with contractual agreements. Within the next 15 days please send copies of the following portions of the medical record for review:

_____
_____
_____
_____
_____
_____

You will be notified in writing of the results of our review within 30 days of our receipt of complete information necessary for the review.

Please note: BlueCross BlueShield of Tennessee will recover all monies previously paid to your facility for the claims if the requested information is not made available for review within the time frame specified.

Thank you for your prompt attention to this matter.

Sincerely,

Manager, Facility Review 3-G
Provider Audit

Sample Facility Review Letter – *Refund Notification*

BlueCross BlueShield
of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Date Prov #

Provider Name
Provider Address
City, State, ZIP

Dear Provider:

After a review of our records by our Facility Review Department, we have determined an overpayment has been made to you in the amount of $XXX.XX. Please reference the attached table for a breakdown of the information related to each claim and the reason for the refund request. At the end of 30 days, the overpayment will be recovered via remittance advice.

If you feel our refund request is incorrect, you may request a reconsideration of this audit decision. You must request this in writing within 30 days from the date of this letter. Please include a copy of our letter in addition to a copy of the member's complete medical record.

This information should be sent to:

ATTN: Audit Technician
Facility Review Department 3G
801 Pine Street
Chattanooga, TN 37402

We appreciate your cooperation in this matter. If you have any questions, do not hesitate to contact one of our Technicians at (xxx) xxx-xxxx.

Facility Review Department
BlueCross BlueShield of Tennessee

FOR OFFICE USE ONLY: If you do not agree with our audit findings and wish to request a reconsideration, please send a written request and a copy of our letter including all attachments, along with any supporting documentation to: BlueCross BlueShield * Facility Review Department 3G * 801 Pine Street * Chattanooga, TN 37402. If you have questions, contact us at (423) xxx-xxxx.

XXIV. BlueAdvantage/BlueAdvantage*Plus*

XXIV. BlueAdvantage/BlueAdvantage*Plus*

A. Introduction

BlueCross BlueShield of Tennessee began offering two Medicare Advantage Private Fee-For-Service products effective January 1, 2006: BlueAdvantage and BlueAdvantage*Plus.* BlueCross BlueShield of Tennessee has chosen to offer a Non-Network PFFS product. A Private Fee-For-Service (PFFS) Medicare Advantage product offers enrollees the ability to receive care from any Physician or Provider eligible to participate in Medicare and willing to accept the plan's terms and conditions of payment. Payment for Covered Services will generally be the Medicare Allowable, less any Member cost-sharing amounts.

B. BlueAdvantage and BlueAdvantage*Plus* Description

BlueAdvantage

BlueAdvantage is a Medicare Advantage Private Fee For Service plan offered by BlueCross BlueShield of Tennessee (BCBST). It is a unique program in that Members may use any doctor, specialist or hospital that accepts the BlueAdvantage terms, conditions and payment rate. Prior to providing services to a BlueAdvantage Member, Providers must agree to the Terms and Conditions of Plan Payment. When Providers choose to extend services to a BlueAdvantage Member, they are acknowledging their agreement and are "deemed" to have a contract with BlueCross BlueShield of Tennessee.

Providers who are aware they are treating a BlueAdvantage Member and decline to accept the Terms and Conditions of the Plan must only do so if the services are extended on an urgent or emergency basis.

BlueAdvantage*Plus*

BlueAdvantage*Plus* combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare plus it offers Medicare Part D prescription drug coverage. It is a unique program in that Members may use any doctor, specialist or hospital that accepts the BlueAdvantage*Plus T*erms and Conditions of Plan Payment

Prior to providing services to a BlueAdvantagePlus Member, Providers must agree to the Terms and Conditions of Plan Payment. When Providers choose to extend services to a BlueAdvantage*Plus* Member, they are acknowledging their agreement and are "deemed" to have a contract with BlueCross BlueShield of Tennessee

Providers who are aware they are treating a BlueAdvantage*Plus* Member and decline to accept the Terms and Conditions of the Plan must only do so if the services are extended on an urgent or emergency basis.

C. Terms and Conditions

Terms and Conditions of Payment Plan

1. Any Provider furnishing health services, except for emergency services furnished in a hospital pursuant to 42 CFR Section 489.24, to a BlueCross BlueShield of Tennessee (BCBST) BlueAdvantage or BlueAdvantage*Plus* (collectively referred to herein as "BlueAdvantage") Member is deemed to have a contract with BCBST if:

a. Services are covered by the Member's plan;
b. The Member is an enrollee of BlueAdvantage;
c. The Provider is aware the Member is a BlueAdvantage enrollee prior to rendering services to the Member; and
d. The Provider knows these Terms and Conditions of Plan Payment ("Terms and Conditions") or has reasonable access to the Terms and Conditions.

A Provider is considered "non-contracted" or "non-deemed" for the BlueAdvantage Member if the above criteria are not met.

2. Physicians treating BlueAdvantage Members must be state-licensed and have a Medicare billing number or be eligible to obtain one.

3. Institutional/facility Providers treating BlueAdvantage Members must be certified to treat Medicare beneficiaries.

4. As a Medicare Advantage Private Fee For Service Plan, BCBST covers the same benefits as Original Medicare in addition to certain preventive services not covered by Original Medicare. A summary of common services and cost-sharing amounts is found under BlueAdvantage and BlueAdvantage Plus Benefit Highlights at www.bcbst.com. See www.bcbst.com for a complete Summary of Benefits.

5. For Covered Services, deemed Providers may collect no more from the BlueAdvantage Member at the time of service than the applicable cost-sharing amount and, if the Provider does not accept assignment, the Medicare limiting charge. If a Provider mistakenly collects more from the Member than the designated cost-sharing amount, the Provider must refund the difference to the Member. Providers who agree to these Terms and Conditions agree not to balance bill plan Members above any applicable cost sharing amounts, except that Providers who do not accept assignment may balance bill up to the Medicare limiting charge.

6. The Provider may collect payment from the BlueAdvantage Member for services not covered under the Member's BlueAdvantage plan.

7. Reimbursement for services rendered to a BlueAdvantage Member will be the equivalent of the current Medicare Allowable Amount for all Medicare covered services less federal exclusions and applicable Member cost-sharing amounts. The federal exclusions are teaching costs (Direct Graduate Medical Education and Indirect Medical Education), which are paid by Original Medicare. See www.bcbst.com for further reimbursement methodology detail.

8. Tennessee Providers should submit claims for BlueAdvantage Members directly to BCBST, using their BCBST **provider number**, as follows:

   - If a Provider currently submits claims electronically to BCBST, the Provider may submit BlueAdvantage claims using the same process.

   - Paper claims may be mailed to the following address:
     BlueCross BlueShield of Tennessee
     Attn: BlueAdvantage
     P. O. Box 180205
     Chattanooga, TN 37402-7205

9. Providers outside of Tennessee should file claims to their local Blue Plan in their normal manner.

10. Claims for BlueAdvantage Members should be filed using the same Centers for Medicaid and Medicare Services (CMS) billing guidelines, forms and codes as Original Medicare.

11. Providers must obtain prior authorization from BCBST for the following services to BCBST's BlueAdvantage Members:

    - All acute care facility, skilled nursing facility, rehabilitation and behavioral health facility inpatient stays
    - All observation stays
    - Home health services
    - Certain specialty pharmacy medications
    - Durable medical equipment - for purchase or rentals if the purchase price is greater than $500
    - Orthotics and prosthetics if the purchase price is greater than $200
    - Speech therapy, occupational therapy and physical therapy

    Notification Requested:
    BCBST requests notification of all Emergency Admissions within 24 hours or one (1) business day after services have started.

    To obtain prior authorization for a medical service call BCBST at 1-800-924-7141. To obtain a prior authorization for a medication request, call Caremark at 1-866-865-0657.

    When prior authorization is required, a Provider must obtain the prior authorization prior to rendering services to a BlueAdvantage Member.

    Services requiring prior authorization rendered without obtaining approval prior to services being rendered are non-compliant with these Terms and Conditions. Failure to obtain prior authorization of inpatient and observation stays will result in denial for non-compliance of all services rendered as part of the stay, whether facility or professional.

    Failure to comply with specified authorization timeframes will result in a denial of benefits due to non-compliance. A Provider may not bill a BlueAdvantage Member for a Covered Service denied due to non-compliance by the Provider.

12. BCBST will conduct retrospective review using National Coverage Decisions, Local Medical Review Policies, BCBST Medical Policy, Milliman Care Guidelines®, BCBST developed guidelines, Durable Medical Equipment Regional Carrier guidelines and the FACETS claim payment system.

13. BCBST delegates to Providers the responsibility for issuing Notices of Discharge and Medicare Appeal Rights (NODMAR) in accordance with applicable Medicare regulations. A model NODMAR form can be found on our website at www.bcbst.com. BCBST reserves its right to revoke this delegation if it or CMS determines that Provider has not performed satisfactorily.

14. A Provider shall not discriminate against BlueAdvantage Members in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, genetic information, source of payment, and mental or physical disability.

15. A Provider shall adhere to all State and Federal laws regarding confidentiality of records, including the Health Insurance Portability and Accountability Act of 1996, and will ensure that BlueAdvantage Members have access to their medical records in accordance with applicable Federal and State laws.

16. As a Medicare Advantage organization, BCBST encourages open patient communication regarding appropriate treatment alternatives. BCBST will not penalize Providers for discussing medical care with the patient.

17. Providers agree to use the BCBST Provider Dispute Resolution Procedure (PDRP) to address matters causing dissatisfaction between the Provider and BCBST. The PDRP can be viewed on the BCBST Web site at http://www.bcbst.com/providers/docs/provider_dispute_resolution_procedure.pdf.

18. BCBST and the U.S. Department of Health and Human Services, the U.S. Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of a Provider involving transactions related to the Provider's treatment of any BlueAdvantage Member. This right to inspect, evaluate, and audit remains in effect for the time period established by Medicare regulations and Providers must retain relevant documents accordingly.

19. Hospital Providers, if permitted by Medicare regulations to balance bill, must provide the Member, before furnishing any services for which balance billing could amount to $500.00 or more:

    a. Notice that balance billing is permitted for those services;
    b. A good faith estimate of the likely amount of balance billing, based on the Member's presenting condition; and
    c. The amount of any deductible, co-insurance, and co-payment that may be due in addition to the balance billing amount.

20. Providers must comply with all applicable Medicare laws, regulations, and CMS instructions. Any services or other activity performed by a Provider in accordance with these Terms and Conditions shall be consistent and comply with BCBST's contractual obligations to CMS.

21. BCBST will pay interest to Providers in accordance with 42 CFR § 422.520 for clean claims that are not timely paid.

22. Providers who do not agree to accept these Terms and Conditions may not provide services to a BlueAdvantage Member unless the services are extended on an urgent or emergency basis. In such cases, the Provider should file the claim in accordance with the claim filing instructions set forth in paragraphs 8 and 9, above.

23. These Terms and Conditions are intended to be consistent with applicable Medicare regulations and BCBST's Medicare Advantage Contract with CMS. Defined terms can be found at www.bcbst.com.

Definition Terms and conditions

- **Balance Billing –** As defined in 42 CFR § 422.2
- **Blue Plan –** Any one of the health plans operating under a license from the BlueCross BlueShield Association.
- **Cost Sharing -** as defined in 42 CFR § 422.2
- **Covered Services –** Medically necessary health care services and supplies delivered to or provided for BlueAdvantage Members for which benefits are available under the terms of the Member's benefit plan.
- **Emergency and Urgently Needed Services –** As defined in 42 CFR § 422.113(b)
- **Medicare Allowable Amount –** The fee that Medicare establishes as reasonable for a covered medical service.

- **Member –** A person who is eligible to receive Covered Services under a BCBST BlueAdvantage or BlueAdvantagePlus Plan.
- **Original Medicare -** As defined in 42 CFR § 422.2
- **Provider -** As defined in 42 CFR § 422.2

D. Reimbursement Methodology

The following information is intended to summarize the reimbursement methodologies for BlueAdvantage and BlueAdvantagePlus:

BlueAdvantage and BlueAdvantagePlus reimburses eligible services to deemed Providers based on Medicare fee schedules, Prospective Payment Systems (PPS), and estimated Medicare payment amounts. Payment methodologies are reviewed by the Centers for Medicare and Medicaid Services (CMS) for accuracy. Payment rates will not be less than under Original Medicare (Medicare fee-for-service) in accordance with 42 CFR 422.114. Details regarding Medicare reimbursement methodologies can be located on the CMS Web site located at http://cms.hhs.gov. Links to the CMS Web site for specific Provider types are included below to facilitate navigation. In the event CMS changes one or more of the links listed below, refer to main CMS Web site located at http://cms.hhs.gov.

If there is a conflict between the information provided below and information published by CMS, the information published by CMS will prevail.

Providers have a right to appeal under BlueAdvantage and BlueAdvantagePlus. If a Provider has information that Original Medicare would pay more for a service, documentation (e.g. copy of a remittance advise or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted to BlueCross BlueShield of Tennessee, Attn: BlueAdvantage, P. O. Box 180205, Chattanooga, TN 37402 for review, verification, and payment adjustment if appropriate.

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Ambulance Services	Effective 01/01/2006, reimbursement is based on the Medicare Ambulance Fee Schedule unless otherwise specified by CMS.	http://www.cms.hhs.gov/suppliers/ambulance/
Ambulatory Surgical Center (ASC)	Reimbursement is based on the Medicare Ambulatory Surgical Center (ASC) Fee Schedule adjusted by the appropriate wage index unless otherwise specified by CMS.	http://www.cms.hhs.gov/suppliers/asc/
Clinical Laboratory	Reimbursement is based on the Medicare Clinical Laboratory Fee Schedule unless specified otherwise by CMS.	http://www.cms.hhs.gov/suppliers/clinlab/default.asp
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Reimbursement is based on the Medicare Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) Fee Schedule unless otherwise specified by CMS.	http://www.cms.hhs.gov/suppliers/dmepos/

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Federally Qualified Health Centers (FQHC)	Reimbursement is based on 80 percent of the lower of the all inclusive rate or the upper limit; plus 20 percent of the FQHC's actual charge unless otherwise specified by CMS.	http://www.cms.hhs.gov/providers/fqhc/
Home Health	Reimbursement is based on the Prospective Payment System (PPS), under home health resource groups (HHRGs) methodology unless otherwise specified by CMS. Providers are reimbursed per 60-day episode of care via submission of a request for accelerated payment (RAP) and the claim. Reimbursement includes adjustments for low utilization payment adjustment (LUPA), significant change in condition (SCIC), partial episode payment (PEP), therapies and outliers. Limited services are reimbursed under OPPS. DME is reimbursed based on the DMEPOS fee schedule.	http://www.cms.hhs.gov/providers/hha/
Hospice	Reimbursement for hospice services is considered a carve-out for Medicare Advantage Program and not payable under BlueAdvantage or BlueAdvantagePlus. These services should be billed to Original Medicare for reimbursement.	http://www.cms.hhs.gov/providers/hospiceps/
Hospitals		http://www.cms.hhs.gov/providers/hospital.asp
Acute Inpatient Services	Reimbursement is based on the Inpatient Prospective Payment System (PPS), under Diagnosis Related Groups (DRGs) methodology unless specified otherwise by CMS. Reimbursement under DRG includes appropriate capital disproportionate share hospital (DSH) and capital indirect medical education (IME) payments. Payments for operating IME, graduate medical education (GME), nursing school, allied health education costs and capital exceptions are considered a carve-out for Medicare Advantage Programs and are not payable under BlueAdvantage or BlueAdvantagePlus. These payments are paid through the fiscal intermediary, if applicable.	http://www.cms.hhs.gov/providers/hipps/

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Critical Access Hospitals	Critical Access Hospitals (CAHs) are exempt from the Inpatient and Outpatient Prospective Payment Systems (PPS). Reimbursement for CAHs is based on current Medicare allowable costs or cost based reimbursement and are paid cost for ambulance services if the CAH is the only ambulance supplier within 35 miles unless otherwise specified by CMS.	http://www.cms.hhs.gov/providers/cah/default.asp
Hospital - Outpatient Services	Reimbursement is based on the Outpatient Prospective Payment System (PPS), under Ambulatory Payment Classifications (APC) methodology unless specified otherwise by CMS.	http://www.cms.hhs.gov/providers/hopps/
Inpatient Rehabilitation Facility	Reimbursement is based on the Inpatient Rehabilitation Facility Prospective Payment System (PPS) unless otherwise specified by CMS.	http://www.cms.hhs.gov/providers/irfpps/
Inpatient Psychiatric Facility (IPF)	Effective with cost reporting periods beginning on or after 01/01/2005 CMS implemented a per diem Inpatient Psychiatric Facility (IPF) Prospective Payment System with a three-year transition period to replace the cost-based payment system. For the first year of the transition, reimbursement is 75 percent cost-based and 25 percent PPS. For the second year of the transition, reimbursement is 50 percent cost-based and 50 percent PPS. For the third year of the transition, reimbursement is 75 percent cost-based and 25 percent PPS. For the fourth year of the transition and after, reimbursement is 100 percent PPS. the transition period also includes a guaranteed average payment per case no less than 70 percent of the Tax Equity and Fiscal Responsibility Act (TEFRA) payment. Refer to the CMS for additional provisions for the IPF PPS reimbursement methodology.	http://www.cms.hhs.gov/providers/ipfpps/

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Long-Term Care Hospital	Reimbursement is based on the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) unless otherwise specified by CMS. A 5-year transition period was implemented by CMS beginning 10/01/2002 to phase-in the PPS for LTCHs from cost-based reimbursement to 100 percent Federal prospective payment. During the 5-year transition, payment will be based on an increasing percentage of the LTCH PPS payment and a decreasing percentage of its cost-based reimbursement rate for each discharge. Effective 10/01/2006, reimbursement will be based on 100 percent Federal prospective payment unless specified otherwise by CMS.	http://www.cms.hhs.gov/providers/longterm/
Drugs Covered by Durable Medical Equipment Regional Carriers (DMERC) and Medicare Fee-For-Service Part B Carriers	Reimbursement is generally based on Average Sales Price (ASP) methodology unless otherwise specified by CMS.	http://www.cms.hhs.gov/providers/pharmacy/
Physicians and Other Healthcare Professionals	Reimbursement is based on the Medicare Physician Fee Schedule unless otherwise specified by CMS. Services are generally reimbursed based on Resource Based Relative Value Scale (RBRVS) methodology subject to adjustment for global days, pre-op, intra-op, post-op, multiple procedures, bilateral surgery, assistant surgery, co-surgery, and team surgery per the National Physician Fee Schedule Relative Value File.	http://www.cms.hhs.gov/physicians/
The following are provisions for other common Physician and health care professional services:		
Anesthesia	Reimbursement for personally performed, medically directed, and medically supervised services is calculated based on the following formula unless otherwise specified by CMS: Anesthesia conversion factor by locality x (sum of uniform base units + time units) x percentage based on anesthesia modifier	

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Assistant-at Surgery Physician	Reimbursement for assistant at surgery services provided by a Physician is 16 percent of the Medicare Physician Fee Schedule.	
Assistant-at-Surgery Physician Assistant	Reimbursement for assistant at surgery services provided by a Physician is 13.6 percent (16 percent x 85 percent) of the Medicare Physician Fee Schedule.	
Clinical Nurse Specialist	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Clinical Psychologist	Reimbursement is based on 100 percent of the Medicare Physician Fee Schedule.	
Clinical Social Worker	Reimbursement is based on 75 percent of the Medicare Physician Fee Schedule.	
Co-Surgery	Reimbursement is based on 62.5 percent of the Medicare Physician Fee Schedule.	
Health Professional Shortage Area (HPSA)	10 percent additional payment in accordance with CMS guidelines	
Nurse Practitioner	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Physician Assistant	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Registered Dietitian	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Physician Scarcity Area (PSA)	5 percent additional payment in accordance with CMS guidelines	
Rural Health	Reimbursement for independent or Provider based Rural Health Clinics (RHCs) is based on 80 percent of the lower of the Provider specific rate or the per visit payment limit; plus 20 percent of the RHC's actual charges unless otherwise specified by CMS. Note: Per visit limits do not apply to RHCs owned by rural hospitals with less than 50 beds and are paid on a cost basis.	http://www.cms.hhs.gov/providers/rh/
Skilled Nursing Facilities	Reimbursement based on the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) unless otherwise specified by CMS. The PPS payment rate is adjusted for case mix and geographic variation in wages and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).	http://www.cms.hhs.gov/providers/snfpps/

E. Claims Information

Tennessee Providers should submit claims for BlueAdvantage/BlueAdvantage*Plus* Members directly to BlueCross BlueShield of Tennessee, using their **BlueCross BlueShield of Tennessee provider number**, as follows:

- If a Provider currently submits claims electronically to BlueCross BlueShield of Tennessee, the Provider may submit BlueAdvantage/BlueAdvantage*Plus* claims using the same process.

- Paper claims may be mailed to the following address:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage
P. O. Box 180205
Chattanooga, TN 37402-7205

Providers outside of Tennessee should file claims to their local Blue Plan in their normal manner.

Claims for BlueAdvantage/BlueAdvantage*Plus* Members should be filed using the same Centers for Medicaid and Medicare Services (CMS) billing guidelines, forms and codes as Original Medicare.

F. Benefit Highlights

1. **BlueAdvantage -** Last updated 9/30/05
   The following grid contains highlights only; see Summary of Benefits at www.bcbst.com for complete outline of Member benefits and cost sharing amounts.

Service	Member Cost-Share Amount
Ambulance services	$150 co-payment per date of service
Chiropractic services (covered by Medicare)	$20 co-payment
Dental services	Dental preventive services covered up to a maximum of $100 per calendar year. No co-payment.
Diabetic monitoring supplies	20% co-insurance
Durable medical equipment	20% co-insurance
Emergency room	$50 co-payment (not waived if admitted)
Eye Exams/Wear (covered by Medicare)	$20 co-payment for exam ($25 co-payment for eyewear following cataract surgery)
Eye Exams (routine). One exam every calendar year.	$20 co-payment for each routine eye exam.
Hearing Exams (covered by Medicare)	$20 co-payment
Hearing Exams (routine) One exam every 2 years	$20 co-payment
Home health services	No co-payment
Immediate Care Facility	$25 co-payment
Immunizations (flu vaccine, Hepatitis B – for at risk, Pneumonia vaccine)	No co-payment pneumonia, flu vaccine No co-payment hepatitis B vaccine
Inpatient hospital	$95 co-payment per day (days 1-7)
Inpatient Mental Health Care – 190 day lifetime limit	$95 co-payment per day (days 1-7)
Office Visit	$20 co-payment covered service
Outpatient Lab Services	$0 co-payment primary care office $0 co-payment specialist office $15 co-payment all other settings
Outpatient Advanced Imaging (such as MRI, MRA, CT Scan or PET)	$25 co-payment. When advanced imaging is performed in a primary care or specialist office the $20 office visit co-payment will apply in addition to the $25 advanced imaging co-payment.
Outpatient Mental Heath (Medicare covered)	$20 co-payment at Physician's office $25 co-payment for partial hospitalization $50 co-payment at hospital facility as an outpatient
Outpatient Substance Abuse (Medicare covered)	$20 co-payment at Physician's office $25 co-payment for partial hospitalization $50 co-payment at hospital facility as an outpatient
Outpatient radiation therapy, X-rays and radiology	$20 co-payment primary care office $20 co-payment specialist office $25 co-payment freestanding outpatient facility $50 co-payment outpatient hospital
Outpatient services (other than surgical)	$25 co-payment free standing facility $50 co-payment outpatient hospital
Outpatient Surgical Service	$25 co-payment freestanding outpatient facility $25 co-payment ambulatory surgical center $100 co-payment for services rendered at hospital facility as an outpatient
Outpatient therapy—physical, speech, occupational and cardiac therapies	$25 co-payment per Provider—all settings
Partial hospitalization for mental health	$25 co-payment per date of service

BlueAdvantage (cont'd)

Service	Member Cost-Share Amount
Podiatry services (covered by Medicare)	$20 co-payment
Preventive Services—immunizations, bone mass measurement, diabetes self monitoring training, colorectal screening, pap smears and pelvic exams, prostate cancer screening and mammography	No co-payment. However, if other services are received during the same office visit, the appropriate co-payment for those other services will apply.
Primary Care Office	$20 co-payment
Renal dialysis	$25 co-payment per date of service – all settings
Routine Physical (1 per year)	$5 co-payment
Skilled Nursing Facility	$95 co-payment per day (days 1-30)
Specialty Care Physician (including mental health Providers)	$20 co-payment
Urgent Care	$20 co-payment at primary care Physician or specialist's office $25 co-payment at immediate care facility $50 co-payment at a hospital emergency room

2. **BlueAdvantage*Plus*** - Last updated 9/30/05
The following grid contains highlights only; see Summary of Benefits at www.bcbst.com for complete outline of Member benefits and cost sharing amounts.

Service	Member Cost-Share Amount
Ambulance services	$150 co-payment per date of service
Chiropractic services (covered by Medicare)	$20 co-payment
Dental services	Dental preventive services covered up to a maximum of $100 per calendar year. No co-payment.
Diabetic monitoring supplies	20% co-insurance
Durable medical equipment	20% co-insurance
Emergency room	$50 co-payment (not waived if admitted)
Eye Exams/Wear (covered by Medicare)	$20 co-payment for exam ($25 co-payment for eyewear following cataract surgery)
Eye Exams (routine). One exam every calendar year.	$20 co-payment for each routine eye exam.
Hearing Exams (covered by Medicare)	$20 co-payment
Hearing Exams (routine) One exam every 2 years	$20 co-payment
Home health services	No co-payment
Immediate Care Facility	$25 co-payment
Immunizations (flu vaccine, Hepatitis B – for at risk, Pneumonia vaccine)	No co-payment pneumonia, flu vaccine No co-payment hepatitis B vaccine
Inpatient hospital	$95 co-payment per day (days 1-7)
Inpatient Mental Health Care – 190 day lifetime limit	$95 co-payment per day (days 1-7)
Office Visit	$20 co-payment covered service
Outpatient Lab Services	$0 co-payment primary care office $0 co-payment specialist office $15 co-payment all other settings

BlueAdvantage*Plus* (cont'd)

Service	Member Cost-Share Amount
Outpatient Advanced Imaging (such as MRI, MRA, CT Scan or PET)	$25 co-payment. When advanced imaging is performed in a primary care or specialist office the $20 office visit co-payment will apply in addition to the $25 advanced imaging co-payment.
Outpatient Mental Heath (Medicare covered)	$20 co-payment at Physician's office $25 co-payment for partial hospitalization $50 co-payment at hospital facility as an outpatient
Outpatient Prescription Drugs	Copayments and coinsurance apply until total yearly drug costs reach $2,250. Member then pays 100% of prescription drug costs until out of pocket drug costs reach $3600. Coinsurance and co-payments then apply again. See Summary of Benefits for detail on co-payments and coinsurance.
Outpatient Substance Abuse (Medicare covered)	$20 co-payment at Physician's office $25 co-payment for partial hospitalization $50 co-payment at hospital facility as an outpatient
Outpatient radiation therapy, X-rays and radiology	$20 co-payment primary care office $20 co-payment specialist office $25 co-payment freestanding outpatient facility $50 co-payment outpatient hospital
Outpatient services (other than surgical)	$25 co-payment free standing facility $50 co-payment outpatient hospital
Outpatient Surgical Service	$25 co-payment freestanding outpatient facility $25 co-payment ambulatory surgical center $100 co-payment for services rendered at hospital facility as an outpatient
Outpatient therapy—physical, speech, occupational and cardiac therapies	$25 co-payment per Provider—all settings
Partial hospitalization for mental health	$25 co-payment per date of service
Podiatry services (covered by Medicare)	$20 co-payment
Preventive Services—immunizations, bone mass measurement, diabetes self monitoring training, colorectal screening, pap smears and pelvic exams, prostate cancer screening and mammography	No co-payment. However, if other services are received during the same office visit, the appropriate co-payment for those other services will apply.
Primary Care Office	$20 co-payment
Renal dialysis	$25 co-payment per date of service – all settings
Routine Physical (1 per year)	$5 co-payment
Skilled Nursing Facility	$95 co-payment per day (days 1-30)
Specialty Care Physician (including mental health Providers)	$20 co-payment
Urgent Care	$20 co-payment at primary care Physician or specialist's office $25 co-payment at immediate care facility $50 co-payment at a hospital emergency room

G. Sample ID Cards

1. BlueAdvantage sample ID card follows:

2. BlueAdvantage*Plus* sample ID card follows:

H. Utilization Management Requirements

1. Authorization Requirements

Prior Authorization requirements:

- All Acute Care Facility, Skilled Nursing Facility, Rehabilitation, and Behavioral Health Facility inpatient stays. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting.
- All Observation stays.
- Home Health Services -skilled nursing visits including those for home infusion therapy.
- Certain Specialty Pharmacy Medications
- Durable Medical Equipment for purchase or rentals if the purchase price is greater than $500.
- Orthotics and Prosthetics if the purchase price is greater than $200.
- Speech Therapy, Occupational Therapy and Physical Therapy.

Notification requested:

- BlueCross BlueShield of Tennessee requests notification of all Emergency Admissions within 24 hours or one (1) business day after services have started.

Prior authorization/notification reviews can be initiated by the Member, designated Member advocate, Practitioner, Provider, or facility. However, it is ultimately the facility and Practitioner's responsibility to contact BlueCross BlueShield of Tennessee to request an authorization and to provide the clinical and demographic information that is required to complete the authorization/notification. Scheduled admissions/services must be authorized up to 24 hours prior to admission.

Notification or prior authorizations may be obtained by calling 1-800-924-7141, or by fax at 1-800-255-0244.

The Practitioner and/or the facility are notified via telephone and/or fax of the decision determination. Written confirmation to the Practitioner, facility and Member follows.

Services requiring prior authorization rendered without obtaining approval, prior to services being rendered, are considered non-compliant. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved.

Requests for tests, procedures, or services requiring prior authorization must contain adequate information for review.

Failure to comply with specified authorization timeframes will result in a denial of benefits due to non-compliance. A Provider may not bill a BlueAdvantage or BlueAdvantage*Plus* Member for a covered service denied due to non-compliance by the Provider.

2. Medical Review Requirements

Inpatient Admission

a. Acute Care Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name; and
- Hospital/Facility's name, provider number, address, telephone number and caller's name.

Clinical information required for prior authorization:

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Comorbidities that impact patient's condition;
- Complications;
- Prognosis or expected length of stay; and
- Current medications.

b. Skilled Nursing Facility (SNF)

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name;
- Hospital/Facility's name, provider number, address, telephone number and caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment;
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination;
- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner's order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.

Evaluation and Plan of Care

Evaluation of the Member must be submitted including the following as appropriate:

- Primary diagnosis
- Circulation and sensation
- Ordering Practitioner and date of last visit
- Gait analysis
- Date of diagnosis onset
- Cooperation and comprehension
- Baseline status
- Developmental delays (pediatric patients)
- Current functional abilities
- Other therapies or treatments
- Functional potential
- Patient's goals
- Strength
- Medical compliance
- Range of Motion
- Support system

Plan of care must be submitted including the following as appropriate:

- Short- and Long-term goals
- Proposed admission date
- Discharge goals
- Frequency of treatment
- Measurable objectives
- Specific modalities, therapy, exercise
- Functional objectives
- Safety and preventive education
- Home program
- Community resources

Therapy Services

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

Nursing Services

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed
  - Tracheostomy
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Levin tube
  - Gastrostomy tube and feedings;
- Complex wound care involving medication application and sterile technique; and
- Treatment of Grade 3 or higher decubitus ulcers or widespread skin disorder.

Nursing and Therapy Services Not Requiring SNF Placement:
Skilled nursing facility placement is not necessary for the services listed below. This list is not all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of occupational Therapy services being provided or vice versa;
- Invasive procedures;
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with any ordered therapy
- Discharge plans & target date

c. Rehabilitation Facility

Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a minimum of 3 hours of daily therapy. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member's impairment. Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, or spinal cord injury.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name;
- Hospital/Facility's name, provider number, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, Member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

Evaluation of the Member must be submitted including the following as appropriate:

- Ordering Practitioner and date of last visit
- Gait analysis
- Primary diagnosis
- Circulation and sensation
- Date of diagnosis onset
- Cooperation and comprehension
- Baseline status
- Developmental delays (pediatric patients)
- Current functional abilities
- Other therapies or treatments
- Functional potential
- Patient's goals
- Strength
- Medical compliance
- Range of Motion
- Support system

Plan of care must be submitted including the following as appropriate:

- Short- and Long-term goals
- Proposed admission date
- Discharge goals

- Frequency of treatment
- Measurable objectives
- Specific modalities, therapy, exercise
- Functional objectives
- Safety and preventive education
- Home program
- Community resources

A sample copy of the *BlueAdvantage Skilled Nursing Facility/Inpatient Rehabilitation Authorization Request Form* follows:

BlueCross BlueShield of Tennessee
P.O. Box 182205
Chattanooga, TN 37402
www.bcbstn.com

THIS INFORMATION IS CONFIDENTIAL

BlueAdvantage
Skilled Nursing Facility/Inpatient Rehabilitation Authorization Request Form
Fax: 1-800-255-0244

☐ **Skilled Nursing Facility** ☐ **Inpatient Rehabilitation**

Member Information
Member Name: _____ Date of Birth: _____
ID Number: _____

Facility Information
Facility Name: _____ Contact Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Provider Number: _____ Tax ID Number: _____

Provider Information
Provider Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Provider Number: _____ Tax ID Number: _____

Clinical Information
Diagnosis: _____
Height: _____ Weight: _____
Patient Level of Orientation:
☐ Alert and Oriented ☐ Willing and Able to Participate ☐ Can Follow Commands
Types of Discipline (Therapy): ☐ Speech ☐ Occupational ☐ Physical
Number of Hours per Day: _____
Type of Surgery: _____ Date of Surgery: _____
Pain Control (by discharge): ☐ PO ☐ IV Please specify: _____
_____
Comorbidity: _____
Pre-Morbid Condition: _____
Home Environment:
Single or Multi Level: _____ Number of steps to enter home: _____

Number of steps within home: _____ Availability of caregiver: _____ -- **include in box**

Current Functional Status (DAY PRIOR TO DISCHARGE FROM ACUTE CARE FACILITY):

BlueCross BlueShield of Tennessee
P.O. Box 1810205
Chattanooga, TN 37402
www.bcbst.com

	Minimum	Moderate	Maximum	Caregiver Assistance	Stand-By Assistance	Assistive Devices
EATING						
DRESSING						
BATHING						
BED/MOBILITY						
SUPINE-SIT						
SIT-STAND						
TRANSFERS						
AMBULATION **DISTANCE**						

Wound Care description: (length, width, drainage), treatment, frequency: _____

_____

Progress toward goals/changes in Plan of Care: _____

_____

Caregiver teaching/training: _____

_____

If Skilled Nursing Facility request, what are other skilled needs? (i.e., intravenous antibiotics, total parenteral nutrition (TPN), oxygen, continuous passive motion (CPM), etc.) Please be specific regarding dosage amounts, frequencies and CPM settings:

_____

Behavioral Health Issues (if applicable): _____

Discharge Goals: Destination/Functional (Home with or without assist, Facility, etc.) _____

_____

d. 23-Hour Observation

Observation stays require prior authorization. For example, BlueCross BlueShield of Tennessee Members reporting to the Emergency Room with symptoms of abdominal pain who are treated and released without extensive intervention should not be granted 23-hour observation status. However, if after review it appears that the Member might have an acute abdomen and is being kept for hydration and observation and requires further studies to establish the diagnosis, 23-hour observation status is appropriate.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission, or within the next business day for emergency admissions to determine Medical Necessity and Medical Appropriateness.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number, address, telephone number and caller's name; and
- Hospital/Facility's name, provider number, address, telephone number and caller's name.

Clinical information required for prior authorization:

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs and abnormal lab results;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact patient's condition;
- Complications;
- Prognosis; and
- Current medications.

e. Home Health Services/Skilled Nursing Visits

Home health services may require prior authorization. Home health services are hands-on, skilled care/services, including those for home infusion therapy, by or under the supervision of a registered nurse that are needed to maintain the Member's health or to facilitate treatment of the Member's illness or injury. In order for the services to be covered under BlueCross BlueShield of Tennessee, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical Appropriateness criteria. Documentation must support the Member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in Member's care.

Documentation for prior authorization:

- Practitioner's verbal or signed medical orders and plan of care for dates of service;
- Number of services requesting;
- Nurse's visit and progress notes;
- Therapist's visit and progress notes, if applicable;
- Availability of a caregiver; and
- Homebound status.

A sample copy of the *BlueAdvantage Home Health Services Prior Authorization Form* and the *Home Infusion Therapy Authorization Request Form* follows:

BlueCross BlueShield of Tennessee
P.O. Box 182205
Chattanooga, TN 37402
www.bcbst.com

THIS INFORMATION IS CONFIDENTIAL

BlueAdvantage
Home Health Services
Prior Authorization Form

1. Prior Authorization is required prior to and/or no later than 24 hours or one business day after services have been started. **The prior authorization form must be completed and faxed to 1-800-225-0244.**
2. **Extensions:** Prior authorization must be requested for continuation of services beyond previously approved dates.
3. When requesting approval for additional services beyond the dates previously approved, the specific services, dates of services, physician's orders and nurse's notes must be faxed along with the request for additional services.

TYPE or PRINT

TO BE COMPLETED BY HOME HEALTH PROVIDER

Member Information
Member Name: _____ Sex: M_____ F_____
Telephone Number: (___)_____ Date of Birth: _____
Complete Address: _____
Is patient covered by other health insurance? Yes___No___If Yes, Insured's Name:_____
Other insurance policy or certificate number:_____

Physician or Supplier Information
Member's Diagnosis:_____
Date of Diagnosis:_____Date of Last Treatment:_____
Prognosis:_____
Physician Name:_____
Complete Address:_____
Telephone Number:(___)_____
Home Health Agency Name:_____
Home Health Agency Complete Address:_____
Telephone Number:(___)_____Fax Number: (____)_____
Contact Person:_____

ACTIVITY

Activity / Limitations:_____
Homebound: Yes_____ No _____ If Yes, explain: _____
_____
Does the patient live alone? Yes_____ No _____ If No, how much care can be given by the caregiver?
_____

Member Name:_____ID Number:_____

BlueCross BlueShield of Tennessee
P.O. Box 180205
Chattanooga, TN 37402
www.bcbst.com

I. Dates of requested Home Health Services:_____
From: _____Thru: _____
SNV_____ PT/ST/OT_____ Other_____

Frequency	Hours per day	Days per week
_____	_____	_____

Treatment:_____
_____
_____
_____

Extensions
The following checked information is needed on the next update before an extension will be considered:
_____Is patient still homebound? Why?
_____Lab results/change in treatment
_____Nursing notes
_____Description and/or photo of wound
_____Has patient/caregiver been trained? If no, why not?
_____Physician's orders
_____Date of next doctor appointment
_____Change of orders since last doctor appointment

II. Dates of requested Home Health services:
From:_____Thru: _____
SNV_____ PT/ST/OT_____ Other _____

Frequency	Hours per day	Days per week
_____	_____	_____

Treatment:_____
_____
_____

Extensions
The following checked information is needed on the next update before an extension will be considered:
_____Is patient still homebound? Why?
_____Lab results/change in treatment
_____Nursing notes
_____Description and/or photo of wound
_____Has patient/caregiver been trained? If no, why not?
_____Physician's orders
_____Date of next doctor appointment
_____Change of orders since last doctor appointment

BlueCross BlueShield of Tennessee
P.O. Box 1 8205
Chattanooga, TN 37402
www.bcbst.com

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Mailing Address:
BlueCross BlueShield of Tennessee
BlueAdvantage
P.O. Box 180205
Chattanooga, TN 37402-7205
Fax: 1-800-255-0244

Home Infusion Therapy Authorization Request Form

MEMBER INFORMATION

Member Name (First, Middle, Last)	ID Number	Date of Birth
Address (Street, City, State, ZIP)	Sex ☐ Male ☐ Female	Primary Insurance Coverage: ☐ Medicare ☐ BlueCare ☐ TennCareSelect ☐ Other /

Primary Diagnosis: ICD-9 Code:	BIT Related Diagnosis: ICD-9 Code:	Other Diagnosis: ICD-9 Code:
Supportive Documentation Attached: ☐ Signed Doctor's Orders ☐ Clinical History ☐ Culture & Sensitivity ☐ Misc. Lab	**Justification for Therapy**	**Dates of Service for this Authorization** From: _____ To:
Daily Administration Schedule for this Infusion Therapy Continuous? ☐ Yes ☐ No Pump Required? ☐ Yes ☐ No	**Type of HIT Therapy** ☐ IV Hydration ☐ TPN ☐ Enteral ☐ IV Drug Administration ☐ Chemotherapy ☐ Aerosol ☐ Other	
	Is the patient receiving any skilled nursing services in addition to home infusion? ☐ Yes ☐ No	
Previous Service? ☐ Yes ☐ No **Reference #:**	**Date of last service:**	

J Code*	Drug/Supplement with Dosage and Frequency *Code J3490 requires NDC Number	Route of Administration IV	IM	SQ	Tube	Other	Total Units Requested

PHYSICIAN AND SUPPLIER INFORMATION

Physician Name	BlueCross BlueShield of Tennessee Provider Number
Address (Street, City, State, ZIP)	Telephone Number ( ) Fax Number ( )
Infusion Agency Name	BlueCross BlueShield of Tennessee Provider Number
Infusion Agency Address (Street, City, State, ZIP)	Telephone Number ( ) Fax Number ( )
Contact Person	Title
Signature X	Date

NOTE: Doctor's orders, clinical information, and appropriate lab results must be received with the request for service or within two (2) business days of receiving the initial request for service.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
H 5884 BA-Home Infusion Therapy Request 8/30/2005

f. Durable Medical Equipment (DME)

Information that needs to be submitted with the prior authorization request:

- Practitioner's name
- Member's diagnosis and expected prognosis;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member’s weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

A sample copy of the *BlueAdvantage Durable Medical Equipment Authorization Form* follows:

BlueCross BlueShield of Tennessee
P.O. Box 1802O5
Chattanooga, TN 37402
www.bcbstn.com

THIS INFORMATION IS CONFIDENTIAL

BlueAdvantage
Durable Medical Equipment
Authorization Request Form
Fax Number: 1-800-255-0244

Member Name: _____ Group Number: _____

ID Number: _____ Date of Birth: _____

Address: _____

Diagnosis: _____ Date Diagnosed: _____

Prognosis: Date Last Seen: Date of Surgery:

Attending Physician: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Supplier: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Contact: _____ Start Date: _____ Duration: _____

Equipment prescribed (s-code, narrative and estimated cost) **Special Features**

1. _____
2. _____
3. _____
4. _____

Misc. Info.:

Oxygen/Equipment

1. Arterial blood gas results, date drawn: _____
2. PO2 levels: _____
3. Oxygen Saturation: _____
4. Were pulmonary function studies done? If so, please include a copy of results. _____

***Please include a copy of the Certificate of Medical Necessity (CMN) and prescription signed by the attending physician.**

H3884 BA-DME Request 9/30/2015

g. Speech, Occupational, and Physical Therapy

In order for therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury.

Required information for prior authorization

- Assessment Requirements (Evaluation and Plan of Care) Evaluation
- Ordering Practitioner and date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status / current abilities
- Functional potential
- Prior level of functioning
- Current functional abilities
- Strength, ROM, if applicable
- Circulation and sensation
- Cooperation and comprehension Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Therapy compliance

Plan of Care

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
  - Duration of therapy
  - Frequency of therapy
  - Date therapy is to begin
  - Specific therapy techniques

A sample copy of the *BlueAdvantage Outpatient Therapy Authorization Form* follows:

BlueCross BlueShield of Tennessee
P.O. Box 182205
Chattanooga, TN 37402
www.bcbst.com

THIS INFORMATION IS CONFIDENTIAL

BlueAdvantage
Outpatient Therapy Authorization Request Form
Fax: 1-800-255-0244

Physical Therapy ☐ **Speech Therapy** ☐ **Occupational Therapy** ☐

Member Information

Member Name: _____ Date of Birth: _____

ID Number: _____

Facility Information

Facility Name: _____ Contact Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ Tax ID Number: _____

Provider Information

Provider Name: _____ Contact Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ Tax ID Number: _____

Clinical Information

Diagnosis: _____

Type of Surgery (if applicable): _____ Date of Surgery: _____

Comorbidities: _____

Date(s) of Service Requested: From: _____ To: _____

Requested Frequency of Visits: _____ Duration: _____

Please attach available supporting clinical information including patient's limitations, current treatment plans, goals, etc. For extension requests, please include therapist's notes including progress toward goals.

h. Orthotics/Prosthetics

Information that needs to be submitted with the prior authorization request:

- Practitioner's name;
- Member's diagnosis and expected prognosis;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable; and
- Appropriate HCPCS codes for equipment being requested.

3. Advance Determination Review

A Member or Provider has the opportunity to seek a determination of coverage before receiving or providing services by requesting an Advanced Determination. Information required for processing Advanced Determination Reviews is found on the following request form:

BlueCross BlueShield of Tennessee
P.O. Box 180205
Chattanooga, TN 37402
www.bcbst.com

THIS INFORMATION IS CONFIDENTIAL

BlueAdvantage Advance Determination Request Form

Date Submitted: _____

Please complete this form when requesting an advance determination of benefits for a specific procedure or type of service. Return the form to: BlueCross BlueShield of Tennessee, BlueAdvantage, P.O. Box 180205, Chattanooga, TN 37402-7205. If you have any questions, please contact us at 1-800-841-7434 or 1-888-423-9490 TTY (for hearing impaired) between the hours of 8 a.m. to 5 p.m. ET, Monday through Friday.

Member Name		
Member ID Number	Date of Birth (mm/dd/yy)	☐ Male ☐ Female

Diagnosis with ICD-9: _____

Procedure(s) or Equipment Being Requested	*CPT® or HCPCS Codes

If DME, is it ☐ Rental or ☐ Purchase?

☐ Inpatient (requires prior authorization)
☐ 23-Hour Observation (requires prior authorization)
☐ Outpatient
☐ Office

Clinical information to support medical appropriateness (e.g. failed outpatient therapy, laboratory or X-ray results, vital signs), medications, presenting symptoms, plan of treatment, brief clinical history:

_____
_____
_____
_____
_____
_____
_____

Please attach additional supporting documentation (e.g. X-rays, pictures, Certificate of Medical Necessity).
☐ Attachment(s) ☐ No Attachment(s)

Physician	Provider Number	Telephone Number
Address		Fax Number
Facility or Supplier	Provider Number	Telephone Number
Address		Fax Number

CPT® is a registered trademark of the American Medical Association

H5884 BA-Adv. Determination Request 9/30/2005

4. Retrospective Review

BlueCross BlueShield of Tennessee will conduct Retrospective Review using National Coverage Decisions, Local Medical Review Policies, BlueCross BlueShield of Tennessee Medical Policy, Milliman Care Guidelines®, BCBST developed guidelines, DMERC guidelines and the FACETS claim payment system.

5. Reconsideration Process

Reconsideration of an adverse organization determination or termination of services decision may be requested by a Member, a Member's authorized representative or a Provider. A written request for reconsideration must be submitted within 60 calendar days from the date of the notice of the organization determination.

Send Reconsideration requests to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage
UM Reconsiderations
PO Box 180205
Chattanooga, TN 37402-7205

A standard reconsideration of the denial of a request for service will be determined no later than 30 calendar days from the date the request of a standard reconsideration is received. The timeframe may be extended up to 14 calendar days at the Member's request.

A Member or Physician may submit a written request for an expedited reconsideration in situations where applying the standard of procedure could seriously jeopardize the Member's life, health, or ability to regain maximum function. If BCBST approves a request for an expedited reconsideration, the review will be completed no later than 72 hours after receiving the request. The 72-hour timeframe may be extended up to 14 calendar days at the Member's request for an extension.

A request for payment of a service already provided to the Member is not eligible to be reviewed as an expedited reconsideration.

I. Pharmacy

1. Formulary

See **www.bcbst.com** for the BlueAdvantage*Plus* formulary.

2. Prior Authorization

Certain drugs with special indications require authorization. These drugs are noted on the formulary. The prescribing Practitioner is responsible for obtaining the necessary authorization from Caremark. Prescription drugs that require a prior authorization are noted on the formulary. This prior authorization must be obtained before the drug is dispensed. Contact Caremark at 1-888-413-2723 for prior authorization.

3. Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. These drugs are noted on the formulary. Greater quantities require Physician request for medical necessity by calling 1-888-413-2723.

4. Appeals

If Caremark has made an adverse determination for a medication or pharmaceutical product, the Member or the Member's Physician may initiate a pharmacy appeal. This appeal must be in writing and can be faxed to 1-888-343-4232.

5. Pharmacy Directory

See **www.bcbst.com** for the BlueAdvantage*Plus* Directory

J. Provider Appeal Process

Provider Dispute Resolution Procedure

A. Inquiry/Reconsideration Level (Written or verbal)

B. Appeal Level (Formal, Written request)
- If not satisfied, submit a written appeal within 30 days of receipt of the reconsideration response
- The request should state the following:
  - Reason for the appeal
  - Why dissatisfied with the reconsideration
  - Any additional information the Provider would like considered in support of the appeal

C. Mediation
- All disputes will be resolved through binding arbitration, unless both parties agreed to mediation

D. Binding Arbitration
- If dispute is not resolved to Provider's satisfaction
- This is the final step in the process

Mail Reconsideration Requests to:

Attn: BlueAdvantage Customer Service
BlueCross BlueShield of Tennessee
P. O. Box 180205
Chattanooga, TN 37402-7205

If you are dissatisfied with our response to your request for Reconsideration, you may submit your **Formal Appeal** to:

Attn: Provider Appeals Coordinator
Provider Networks & Contracting Division
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402-2555

A sample copy of the *Provider Dispute Form* follows:

BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402-2555
www.bcbst.com

Provider Dispute Form

-- Confidential --

I wish to submit the following dispute in accordance with the Provider Dispute Resolution Procedure:

☐ **Level 1 Inquiry - Attention: Customer Service**

☐ **Level 2 Appeal - I have submitted this dispute through the Inquiry Level of the procedure and am dissatisfied with the response.** ***(Please attach a copy of the response received from the Customer Service Inquiry if applicable.)***

Date	Provider Name
Provider No.	Patient Name
Provider Contact	Member ID No.
Provider Fax No.	Date of Service
Provider Telephone No.	Claim No./Decision/Issue Disputed

When submitting your dispute in accordance with the Inquiry or Appeal level of the procedure, please indicate a detailed reason for your dispute. If applicable, please include all pertinent information including prior correspondence, medical records and all documentation you wish to have considered in the final determination of your dispute. (You may also use the back of this form if necessary.) Please return this completed form along with the requested documentation to:

For Commercial *Members*
Mail Level 1 Inquiry to:
Attn: Customer Service
BlueCross BlueShield of TN
P. O. Box 180150
Chattanooga, TN 37401

For BlueAdvantage or BlueAdvantage*Plus* Members
Mail Level 1 Inquiry to:
Attn: BlueAdvantage Customer Service
BlueCross BlueShield of TN
P.O. Box 180205
Chattanooga, TN 37402-7205

For BlueCare® or TennCare*Select* Members
Mail Level 1 Inquiry to:
Attn: Customer Service
BlueCare
P.O. Box 182277
Chattanooga, TN 37422

For All BlueCross BlueShield of TN Members
Mail Level 2 Provider Appeal to:
Attn: Provider Appeals Coordinator
Provider Networks and Contracting Division
801 Pine Street
Chattanooga, TN 37402-2555

GO-053 (09/05)

Provider Dispute Form

K. Web site Related Links

Links to the Centers for Medicare and Medicaid Services (CMS) Web site, Quarterly Provider Update Site and the Medicare Coverage Home page follow. The Medicare Coverage Home page includes a search function for national and local coverage decisions.

CMS Web site

http://www.cms.hhs.gov/

Quarterly Provider Update

http://www.cms.hhs.gov/providerupdate

Medicare Coverage Home page

http://www.cms.hhs.gov/coverage/default.asp

L. Contact Us

Learn more about BlueCross BlueShield of Tennessee Medicare Advantage plans:

Web site:	**www.bcbst.com**
BlueAdvantage Provider Service:	1-800-841-7434 Mon-Fri 8 a.m. to 5 p.m. ET
Prior Authorizations:	1-800-924-7141
Claims and UM Reconsiderations:	BlueAdvantage UM Reconsiderations PO Box 180205 Chattanooga, TN 37402-7205
Caremark:	1-866-865-0657
BlueAdvantage Fax number:	1-800-255-0244

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Glossary

These term definitions have been edited for this medium and are not as complete or detailed as some of the glossary definitions that come with BlueCross BlueShield of Tennessee contracts.

Ambulance: A specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Surgical Facility: An Institution which:

1. primarily performs surgical procedures on an outpatient basis;
2. does not provide inpatient care;
3. has an organized staff of Practitioners and permanent facilities and equipment;
4. may not be primarily used as an office or clinic for a Practitioner's or Other Professional's practice; and
5. is a licensed Institution.

Benefit Period: A calendar year during which benefits are available for Covered Services.

BlueCard® Program: A program established by BlueCross and/BlueShield organizations and the Blue Cross and BlueShield Association to process and pay claims for Covered Services received by a Member of a BlueCross and/or BlueShield organization from a Provider outside the organization's service area.

Coinsurance: The portion of an eligible medical bill a Member must pay out-of-pocket before BlueCross BlueShield of Tennessee begins paying insurance benefits. Coinsurance amounts are usually a percentage of the total medical bill, i.e., 20 percent. Coinsurance applies after the Member meets a required Deductible or Copay amount. Coinsurance is part of certain health plans.

Concurrent Review: A determination of whether continued inpatient care, or a given level of services being received, is Medically Necessary for the Member's medical condition. This review can be performed by the Provider's utilization review staff, BlueCross BlueShield of Tennessee 's review coordinator or Medical Director, or any other entity or organization under contract with BlueCross BlueShield of Tennessee. Once the case is reviewed, BlueCross BlueShield of Tennessee will notify the Practitioner and the Member of the results.

Copay or **Copayment**: A copay is a fixed-dollar amount that a Plan Member pays to a participating network doctor, caregiver, or other medical Provider or pharmacy each time health care services are received. A Copay is paid before BlueCross BlueShield of Tennessee pays the covered benefit amount. Copays are part of certain health care plans.

Contract: The entire agreement between BlueCross BlueShield of Tennessee and the Member. It including a contract document, the signed application and any attached papers or riders. A rider is an extra provision that is added to the basic Contract. BlueCross BlueShield of Tennessee considers the statements an individual makes in the application to be representations, not warranties.

Contract Date or **Effective Date**: The date coverage begins.

Covered Service: A Medically Necessary service or supply shown in the Contract for which benefits may be available.

Custodial Care: Care provided primarily for maintenance designed to assist the Member in activities of daily living. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.

Deductible or **Deductible Amount:** A Deductible is a fixed-dollar amount that a Member must pay for eligible services before BlueCross BlueShield of Tennessee begins applying insurance benefits. Usually Deductibles apply every calendar year. Deductibles are part of certain health care benefits plans.

Dependent: Another family member covered under a Member's health care benefits plan. May be a spouse and/or unmarried children who meet eligibility requirements of the Plan.

Diagnostic Service: A procedure ordered by a Practitioner or Other Provider to determine a specific condition or disease. Some common diagnostic procedures include:

1. X-rays and other radiology services;
2. laboratory and pathology services; and
3. cardiographic, encephalographic and radioisotope tests.

Durable Medical Equipment (DME): Equipment which:

1. can only be used to service the medical purpose for which it is prescribed;
2. is not useful to the Member or other person in the absence of illness or injury;
3. is able to withstand repeated use; and
4. is appropriate for use in an ambulatory or home setting.

Such equipment will not be considered a Covered Service, even if it is prescribed by a Practitioner or Other Provider simply because its use has an incidental health benefit.

Effective Date: The date on which coverage begins for a Member.

Eligible Person: A person entitled to make application for coverage.

Emergency or **Emergency Medical Condition**: An emergency is the sudden occurrence of a medical condition so severe that, without immediate medical attention, the condition could reasonably be expected to cause serious impairment to bodily functions, serious dysfunction of a bodily organ, or otherwise place the Member's health in serious danger. For behavioral health benefits, an Emergency is a sudden or rapidly escalating behavioral condition that, without immediate psychiatric or substance abuse attention, could reasonably be expected to cause serious emotional or physical dysfunction, or otherwise place the Member's or other's health and well-being in serious danger.

Emergency Admission: Admission as an Inpatient in connection with an Emergency.

Emergency Services: Health care services and supplies furnished in a hospital which are needed to determine, evaluate and/or treat an emergency medical condition until the condition is stabilized, as directed or ordered by a Practitioner or hospital protocol.

Fee Schedule or Fee for Services: The maximum fee that BlueCross BlueShield of Tennessee will pay for specified Covered Services.

Freestanding Diagnostic Laboratory: An Other Provider that provides laboratory analysis for other Providers.

Freestanding Dialysis Facility: A Facility Other Provider that provides dialysis treatment, maintenance, and training to Members on an outpatient or home health care basis.

Health Care Professional: A Podiatrist, Dentist, Chiropractor, Nurse Midwife, Registered Nurse, Optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which that health Care Professional practices.

Home Health Care Agency: An Other Provider, which is primarily engaged in providing home health care services.

Hospital: A short-term, acute-care, general hospital which:

1. is a licensed institution;
2. provides inpatient services and is compensated by or on behalf of its patients;
3. provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;
4. has a staff of Practitioners licensed to practice medicine; and
5. provides 24-hour nursing care by registered graduate nurses.

A facility which serves, other than incidentally, as a nursing home, custodial care home, health resort, rest home, rehabilitative facility or place for the aged is not considered a hospital.

In-Network: Practitioners, caregivers and medical facilities are considered “in-network” if they participate in an agreement with BlueCross BlueShield of Tennessee to provide services according to specific terms and rates.

Inpatient: Inpatient medical care is when treatment is provided to a Member who is admitted as a bed patient in a hospital or other medical facility, and room and board charges are incurred. For behavioral health benefits, Inpatient care can refer to treatment received at a hospital, a behavioral health facility or a behavioral health program. Most benefit plans require prior authorization for Inpatient care before a Member is admitted to a hospital, skilled nursing facility or rehabilitation facility.

Investigational: A drug, device, treatment, therapy, procedure, or other services or supplies that do not meet the definition of Medical Necessity:

1. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) when such approval has not been granted at the time of its use or proposed use;
2. is the subject of a current investigational new drug or new device application on file with the FDA;
3. is being provided according to a Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (participation in a clinical trial shall not be the sole basis for denial);
4. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives;
5. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS);
6. the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is Investigational or that there is insufficient data to determine if it is clinically acceptable;
7. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings;
8. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives; and/or
9. the service or supply is required to treat a complication of an Investigational service.

The Medical Director shall have discretionary authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Investigational service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all the following, at his or her discretion:

1. Member’s medical records;
2. the protocol(s) under which proposed service or supply is to be delivered;
3. any consent document that has been executed or the Member is asked to execute, in order to receive the proposed service or supply;

4. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses;
5. regulations or other official publications issued by the FDA and/or HHS;
6. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services; and/or
7. the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

Maximum Allowable Charge: The highest dollar amount of reimbursement by BlueCross BlueShield of Tennessee for a Covered Service. This amount is based on the rates or fees negotiated between BlueCross BlueShield of Tennessee and certain Practitioners, Health Care Professionals, or Other Providers, and whether Covered Services are received from a participating or non-participating Provider. Reimbursement for Out-of-Network services will be the stated percentage of the Maximum Allowable Charge or Billed Charges, whichever is less.

Medical Care: Professional services by a Practitioner or Professional Other Provider to treat an illness, injury, pregnancy, or other medical condition.

Medically Appropriate: Services, which have been determined by the Medical Director of BlueCross BlueShield of Tennessee to be of value in the care of a specific Member. To be Medically Appropriate, a service must:

1. Be Medically Necessary.
2. Be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
3. Be consistent with current standards of good medical practice for the Member's medical condition.
4. Be provided in the most appropriate site and at the most appropriate level of service of the Member's medical condition.
5. On an ongoing basis, have reasonable probability of:
   - correcting a significant congenital malformation or disfigurement caused by disease or injury;
   - preventing significant malformation or disease; or
   - substantially improving a life-sustaining bodily function impaired by disease or injury.
6. Not be provided solely to improve a Member's condition beyond normal variation in individual development and aging including:
   - Comfort measures in the absence of disease or injury; or
   - Improving physical appearance that is within normal individual variation.
7. Not be for the sole convenience of the Provider, Member or Member's family.
8. Not be an Investigational service.

Medically Necessary or **Medical Necessity**: Services, which have been determined by Medical Director of BlueCross BlueShield of Tennessee to be of proven value for use in the general population. To be Medically Necessary, a service must:

1. Have final approval from the appropriate government regulatory bodies.
2. Have scientific evidence permitting conclusions concerning the effect of the service on health outcomes.
3. Improve the net health outcome.
4. Be as beneficial as any established alternative.
5. Demonstrate the improvement outside the investigational setting.
6. Not be an Investigational service.

Medicare: The program of health care for the aged and disabled established by Title XVIII of the Social Security Act as amended.

Member: Any person covered under a health plan from BlueCross BlueShield of Tennessee, including that person's eligible spouse and/or eligible, unmarried children.

Nervous and Mental Disorder: A condition characterized by abnormal functioning of the mind or emotions in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Nervous and Mental Disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement. Nervous and Mental Disorders include alcohol, drug or chemical abuse or dependency, but do not include learning disabilities, attitudinal disorders, or disciplinary problems.

Non-Participating Provider: A Practitioner, hospital or ambulatory surgical facility that has not contracted with BlueCross BlueShield of Tennessee to furnish services and to accept specified levels of payment, plus applicable Deductibles and Copayment amounts, as payment in full for Covered Services.

Other Provider: An individual or facility, other than a Hospital or Practitioner, duly licensed to render Covered Services.

1. The following institutions are **Facility Other Providers** which may provide Covered Services:

   - Freestanding Dialysis Facility;
   - Ambulatory Surgical Facility;
   - Skilled Nursing Facility;
   - Substance Abuse Treatment Facility;
   - Residential Treatment Facility; and/or
   - Licensed Birthing Center.

2. The following **Professional Other Providers** may provide services covered by certain BlueCross BlueShield of Tennessee Contracts. In order to be covered, all services rendered must fall within a specialty (as defined below) and be those normally provided by a Practitioner within this specialty or degree. All services or supplies must be rendered by the Practitioner actually billing for them and be within the scope of his or her Licensure.

   - Doctor of Osteopathy (OD);
   - Doctor of Dental Surgery (DDS);
   - Doctor of Dental Medicine (DDM);
   - Doctor of Optometry (OD);
   - Doctor of Podiatric Medicine (DPM);
   - Doctor of Chiropractic (DC);
   - Licensed Clinical Social Worker (LCSW);
   - Licensed Independent Practitioners of Social Worker (LIPSW);
   - Licensed Marriage and Family Therapist (LMFT);
   - Licensed Practical Nurse (LPN);
   - Licensed Professional Counselor (LPC)
   - Licensed Psychological Examiner (LPE) supervised in accordance with Tennessee law
   - Licensed Psychologist;
   - Nurse Midwife (NM), licensed as a RN and certified by the American College of Nurse Midwives);
   - Registered Nurse (RN), including an RN who is a nationally-certified Nurse Practitioner (NP), Nurse Anesthetist (NA), or Clinical Specialist (CS);
   - Registered Nurse Anesthetist (RNA);
   - Registered Physiotherapist (RPT);
   - Licensed Pharmacist (D. Pharm.);
   - Occupational Therapist (for services to restore functioning of the hand following trauma only); and/or
   - Registered Dietitian or Nutritionist approved by BlueCross BlueShield of Tennessee (for nutritional counseling in connection with the treatment of diabetes only)

3. The following **Other Providers** may also provide services covered by certain BlueCross BlueShield of Tennessee Contracts:

   - Suppliers of durable medical equipment, appliances and prosthesis;
   - Suppliers of oxygen;
   - Certified ambulance service;
   - Hospice;
   - Pharmacy;
   - Freestanding Diagnostic Laboratory; and/or
   - Home Health Care Agency.

Out-of-Network Benefits: Reduced benefits, or Out-of-Network benefits take effect when a Point of Service (POS) Member seeks care from a Provider without a valid, approved referral. Without a referral, benefits are reduced even if the selected Provider is in-network and benefits are substantially reduced if the Provider is considered out-of-network. In both cases, the Member may incur substantial Out-of-Pocket costs.

Out-of-Network Provider: A Practitioner, caregiver or medical facility that does not participate in an agreement with BlueCross BlueShield of Tennessee to provide services according to specific terms and rates.

Out-of-Pocket Maximum: The dollar amount, which a Member must pay for Covered Services during a benefit period (does not apply to psychiatric care services).

Outpatient: Outpatient medical care is when treatment is provided to a Member in a facility or setting where room and board charges are not incurred. Outpatient medical services may be provided in a Practitioner's office, the Outpatient department of a hospital, or in some other medical setting. For behavioral health benefits, Outpatient care refers to routine visits to a behavioral health professional. Most benefit plans require prior authorization for certain Outpatient medical services.

Outpatient Surgery: Surgery performed in an Outpatient department of a hospital, Practitioner's office or Facility Other Provider.

Physical Therapist: A licensed Physical Therapist. (In states where there is no Licensure required, the Physical Therapist must be certified by the appropriate professional body or accrediting organization.)

Point of Service (POS): POS plans require Members to select a Primary Care Practitioner (PCP). Members receive the highest level of benefits when they have their medical care coordinated by his/her PCP. Referrals are required in a POS plan. Without a referral, Members receive a lower level of benefits.

Participating Provider: A Practitioner, Hospital, or Ambulatory Surgical Facility or Other Health Care Provider that has contracted with BlueCross BlueShield of Tennessee to furnish services and to accept BlueCross BlueShield of Tennessee payment for Covered Services after applicable Deductibles, Coinsurance or Copayment amounts have been paid by the Member.

Practitioner: A licensed Practitioner legally entitled to practice medicine and perform surgery. All Practitioners must be licensed in Tennessee or in the state in which Covered Services or rendered.

Preferred Provider Organization (PPO): A PPO plan offers a network of Practitioners, caregivers and medical facilities that agree to provide health care services to Members at less than the usual service fees. Members receive the highest level of benefits when network Providers are used. Members may seek medical care outside the network, but benefits are reduced substantially.

Primary Care Practitioner (PCP): A Practitioner selected by the Member to coordinate all his or her health care, including routine checkups and treatment for medical conditions. A PCP is usually a Practitioner in general practice, family practice, internal medicine or pediatrics. Certain health plans require the Member to select a PCP.

Prior Approval: See "Prior Authorization".

Prior Authorization: Prior Authorization verifies the Medical Necessity of certain treatments, as well as the setting where medical services are provided. For pharmacy benefits, Prior Authorization helps determine cost-effective alternatives for certain prescription drugs.

Provider: A Provider is a Practitioner, other professional caregiver, medical facility, or medical supplier that supplies health care.

Referral: The process by which a PPO Member's Primary Care Practitioner authorizes treatment from a medical specialist.

Skilled Nursing Facility (SNF): A facility, which provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Practitioner.

Specialist: A Specialist is a Practitioner highly trained in a specific area. Specialists may refer to a sub-Specialist in complex cases. Some examples of a Specialist include:

- Cardiologist
- Dermatologist
- Neurologist
- Obstetrician
- Podiatrist
- Psychiatrist

Surgery: Surgery is defined as follows:

1. operative and cutting procedures, including use of special instruments;
2. endoscopic examinations (the insertions of a tube to study internal organs) and other invasive procedures;
3. treatment of broken and dislocated bones;
4. usual and related pre-and post-operative care when billed as part of the charge for Surgery; and
5. other procedures that have been approved by BlueCross BlueShield of Tennessee.

Termination Date: The date a Contract ends and the date Benefits end.

Therapy Services: Services for treatment of illness or injury defined below:

1. Radiation Therapy – treatment of disease by X-ray, radium, or radioisotopes;
2. Chemotherapy – treatment of malignant disease by chemical or biological agents;
3. Dialysis – treatment of a kidney ailment, including the use of an artificial kidney machine;
4. Physical Therapy – treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part;
5. Respiratory Therapy – introduction of dry or moist gases into the lungs; and
6. Home Infusion Therapy (HIT) – therapy in which fluid or medication is given intravenously, subcutaneously, intramuscularly, or epidurally, at the patient's home, including total Parenteral Nutrition, Enteral Nutrition, Hydration Therapy, Chemotherapy, and Aerosol Therapy and Intravenous Drug Administration.

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