BlueAlert

provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

January 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective Feb. 10, 2008

- Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Individuals with NSCLC

Note: Effective date(s) apply to BlueCare® and TennCare*Select* pending State approval.

Modified Milliman Care Guideline updates/changes

BlueCross BlueShield of Tennessee's Web site has been updated to reflect upcoming modifications to select Milliman Care Guidelines®. The *Modified Milliman Care Guidelines* can be viewed on the Utilization Management Web page at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm>.

Effective Feb. 28, 2008

The following as relates to Ambulatory Care:

- Bladder Instillation for Treatment of Interstitial Cystitis
- Sling Operation for Correction of Male Urinary Incontinence

The following as relates to Inpatient and Surgical Care:

- Laparoscopy, Surgical with Radical Hysterectomy
- Transcatheter Permanent Occlusion or Embolization

Note: Effective dates apply to BlueCare and TennCare*Select* pending state approval.

Clarification: Arranging a peer-to-peer discussion

To arrange a peer-to-peer discussion with a BCBST medical director, office staff should call one of the following numbers:

BlueCare or TennCare*Select*
1-800-924-7141

All other lines of business
1-800-228-2096

ADMINISTRATIVE

Coordination of benefits questionnaire available online

Effective Jan. 1, 2008, a coordination of benefits (COB) questionnaire will be available on the company Web site, www.bcbst.com for use in assisting your patients needing to update their "other coverage" information.

To retrieve the form for the member to complete and mail directly to his/her local BlueCross BlueShield Plan, go to the Provider's page, click on "Administration", "Forms", form is located under "Commercial" heading.

The member's COB information only needs updating once within a 12-month period unless there has been a change.

BCBST begins accepting present on admission (POA) codes

Effective Jan. 1, 2008, for all claims for inpatient admissions to general acute care hospitals, BlueCross BlueShield of Tennessee **will begin accepting** the Present on Admission (POA) code on diagnoses for discharges on or after Dec. 31, 2007.

Note: Effective April 1, 2008, the POA code **will be required.**

BCBST partners with American Cancer Society (ACS) in promoting cancer screening guidelines

BlueCross BlueShield of Tennessee and the ACS has partnered to make cancer screening educational material available to providers for sharing with their patients. Regional Nurse Liaisons (RNLs) distribute a pad, similar to a prescription pad, where providers can document what screenings a patient may need and give to the patient. Additionally, providers are supplied with a pad of the *ACS Screening Guidelines* containing age and gender-appropriate screenings for patient use.

We encourage you to use the ACS screening guidelines to educate your patients on obtaining the appropriate cancer screenings.

If you have questions or would like a supply of these materials, please visit the ACS Web site, www.cancer.org or contact your local RNL at one of the following numbers:

Chattanooga	423-535-6458
Jackson	731-664-4136
Johnson City and Knoxville	423-854-6025
Memphis	901-544-2140
Nashville	615-386-8535

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Correct reporting of Modifier 59

Modifier 59 represents a procedure/service not ordinarily encountered or performed on the same day by the same physician. It should only be reported when the physician needs to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may be due to a:

- different session or patient encounter;
- different procedure or surgery;
- different site or organ system;
- separate incision/excision;
- separate lesion; or
- separate injury.

When using Modifier 59, it:

- *should **only** be reported* if another modifier does not describe the situation more accurately; or
- *should **only** be reported* on the "edited" code – **NOT** on the primary or comprehensive code. (Example: A provider performs a tendon injection, CPT® 20551, and trigger point injection, CPT® 20552, at the same patient encounter. To indicate that these were separate and distinct procedures, the provider should report a Modifier 59 on the edited code, CPT® 20552, and must be able to provide supporting medical documentation in the patient record.
- *should **NOT** be reported* on Evaluation and Management codes.

For more information on reporting Modifier 59 correctly, visit the Centers for Medicare & Medicaid Web site, www.cms.hhs.gov.

Reminder: NPI reporting requirements

Effective Jan. 1, 2008, commercial institutional providers will be required to submit their NPI number in the applicable fields on the CMS 1450 claim form.

Effective March 1, 2008, NPIs will be required on all commercial professional CMS-1500 claim forms.

For BlueCare and TennCare*Select*, effective Jan. 1, 2008, the State of Tennessee is requiring the NPI be submitted on both institutional CMS-1450 and professional CMS-1500 claim forms.

You may continue to use the legacy number as long as the NPI is also submitted.
Note: All NPI numbers submitted must be on file with BlueCross BlueShield of Tennessee or your claim(s) will be returned unprocessed.

Coding clarification for reporting spinal osteotomy procedures

According to the 2008 CPT® Manual, spinal osteotomy procedures are reported when a portion(s) of the vertebral segment(s) is cut and removed in preparation for re-aligning the spine as part of a spinal deformity correction. This clarification was added to the introductory language of the 2008 CPT® Manual to avoid confusion regarding the use of osteotomy codes. CPT® codes 22206-22226 should **only** be used to report spinal osteotomies for correction of a spinal deformity.

It is important to note that in performing many spinal procedures, an osteotomy is considered an integral part of the comprehensive procedure and should not be separately reported. For example, if removing osteophytes or endplates in preparation for fusion, these procedures would be included in the more comprehensive procedure (laminectomy, discectomy, etc.). The use of CPT® codes 22206-22226 was not intended for purposes other than the correction of spinal deformity.

Reminder: Filing multi-line and multi-page claims appropriately

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.

All services for the same patient, same date of service, same place of service, and same provider **must be billed on a single claim submission**. Billing multiple lines can result in a multi-page claim. When submitting 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. Billing guidelines for multi-page claims are found in the provider administration manuals located on the company Web site, www.bcbst.com.

Clinical information essential to timely requests

In order to obtain a timely decision, MedSolutions needs to gather clinical information related to the requested imaging. It is helpful to have the patient's clinical information available and reviewed prior to calling. Standard information needed is listed below.

- History – onset of symptoms and related conditions
- Current Physical Exam – Date of Service and findings
- Medications – related to treatment of symptoms
- Therapy – Date of Service
- Specialist Consultation – Date of Service and findings
- Prior imaging related to the request
- Current or Serial Labs

Commercial code bundling rules updated

Effective for dates of service Jan. 1, 2008 – March 31, 2008, in accordance with BlueCross BlueShield of Tennessee's policy on Quarterly Reimbursement Changes, the code bundling rules for professional commercial claims will be updated.

Providers may review the updated code bundling rules on the company Web site at <http://www.bcbst.com/providers/code_bundling/>.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

e-Health Services enhances patient information

e-Health Services, located on BlueAccess, BCBST's secure area on the company Web site, www.bcbst.com now offers providers enhanced links to member-specific prior authorization requirements and claims information.

A "Prior Authorization Requirements" link has been added to the *Claims and Authorization Inquiry* section on the Patient Information Page. Providers can quickly view whether a patient's BCBST plan requires prior authorization for a specific procedure or service by simply clicking on the new link. As with any data enhancement, it must be rolled out in segments. Therefore, this information is not available for use with all BCBST members at this time. If the information is not available for a particular member, you will be directed to contact Provider Service.

Additionally, providers will receive more enhanced claims information on the "Find Claims" page.

Reminder: Filing sleep study claims appropriately

Sleep studies must be performed in a certified place of service, as required by applicable state and federal regulations, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or American Osteopathic Association (AOA) and/or the American Academy of Sleep Medicine. The evaluating physician and staff are required to have specialized training that meets the standards set forth by the American Academy of Sleep Medicine.

To avoid delays in receiving payments, unnecessary overpayments, and to ensure the most appropriate member benefit is applied, providers are reminded to submit claims with the most appropriate Revenue Code, Procedure Code and HCPCS code in effect on the date of service. The preferred Revenue Code for Outpatient Sleep Studies is 0740 or 0749.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Erythropoietin stimulating agents require prior authorization

Effective Feb. 1, 2008, BlueCare and TennCare*Select* will require prior authorization for self-administered and provider-administered erythropoietin stimulating agents before dispensing from a pharmacy or for outpatient administration.

Authorization will be based on medical appropriateness criteria, such as hemoglobin and hematocrit levels, which can be found online in the *BCBST Medical Policy Manual* at <http://www.bcbst.com/UpcomingMPs/upcoming_mps.htm>. These medications, which include epoetin alfa (Procrit®; Epogen®) and darbepoetin alfa (Aranesp®) are available through the Bureau of TennCare's Pharmacy Benefits Manager, First Health Services Web site at https://tennessee.fhsc.com/.

Updated national drug code (NDC) requirements for filing CMS-1450 claim form

As previously communicated, effective for dates of service on or after Jan. 1, 2008, institutional providers must include NDC information for all J codes for BlueCare and TennCare*Select* claims. We announced that claims containing an NDC with less than 11 digits and the NEW data elements would be returned unprocessed. Instead, all institutional claims will be processed and only the individual line(s) containing J codes with missing NDC information will be rejected.

Reminder: Supplying appropriate information improves prior authorization request response time

In the June 2007 issue of *BlueAlert*, we advised that BlueCare and TennCare*Select* can receive authorization requests by fax, phone or electronically through BlueAccess, BlueCross BlueShield of Tennessee's secure area on the company Web site, www.bcbst.com.

Submitting all appropriate medical and demographic information at the time of the request helps ensure you receive a more timely response. Insufficient information can result in a medical necessity denial. Additional clinical information may also be called in within 24 hours of the request to expedite your authorization or determination request.

Reconsiderations

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 BCBST from the provider or provider representative. A provider can request a peer-to-peer discussion at any time during the Utilization Management Provider Appeals Process. The process can be found on our Web site, www.bcbst.com in the *BlueCare Provider Administration Manua*l.

If you have any questions, please call the appropriate **Notification/Prior Authorization** number listed below:

BlueCare	1-888-423-0131
TennCare*Select*	1-800-711-4104

BlueCard®

ADMINISTRATIVE

Blues move to automatic crossover for all Medicare claims

All claims will be automatically submitted to the secondary payer

Effective Jan. 1, 2008, all Blue Plans will crossover Medicare claims for services covered under Medigap and Medicare

BlueCard®

ADMINISTRATIVE

Blues move to automatic crossover for all Medicare claims (cont'd)

Supplemental products. This will result in automatic claims submission of Medicare claims to the Blue secondary payer, and reduce or eliminate the need for the provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide.

Providers can learn more about the Medicare crossover process by visiting the company Web site at http://www.bcbst.com/providers/news/.

BlueCard eligibility line expands hours of operation

Effective Jan. 1, 2008, the BlueCard Eligibility line's automated voice response system, 1-800-676-BLUE, will be accessible to providers 24 hours-a-day, 7 days-a-week. This enhancement will support the growing trend of self-service and help ensure providers have access to Plans' self service eligibility information at all times.

The BlueCard Eligibility Call Center is a centralized service which transfers providers to members' Home Plans for benefit and eligibility information, using a member's alpha prefix. Previously, the line was available Monday through Friday, 7 a.m to10 p.m. (ET).

Identifying Blue Precision members

Effective Jan. 1, 2008, Blue Precision, a cost-effective plan option with a more limited but efficient network will be available to the Wal-Mart group in the Knox County area. Members can easily be identified by their BlueCross BlueShield member identification number. The alpha prefix "WMZ" will be reflected on the front of the member ID card along with the Blue Precision and empty suitcase logos.

Cover Tennessee

ADMINISTRATIVE

Important changes to AccessTN Health Plans

Effective Jan. 1, 2008, the following changes will apply to AccessTN plans:

Plan Option	Change
AccessTN 1000 AccessTN 5000	Maximum annual benefit increased to $200,000
AccessTN 1000 AccessTN 1250 AccessTN 5000	Pre-existing waiting period will remain 6 months during which time, plan will pay 50 percent of the allowed amount for medical services. ***Excludes***: ➢ Outpatient behavioral health services ➢ Outpatient chemotherapy and radiation therapy for treatment of cancer ➢ Prescription medications

Reminder: Use preventive diagnosis codes for annual physical examinations

It is important to use preventive diagnosis codes when filing AccessTN member claims for annual physical examinations. If a condition is found during the exam, that diagnosis will supersede the preventive exam diagnosis causing the services to possibly be subject to pre-existing review. This could result in increased member cost-sharing and possible claims payment delays.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

BlueAdvantage begins accepting present on admission (POA) codes

Effective Jan. 1, 2008, for all BlueAdvantage claims for inpatient admissions to general acute care hospitals, BlueCross BlueShield of Tennessee will begin accepting the Present on Admission (POA) code on diagnoses for discharges on or after Dec. 31, 2007. BlueAdvantage claims submitted without the POA code on or after April 1, 2008, will be returned to the hospital for correct submission of POA information.

Critical Access Hospitals, Maryland Waiver Hospitals, Long Term Care Hospitals, Cancer Hospitals and Children's Inpatient Facilities are exempt from this requirement as are all hospitals paid under any other type of Perspective Payment System (PPS) system other than the acute care hospital PPS system.

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†Provider Service lines

Featuring Touchtone" or "Voice Activated" Responses"

Commercial Lines; CoverTN; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the new "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage 1-800-841-7434
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 1Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml

Effective March 14, 2008

- PET for Oncology Applications
- Cryosurgical Ablation for the Treatment of Prostate Tumors
- Cryosurgical Ablation for the Treatment of Renal Tumors
- Temsirolimus
- Zoledronic Acid
- Alemtuzumab
- Pharmaceutical Management of Chronic Hepatitis B Virus (CHBV)

Note: Effective date(s) apply to BlueCare® and TennCare*Select* pending State approval.

Clinical Practice Guidelines adopted

BlueCross BlueShield of Tennessee adopted the following guidelines as recommended best practice references:

Guidelines for the Treatment of ADD/ADHD
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/5/1158.pdf>
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/4/1033.pdf>

Management & Prevention of Chronic Obstructive Pulmonary Disease (COPD)
http://www.goldcopd.org/index.asp?l1=1&l2=0

Hyperlinks to these guidelines are available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company Web site at http://www.bcbst.com/providers/hcpr/ Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Reminder: Encourage smokers to quit

All health care providers, especially those with direct patient contact, have an opportunity to help tobacco users quit. We encourage providers to actively counsel patients who currently smoke or those who are recent quitters (six months or less) on the dangers of smoking. Encourage smokers to:

1. Set a quit date, within 2 weeks;
2. Solicit support from family, friends, and coworkers;
3. Review past quit attempts—identify what helped, what led to relapse;
4. Anticipate challenges, including nicotine withdrawal; and
5. Identify reasons for quitting and benefits of quitting.

It is important to note that many smokers quit upon the advice of their doctor.

ADMINISTRATIVE

Reminder: Do you have your National Provider Identifier (NPI)?

*Share it with **all** insurance carriers.*

BCBST provides the following methods for reporting your NPI.

1. Print, complete and mail or fax the NPI form (located in the NPI topic on the Provider page of the company Web site, bcbst.com) to:
   BlueCross BlueShield of Tennessee
   ATTN: Provider Network Svc – 3TC
   801 Pine Street
   Chattanooga, TN 37402
   Fax: 423-535-5808
2. Call the Provider Service Line, 1-800-924-7141 and say "Contracting".
3. E-mail your Provider Name, BCBST Provider Number and NPI to PNS_GM@BCBST.com; or
4. Complete and mail the return post card included in the May, June or August 2006 issues of *BlueAlert*

Steps you should do:

1. Apply for your number from the Centers for Medicare & Medicaid Services (CMS),
2. Share your NPI with **all** insurance carriers with whom you do business.

If you do not have an NPI, learn how to apply by visiting the CMS Web site, www.cms.hhs.gov.

Reminder: Prior authorization guidelines for Positron Emission Tomography (PET) studies

All PET imaging studies must be consistent with BCBST medical policy guidelines in order to be considered for reimbursement.

MedSolutions conducts prior authorization medical necessity review for a large number of Blue Network P and Blue Network S members. For those members not requiring prior authorization for PET studies (you do not receive an approval or a denial) through MedSolutions, the scan must still meet BCBST medical policy guidelines for consideration of reimbursement.

Providers may request a predetermination for PET imaging services by calling the BCBST Provider Service line†.

Note: This does not apply to BlueCare or TennCare*Select*.

BlueCare/TennCare*Select*

ADMINISTRATIVE

LabOne no longer exclusively providing routine outpatient laboratory services*

Effective March 1, 2008, LabOne will no longer be exclusively providing routine outpatient laboratory services to BlueCare/TennCare*Select* members. Rather, providers will be able to utilize any BlueCare/TennCare*Select* participating independent lab for these services.

Lab services provided by participating labs will not require authorization; however, prior authorization will still be required when services are provided by non-participating labs.

National Drug Code (NDC) CMS-1450 claim filing requirement delayed

The Deficit Reduction Act of 2005 requires institutional claims submissions to include the NDC of the drug(s) administered, along with the correct quantity and unit for BlueCare and TennCare*Select* claims. The Centers for Medicare & Medicaid Services has announced this requirement will be delayed until Apr. 1, 2008, **for outpatient hospital claims only.**

Note: This requirement does not apply to commercial lines of business.

New provider appeal toll-free fax number now available for BlueCare and TennCare*Select* *

We recently added a new toll-free fax number, **1-888-357-1916**, solely for use in faxing a standard appeal for denied services. Provider use of this dedicated fax number will help ensure all faxed standard appeals are imaged into our system in a timely manner. This enhanced process will help expedite standard appeals and ensure the most current information is available to you when checking the status of your appeal.
When faxing a standard appeal the following documentation must be provided:

- The principle reason for upholding the non-certification determination,
- Detailed clinical rationale, and
- Pertinent medical records for the specific case you are appealing.

Reminder: Changes to billing guidelines for hospice continuous home care

In the April 2007 issue of *BlueAlert*, we advised that effective for dates of service on or after May 1, 2007, BlueCare and TennCare*Select* would change their billing guidelines for reporting Hospice Continuous Home Care (Revenue Code 0652) to 15-minute increments. Previously, the Centers for Medicare & Medicaid Services required these services be reported in 1-hour increments.

Reminder: Prenatal preventive care

Members under age 21 years who are receiving prenatal care are also eligible to receive TENNderCare services from their obstetrician. Providers may bill a preventive code, plus an Evaluation & Management code with modifier 25 when the visit includes both preventive care and prenatal services.

VSHP initiating annual accreditation and reporting projects

Volunteer State Health Plan, Inc., (VSHP) will soon begin their annual Health Plan Effectiveness Data Information Set (HEDIS) project to meet National Committee for Quality Assurance (NCQA) accreditation and the Bureau of TennCare reporting requirements for the BlueCare and TennCare*Select* programs.

Measures that require additional information from medical record documentation to report accurate results include childhood immunizations, prenatal and postpartum care, cervical cancer screening, cholesterol management and comprehensive diabetes management.

A representative from BlueCross BlueShield of Tennessee may contact your office to request documentation or schedule an onsite review of medical records for data abstraction.

Reminder: Lab procedures for TENNderCARE screening

Practitioners are reminded to perform and document all necessary lab procedures for TENNderCare screenings. Lab procedures or screenings that should be provided in accordance with the American Academy of Pediatrics' (AAP) Recommendations for Preventive Pediatric Health Care include:

- ✓ Hereditary/Metabolic Screening
- ✓ Hematocrit/Hemoglobin
- ✓ Urinalysis
- ✓ Lead Screening and Testing
- ✓ Tuberculosis Screening and Testing
- ✓ Cholesterol Screening
- ✓ Sexually Transmitted Diseases

Documentation of all lab test results must be included in the member's medical record.

Reminder: Member access-to-care is monitored

To help ensure our members have 24-hour-a-day, 7-days-a-week access to network practitioners, BlueCross BlueShield of Tennessee maintains access and availability standards in accordance with applicable regulatory and accrediting bodies.

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 primary care practitioners who participate in our provider networks.

Our clinical audit staff monitors practitioner availability for after-office hours in coordination with the routine practice site or medical record review process for Primary Care and OB/GYN Practitioners. Routine telephone calls are made after regular office hours, using current Network Directory information available to BlueCross BlueShield of Tennessee Commercial, BlueCare and TennCare*Select* members, to assess practitioner compliance with published standards for telephone access after regular clinic/office hours.

Non-compliant results are shared with the practitioner and/or office representative, and are also reported to the Clinical Risk

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Member access-to-care is monitored (cont'd)

Management Department for continued monitoring.

These standards can be found on the Provider page of the company Web site at http://www.bcbst.com/providers/prov_man.shtm.

Note: To report any changes in demographical information, please call the BlueCross BlueShield of Tennessee Provider Service line†.

Reminder: Are you responsible for providing 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 are to be provided by the entity at the level at which the request for service is received. Anyone who does not speak English as his/her primary language and/or has reading, writing or English-speaking limitations is considered limited English proficient.

It is the responsibility of any entity that receives federal financial assistance, e.g., Medicare, BlueCare, TennCare*Select*, to provide interpretation services for medical treatment. Providing interpretation services is vital to ensuring patient welfare.

When deciding to use interpreters, the following may offer some cost-effective language assistance:

- train bilingual staff;
- utilize telephone and video conference services;
- use qualified translators and interpreters; and
- use qualified volunteers.

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.

Additional information can be found on the Provider page of the company Web site, www.bcbst.com in both the BlueCross BlueShield of Tennessee and BlueCare provider administration manuals.

Reminder: Billing process for Medicare/Medicaid dual eligible members

Claims filed electronically for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed to Medicare for primary payment. Medicare should crossover to the State of Tennessee for Medicare co-insurance amounts.

Paper claims filed for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed with Medicare for primary payment. After Medicare pays, providers should file the paper claims along with the Medicare Summary Notice to the State of Tennessee for reimbursement of Medicare coinsurance amounts. Mail paper claims for secondary payment to:

Tennessee Bureau of Medicaid
P.O. Box 460
Nashville, TN 37202-0460

Uninsured/Uninsurable members (Eligibility Class 77 with Medicare) should be billed directly for any deductible/coinsurance amounts due after Medicare pays primary. BlueCare will not pay these amounts; however, the member is liable for their Medicare deductible/coinsurance.

Claims filed for non-Medicaid members after Medicare has paid primary will show patient liability as zero (0) on the BlueCare/TennCare*Select* Remittance Advice. However, the member may be billed for any Medicare deductible/coinsurance amounts. Medicare/Medicaid dual eligibles should not be billed for any Medicare deductible/coinsurance amounts, as these should crossover to the Tennessee Bureau of Medicaid for secondary payment.

Eligibility classification may be determined by the last two digits of the group number or by reviewing the classification listing in the *BlueCare Provider Administration Manual* available on the Provider page of the company Web site, www.bcbst.com.

Update: National Drug Code (NDC) CMS-1450 claim filing requirements

In the Nov. 2007 issue of *BlueAlert*, we advised that when submitting paper claims one space should follow the NDC number and the number quantifying the number of units, grams or milliliters administered should not exceed 7 digits. The Bureau of TennCare announced effective Apr. 1, 2008, it will adopt the National Medicaid EDI HIPAA workgroup's standard of utilizing the N4 qualifier, followed by the 11-character NDC, followed by the unit measurement qualifier, followed immediately by the quantity with **NO** spaces. All data elements should be left-justified with no leading zeros on the quantity.

Example: N412345678901UN1234.567

Additionally, we announced that claims containing NDCs with less than 11 digits and the NEW data elements would be returned unprocessed. Instead, all institutional claims will be processed and only the individual line(s) containing J-codes with missing NDC information will be rejected.

This requirement does not apply to commercial claims submitted on the CMS-1450 claim form.

BlueCard®

ADMINISTRATIVE

Marking claim attachments inappropriately may cause delays in response time

BCBST utilizes the Optical Character Recognition (OCR) scannable format to read paper claims and any attachments. Recently we have received a number claims with Explanation of Payments (EOPs) and Remittance Advices (RAs) having highlighted or circled notations reflected on them. While we appreciate the assistance you are attempting to offer, these types of indicators prevent accurate reading of the data during scanning and may delay the adjudication process.

If you wish to bring our attention to a specific area on an attachment, please draw

BlueCard®

ADMINISTRATIVE

Marking claim attachments inappropriately may cause delays in response time (cont'd)

an arrow (use a pen with black ink only) pointing toward the specific line(s) rather than using other methods. Following this tip will help prevent the need for retrieving original document(s) from storage; thus causing untimely delays in the process.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Reminder: Reimbursement for ambulatory surgical centers based on OPPS system

Providers are reminded that effective Jan. 1, 2008, reimbursement for ambulatory surgical centers is based on the hospital Outpatient Prospective Payment Systems (OPPS) system. This is in accordance with the Centers for Medicare & Medicaid Services reimbursement guidelines.

Correction: File claims timely to avoid penalties

In December 2007 issue of *BlueAlert*, we reminded providers that claims filed for BlueAdvantage Private Fee-for-Service (PFFS) and BlueAdvantage Preferred Provider Organization (PPO) members must be received within 365 days from the date of service to be considered timely. However, in accordance with federal guideline 42 CFR, this requirement does not apply to BlueAdvantage PFFS claims, which are governed by the Centers for Medicare & Medicaid Services (CMS) timely filing guidelines. CMS timely filing guidelines can be found on the CMS Web site at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=bc033d9a3864bd39aa4a394b403e984f&rgn=div8&view=text&node=42:3.0.1.1.11.3.2.8&idno=42>. We apologize for any inconvenience the original information may have caused.

Advance determinations available online for BlueAdvantage PFFS members*

BlueCross BlueShield of Tennessee providers serving BlueAdvantage Private Fee-for-Service (PFFS) members can submit electronic advance determination requests for inpatient, 23-hour observation and pharmacy (part B drugs only) via *e-Health Services*® located on *BlueAccess*, the secure area on the company Web site, www.bcbst.com. To access *e-Health Services*, enter your user ID and password in the secure area login box or for first-time users, click on the "register now" tab and follow the prompts.

Advance determination requests for Inpatient, 23-hour observation and Part B Pharmacy Drugs will pend into the BCBST real-time system for nurse review and response. This service is available 24-hours-a-day, 7-days-a-week to all BCBST registered providers.

Note: This process is currently not available for BlueAdvantage Participating Provider Organization (PPO) members.

Reminder: E-mail box available exclusively for BlueAdvantage inquiries

Providers now have an e-mail box available for use in submitting questions and/or inquiries specific to BlueAdvantage.

Our goal is to respond to your inquiries within 2 business days. Please send your BlueAdvantage questions/inquiries to BlueAdvantageClaims@bcbst.com or call our BlueAdvantage Provider Service line†.

Cover Tennessee

ADMINISTRATIVE

State removes benefit limitation on outpatient diabetes education services

Recently, the State of Tennessee removed the $500 benefit limit on outpatient diabetes education services for both its CoverKids and AccessTN health care products. Based on this change, BlueCross BlueShield of Tennessee removed the limit Jan. 9, 2008, from its claim processing system, retro-effective to the April 1, 2007, product inception date.

Any claims previously affected by this benefit limit will be reopened and adjusted. You do not need to resubmit these claims for reprocessing to occur.

Reminder: Non-routine diagnostics non-covered when performed in practitioner office

Providers are reminded that non-routine diagnostics, including but not limited to MRIs, CT Scans, and PET Scans are excluded from CoverTN member coverage when performed in the practitioner's office.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; CoverTN; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the new "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage 1-800-841-7434
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 1Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert
provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

March 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective April 11, 2008

- Genetic Testing for Warfarin Dose
- Intrauterine Laser Ablation of Placental Vessels for Twin-to-Twin Transfusion Syndrome (TTTS)
- Genetic Testing for BRCA1 and BRCA2 for Breast Cancer

Note: Effective date(s) apply to BlueCare® and TennCare*Select* pending State approval.

New drugs added to commercial specialty pharmacy listing

Effective Dec. 12, 2007, the following drugs have been added to our specialty pharmacy listing. Those requiring prior approval are identified by a (PA).

Provider-administered via medical benefit

- Reclast
- Torisel
- Xolair (PA) – (Previously listed on specialty pharmacy listing as *self-administered*. Effective Oct. 1, 2007, moved to *provider-administered.*)

ADMINISTRATIVE

Electronic funds transfer (EFT)

Providing safe, secure and cost-effective payments

EFT provides a method of transferring payments automatically from BCBST's account directly to your bank by electronic means without any paper money changing hands. EFT is available for all BCBST lines of business including BlueCare, TennCare*Select*, BlueCard, Federal Employee Program (FEP) and Preferred Dental.

The growing popularity of EFT for online bill payment is paving the way for a paperless universe where stamps, checks, and paper bills are obsolete. Sign up today for EFT and enjoy benefits such as:

- Increased efficiency
- More secure payment process – less chance for check misplacement
- Earlier receipt of payments than when mailed
- Reduced administrative costs
- Simplified bookkeeping – less paper

In order to participate in the EFT process, providers must complete the ***EFT Enrollment Form*** and return it along with a voided check to:

BlueCross BlueShield of Tennessee
Attn: Provider Network Mgmt – 3TC
801 Pine Street
Chattanooga, Tennessee 37402

The EFT Enrollment Form and Frequently Asked Questions (FAQs) containing important information about the EFT process can be found on the Provider page of the company Web site, www.bcbst.com. To access the form and FAQs, choose "Administration" and click on the "Forms" tab.

Billing units for MRI/MRA contrast materials*

HCPCS codes A9576, A9577, A9578, and A9579 became effective Jan. 1, 2008. Based on the code descriptions, 1 unit of the code is equivalent to 1 milliliter (ml) of the contrast material.

Code A9579, a '*not otherwise specified*' code, will require the contrast name, a valid NDC number, and the appropriate number of units billed in accordance with the code description to determine correct reimbursement. Contrast material(s) billed with these codes is considered separately only with those MRI/MRA procedure codes containing the phrase "*without contrast material, followed by contrast material(s) and further sequences*".

Health care fraud

More damaging than you imagine

According to the National Health Care Anti-Fraud Association, health care fraud accounts for at least three percent of total health care spending, resulting in over $60 billion in losses in 2005.

Health care fraud is intentional, unlawful and sometimes repetitive deception for the purpose of gaining unauthorized benefits, financial or otherwise.

Perhaps you have heard about multi-state fraud rings that devise schemes to defraud patients and insurance companies, or the increasing number of medical ID thefts. These high-profile cases command our attention but are dwarfed by more common examples that happen every day. Some of these include:

- deliberately submitting or filing false claims;
- billing for services not rendered;
- purposely misrepresenting a condition or the types of services provided;
- intentionally omitting information about a condition, symptoms or services received; and
- patients utilizing false IDs.

Fraud damages the credibility of our health care system, eroding trust among patients, doctors, hospitals and insurance companies.

Providers can report possible health care fraud anonymously by calling our 24-hour confidential hotline, 1-800-496-9600 or by completing the form found under the "**fight fraud**" tab located on the Home page of our company Web site, www.bcbst.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Requesting benefits for nuclear stress testing

When requesting benefits for nuclear stress tests, please have the procedure code available and/or indicate if the service is considered routine or non-routine (advanced radiological imaging). Because benefits for nuclear stress testing vary based on whether the service is routine or non-routine, having the specific procedure code will assist our Customer Service staff in providing more accurate benefits information. If you do not have the procedure code available, please request benefits for both routine and non-routine.

Billing for compound drugs

Per Centers for Medicare & Medicaid Services (CMS) guidelines, when using compounded drugs, providers must bill with either J3490 (unclassified drug) or J9999 (not otherwise classified anti-neoplastic drug) as appropriate to the situation. Providers should **not** use a specific HCPCS code when billing for compounded drugs.

When billing for compound drugs with miscellaneous codes, the following is required for appropriate reimbursement:

- Name of the drug component(s)
- Valid NDC number for component(s)
- Specific dosage of each component administered in unit of weight (i.e. milligrams) rather than volume (i.e. cubic centimeters)

Reporting modifier 25 appropriately*

Under certain circumstances, the physician may need to indicate that a significant and separately identifiable evaluation and management (E&M) service was performed beyond the usual pre-procedure, intra-procedure, and post-procedure physician work; or beyond the normal components of another E&M service (e. g., preventive medicine service, anticoagulation management service, osteopathic manipulative treatment, chiropractic manipulative treatment, ophthalmological evaluation service) requiring significant additional work. The E&M service may or may not require a different diagnosis.

Correct Reporting of Modifier 25 includes, but is not limited to the following:

- There is documentation of a significant, separately identifiable E&M service which must contain the required number of key elements (history, examination, and medical decision making) for the E&M service reported
- The E&M service is provided beyond usual preoperative, intraoperative, or postoperative care associated with a procedure performed on the same day
- A symptom or procedure presents that prompts the E/M service (may not require a separate diagnosis)
- An initial hospital visit, an initial inpatient consultation, and a hospital discharge service is billed for the same date of service as an inpatient dialysis service
- Critical care codes are billed within a global surgical period
- A Medically Necessary visit is performed on the same day as routine foot care

Inappropriate Reporting of Modifier 25 includes, but is not limited to the following:

- E&M service that resulted in decision for surgery
- Ventilation management in addition to E&M service
- Use on surgical codes
- Use on same day of minor procedure
- Use within global surgical period (pre- or postoperative care)

Use of Modifier 25 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement. Documentation for the E&M service must be able to stand alone.

For more information, please refer to the Current Procedural Terminology (CPT®) Manual.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Completing "patient relationship information" claim fields appropriately

Effective for dates of service on or after April 1, 2008, all BlueCare and TennCare*Select* claims submitted on paper CMS-1500 and CMS-1450 Health Insurance Claim forms or submitted electronically in the ANSI-837 version 4010A1 format without the correct insured and patient relationship information will be returned to the provider unprocessed. The required data form content and field description format for completing these fields can be viewed in the Billing and Reimbursement section of the *BlueCare Provider Administration Manual* available on the Provider page of the company Web site, www.bcbst.com or on Blue*Source*, BCBST's quarterly provider information CD.

Additional reference sources include:

- *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual* for 08/05 Version and
- *National Uniform Billing Committee UB04 Data Specifications Manua*l

To help avoid delays in payment, please have someone review your billing system to ensure that all required information is being submitted correctly.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Verifying eligibility for undocumented aliens*

Eligibility information for undocumented aliens will not be reflected on the Tennessee Anytime Web site. Providers should call TennCare*Select* at 1-800-276-1978 to verify eligibility

Medical emergency services (inpatient and outpatient), along with maternity services are the only benefits available to the Undocumented Alien population. Maternity benefits consist of labor and delivery services only.

Reminder: filing dialysis claims appropriately

Effective April 1, 2008, BlueCare and TennCare*Select* dialysis claims will be denied if the claim is filed with:

- condition code 71 billed with revenue code 084X and 085X, or
- revenue codes 0380, 0381, or 0382 are billed with value code 37, and no units are indicated.

We encourage providers to review the dialysis billing guidelines available in the *BlueCare Provider Administration Manua*l located on the Provider page of the company Web site, www.bcbst.com and on the Blue*Source Provider Information* CD.

If you have questions, please call the appropriate BlueCare or TennCare*Select* Provider Service line†.

BlueCare and TennCare*Select* migrates to BCBST claims processing system

Beginning April 1, 2008, BlueCare and TennCare*Select* will transition their claims processing system to the processing system used for BlueCross BlueShield of Tennessee commercial lines of business. This migration will modify the appearance of some reports providers receive, as they will more closely match documents generated from our commercial processing system. Transitioning to one processing system for both our Medicaid and commercial business brings more uniformity for providers who service both populations. Some key changes resulting from this transition are outlined below:

Clinical Editor
Effective April 1, 2008, Clear Claim Connection, BlueCare and TennCare*Select*'s interactive online code auditing disclosure tool will be available for claims with dates of service prior to the April 1 date. Commercial Code Bundling (which will become Commercial and Medicaid Code Bundling) will be utilized for all claims submitted with dates of service April 1, 2008, and after. Bundling rationale can be found on the Provider page of the company Web site, www.bcbst.com.

Explanation of Capitation Detail (EOC) and Retro checks
Capitated providers will notice a layout modification on their monthly EOCs. During the system migration, providers may receive up to four EOCs and checks depending on their membership mix and any capitation retroactivity – one from each processing system for each line of business.

Interim Bills
Effective with date of service April 1, 2008, and after, front-end paperless edit modifications will require all BlueCare and TennCare*Select* interim bills be billed in 30-day increments thus aligning the interim billing guidelines between our commercial and Medicaid lines of business. This modification will apply the following five additional paperless edits to BlueCare and TennCare*Select* claims:

Code Edit Description	
150010	FACILITY TYPE CODE NOT ACCEPTED
150056	STMT ROM DT <>ADMIT DT – 1ST INTERM
150057	TOB 113 FROM DT NOT >=ADM DT +29
150074	TOB 112/113 ACCOM DAYS NOT 30 OR >
150075	TOB 112/113 THRU DT NOT>=FROM DT+30

More information regarding paperless edits may be found in the E-Commerce section on our Web site, www.bcbst.com.

Negative Balances
Any negative balances which may be created from claim overpayment activity will appear in a similar format as the commercial line of business

New BlueCare and TennCareSelect Group Number
BlueCare and TennCare*Select* member group numbers will change to **125000**. This new number will be reflected on member ID cards, EOCs, letters generated through our core processing system and when performing member-specific activities in BlueAccess, the secure area on our Web site, www.bcbst.com.

Primary Care Practitioner (PCP) Membership Listings
PCP Membership Listings will have slight formatting changes; however the overall content and layout will remain the same as current listings.

Remittance Advice Explanation Codes
Remittance advice explanation codes and descriptions will reflect those found on commercial remittance advices. These same codes and descriptions will also apply to online remittance advices, available in BlueAccess.

Remittance Advices (RA) Adjustments and Subrogation Claims
RAs and the adjustment summary page will be redesigned to have the same format as the commercial RA. Subrogated claims will also display on RAs in a similar format as commercial claims.

Third Party Liability (TPL) Claims Report
Formatting changes to the TPL Claims Report will continue to provide other insurance information for any BlueCare or TennCare*Select* member whose claim was denied due to the existence of a primary carrier.

Web site
BlueAccess will continue to support eligibility and claims inquiry capability, as well as authorization submissions for BlueCare and TennCare*Select* members. Additionally, providers will be able to access commercial, BlueCare and TennCare*Select* information through a single BlueAccess entry point.

If you have questions about these changes, please call the appropriate BlueCare or TennCare*Select* Provider Service line†.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Terms and Conditions Web finder now available

Any Blues Plan offering a private fee-for-service (PFFS) product must publish the Plan's *Terms and Conditions of Plan Payment* on its Web site.

In conjunction with the BlueCross BlueShield Association, all Blue Plans now have a "neighborhood" link allowing providers access to the appropriate Plan's document by entering the first three letters of the member's ID number.

Providers may view/utilize this tool on the BlueCross BlueShield of Tennessee Web site at <http://www.bcbst.com/providers/macheck.shtml>.

Correction: Code edit changes for oral supplements

In the November 2007 issues of BlueAlert we advised that claims filed to BlueCare and TennCare*Select* for oral supplements with a "BO" modifier for members age 21 years and older will pend for retrospective claims review based on guidelines listed in the Medicaid and Standard TennCare Exclusion Rules. In the article, we inadvertently listed an incorrect code. The correct codes are:

- B4102
- B4149
- B4150
- B4152
- B4153
- B4154
- B4155

Additionally, B4100 will pend for retrospective claims review; however, it is not to be billed with "BO" modifier.

We apologize for any inconvenience this error may have caused.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Medical record documentation and proper ICD-9-CM coding

The Centers for Medicare & Medicaid Services (CMS) risk adjustment model relies on accurate ICD-9-CM diagnosis codes to prospectively reimburse Medicare Advantage Organizations, including BlueCross BlueShield of Tennessee, based on the health status of their enrolled beneficiaries.

To help ensure proper payment, providers should:

- conduct regular patient appointments while reporting the patient's conditions at a minimum of once per year;
- include documentation of all conditions treated or monitored at the time of the visit in support of the reported diagnoses codes;
- report ICD-9-CM diagnosis codes to the highest level of specificity and accuracy; and
- ensure documentation in medical records is accurate, legible, and authenticated by the respective provider.

Providers are required to report any erroneous data that has been submitted to the health plan. Identifying and correcting these errors can help ensure appropriate reimbursement. Using up-to-date superbills and coding tools may reduce errors and improve accuracy in coding to the highest level of specificity. More information on reporting errors is found in the *BCBST Provider Administration Manual* located on the Provider page on the company Web site, www.bcbst.com.

BlueCross BlueShield of Tennessee's Risk Adjustment department continually conducts medical record reviews to monitor and improve medical record documentation.

Providers may receive requests by the Risk Adjustment area for medical records with specific dates of service for review. Medical records can be mailed, faxed or retrieved from the provider's office by a Risk Adjustment Nurse Coordinator.

Cover Tennessee

ADMINISTRATIVE

Front end claim edits being implemented for diagnostic and therapeutic radiopharmaceutical services

Effective April 1, 2008, BlueCross BlueShield of Tennessee will implement front end edits on Cover Tennessee claims for Revenue Codes 0343 (Diagnostic Radiopharmaceuticals) and 0344 (Therapeutic Radiopharmaceuticals). These services are not separately reimbursed under the Cover Tennessee Plans. No adjustments will be made on claims incurred prior to the April 1 effective date.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; CoverTN; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the new "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 2Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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April 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective May 10, 2008

- Evoked Otoacoustic Emissions (OAE)
- Ingestible Video Capsule Imaging of the Gastrointestinal Tract
- Wireless Pressure Sensors in Endovascular Aneurysm Repair

Note: Effective date(s) apply to BlueCare® and TennCare*Select* pending State approval.

ADMINISTRATIVE

Real-time claim estimation/adjudication online application enhanced

The "patient search" function of the *Real-Time Claim Estimation/Adjudication* application located on the secure area on our company Web site, www.bcbst.com was recently enhanced. It is no longer required to enter the alpha suffix when entering the patient's ID number. Once the ID number is entered, the application will provide a list of all family members associated with that ID number. Simply click on the family member's name to select the patient for whom you wish to enter an estimate or submission.

The application tutorial (available just below the Real-Time Claim Estimation/Adjudication link on BlueAccess,) details the enhanced functionality. Additional enhancements are forthcoming and will be communicated to you as they become available.

Reminder: Allow adequate time before requesting claim status

When requesting status of a claim, we encourage providers to wait at least 30 days from the date a claim has been submitted before calling us. This will help ensure adequate time for successful submission and claims processing.

Providers may also check claims status online through BlueAccess, the secure section on BCBST's Web site, www.bcbst.com.

Reminder: Billing Workers' Compensation claims

In most cases, Workers' Compensation claims are excluded from the member's contract. However, the provider should still:

- file the claim for the member with BlueCross BlueShield of Tennessee;
- submit the claim within 120 days from the date of service to avoid timely filing denial; and
- indicate in the appropriate claim field if injury is work-related.

Once a denial is received, the claim should then be filed with the member's Workers' Compensation carrier.

Changes to CMS-1450 billing guidelines*

Effective for dates of service May 1, 2008, and after, BCBST will require a valid HCPCS/CPT® code be filed on a CMS-1450 claim form when billing Revenue Codes 0636, 0920-0929, and 0940-0949. For Revenue Codes 0343 and 0344, HCPCS/CPT® Codes are preferred, if applicable.

This billing guideline only applies to BCBST commercial lines of business.

Clarification: Network acceptance requirements for nurse practitioner (NP) and physician assistant (PA)

In an effort to clarify network acceptance requirements for nurse practitioners and physician assistants in one of BlueCross BlueShield of Tennessee's provider networks, the following applies:

- The oversight physician(s) must participate in the network the NP and/or PA is requesting to participate;
- The NP and/or PA must have admitting privileges or the provision for at a BlueCross BlueShield of Tennessee participating hospital; and
- The NP and/or PA must be of the same scope of practice as the oversight physician(s).

For questions regarding network participation, please call the BCBST Provider Service line†.

Reminder: Filing the provider legacy number appropriately on CMS-1450 claim form

A number of CMS-1450 (UB-04) institutional claims have recently been received reflecting the provider legacy number incorrectly in Form Locator 57, *Other Provider ID*, causing claims to reject. The title for this field is typed vertical rather than horizontal appearing to be a label for each "A", "B", or "C" line when it is not.

The provider's legacy number should be entered in Form Locator 57 on line, "A", "B", or "C" depending on whether the provider is primary (A), secondary (B) or tertiary (C).

To help avoid delays in payment, please review your billing system to ensure all required information is being submitted correctly.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Reporting anesthesia services appropriately

According to Current Procedural Terminology (CPT®), services for the administration of anesthesia are reported by the use of the anesthesia five-digit procedure codes (00100-01999) plus any applicable anesthesia modifier codes.

The following components are considered an integral part of the anesthesia service and are not considered for additional payment:

- Pre-anesthesia evaluation;
- Postoperative visits;
- Anesthetic or analgesic administration;
- Usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry);
- Intraoperative administration of drugs, I.V. fluids and supplies, blood, etc., and;
- Services administered in recovery room.

Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included in the primary anesthesia service.

Drugs, I.V. fluids and supplies are considered a part of the Ambulatory Surgery Center and/or the Outpatient Facility fee. These should not be billed separately.

Reminder: Acknowledgement of financial responsibility

If a BCBST 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) and any related services. The Waiver form may also be utilized in the event the member requests non-emergency, cosmetic, or elective services specifically excluded under the member's health benefits plan. An example of another use of the form is when a member requests more advanced imaging services rather than, or in addition to, routine radiological services. If BCBST does not authorize the higher-tech imaging services due to Medical Necessity, the member can sign the waiver form accepting financial responsibility for those services.

To assist in this process, BCBST developed for provider use the *Acknowledgement of Financial Responsibility for the Cost of Services* form. A copy of this form can be found on the company Web site, www.bcbst.com and in the provider administration manuals included on *BlueSource*, BCBST's quarterly provider information CD. We **strongly** encourage providers use this form as it meets the contractual obligations of BCBST provider Agreements. However, if a provider elects to use his/her own form, it is essential the signed statement includes the following information:

1. The name of the specific service/procedure the Provider will perform;
2. The 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. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
5. A 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;
6. A statement indicating the form is only valid for one (1) service/procedure; and
7. A specific expiration date.

Providers should keep the signed statement on file as it may be necessary to provide a copy to BCBST verifying the member's agreement to the financial responsibility.

BlueCard®

ADMINISTRATIVE

BlueCross and BlueShield Association (BCBSA) provider satisfaction initiative

Since 2005, the BlueCross and BlueShield Association has administered online surveys to help support its Provider Satisfaction strategy initiative. These online surveys were in addition to the bi-annual Provider Satisfaction Survey and were performed with a number of providers from 13 participating Blue Plans.

Beginning this year, the Association will be offering an online survey to providers from all BlueCross and BlueShield Plans. This process will help improve the validity of the survey by increasing the number of respondents and providing us with broader outcomes on specific topics of interest and emerging issues. In addition to online surveys, the Association plans to work with specific BlueCross and BlueShield Plans by contacting providers interested in participating in several upcoming focus groups. Please note participation in the focus groups is strictly voluntary.

Reminder: Blues move to automatic crossover for all Medicare claims

All claims automatically submitted to the secondary payer

Effective Jan. 1, 2008, all Blue Plans began crossing over Medicare claims for services covered under Medigap and Medicare supplemental products. This results in automatic claims submission of Medicare claims to the Blue secondary payer, and reduces or eliminates the need for additional claims submission to the secondary carrier. Medicare claims will crossover in the same manner nationwide with all Blue Plans participating in this process.

Providers can learn more about the Medicare crossover process by visiting the company Web site at http://www.bcbst.com/providers/news/.

BlueCard®

ADMINISTRATIVE (cont'd)

Get faster, easier information electronically for Blue members

Want a faster and easier service that reduces the time your office staff spends checking eligibility and claims status for Blue members?

With one click of a mouse, you can directly access BlueCross BlueShield of Tennessee's electronic gateway for:

- **Checking Eligibility** - Get a faster way to verify eligibility and benefits for members of other Blue Plans.
- **Viewing Claim Status** - Avoid unnecessary resubmission by checking claims status electronically for Blue members.
- **Timely Electronic Transactions** - Go electronic and get faster responses to your inquiries for local members and members from other Blue Plans.
- **Reliable Local Service** - BlueCross BlueShield of Tennessee is your single point of contact for submitting claims electronically. Use electronic capabilities to reduce your time completing claims forms and get faster and more accurate claims processing.

For more information on electronic services, please call the BCBST Provider Service line†.

BlueCare/TennCare*Select*

ADMINISTRATIVE

NOTICE: BlueCare and TennCare*Select* migration to BCBST claims processing system delayed

In the March 2008 BlueAlert, we informed providers that effective April 1, 2008, BlueCare and TennCare*Select* would be transitioning to the claims processing system used for BlueCross BlueShield of Tennessee commercial lines of business. This transition has been delayed until May 1, 2008.

Reminder: Reporting National Drug Code (NDC) on CMS-1450 institutional claim forms

We recently communicated effective April 1, 2008, institutional claims submissions must include the NDC of the drug(s) administered, along with the correct quantity and unit for BlueCare and TennCare*Select* **outpatient hospital claims**. When an NDC code is required, **all** of the following data elements are required in addition to the HCPCS/CPT® code. Institutional claims containing NDCs with less than 11 digits and the data elements will be processed and only the individual line(s) containing J-codes with missing NDC information will be rejected.

Item	Description
NDC Qualifier	N4
NDC Number	11 - digit number
NDC Quantity Qualifier	F2 – International Unit GR – Gram ML – Milliliter UN - Unit
NDC Quantity	Numeric value
NDC Unit Price	(ANSI-837 only)

Note: This requirement does not apply to commercial lines of business.

Bureau of TennCare announces implementation date for tamper-resistant prescription pads*

In the October 2007 issue of *BlueAlert*, we advised that effective Oct. 1, 2007, prescriptions for TennCare patients could not be filled at the pharmacy unless written on a tamper-resistant prescription pad. Subsequently, a six-month delay of this requirement was announced in the November 2007 issue of *BlueAlert*.

Recently, the Bureau of TennCare, in accordance with a Centers for Medicare & Medicaid Services (CMS) requirement, announced effective April 1, 2008, **all** TennCare patient prescriptions must be written using tamper-resistant pads/paper with limited exceptions outlined below:

1. Refills of written prescriptions presented at a pharmacy before April 1, 2008;
2. Prescription sent to the pharmacy electronically (either by e-prescribe or by fax;
3. Prescription communicated to the pharmacy by telephone; or
4. Drugs administered in nursing facilities and intermediate care facility for the mentally retarded.

Additionally, on or after Oct. 1, 2008, pharmacists **cannot** fill prescriptions for TennCare members unless the prescription is written on a tamper-resistant pad or unless the prescription is subject to one of the above listed limited exceptions.

If you are not using tamper-resistant prescription pads, contact your local supplier and order a supply prior to Oct. 1, 2008.

Providers may view the announcement in its entirety in the "NEWS" section located on the Provider page of the company Web site, www.bcbst.com, the Centers for Medicare & Medicaid Web site, http://www.cms.hhs.gov/ or the Bureau of TennCare Web site, <http://state.tn.us/tenncare/pro-pharmacynews.html>.

If you have any questions, please call the appropriate BlueCare or TennCare*Select* Provider Service line†.

Completing claims form information appropriately helps expedite claims payment

Recently, a number of institutional claims have been received with statement dates not equal to the number of room and board units filed. Claims submitted with incorrect information entered in Form Locator 6 on paper CMS-1450 Health Insurance Claim form or in loop 2300 on the electronic ANSI8371 version 4010A1 will be returned unprocessed to the provider

To help avoid delays in payment, please review your billing system to ensure all required information is being submitted correctly.

BlueCare/TennCare*Select*

ADMINISTRATIVE

TennCare pharmacy preferred drug list (PDL)

Effective April, 1, 2008, TennCare will make revisions to its PDL. The revised PDL can be viewed in its entirety on the Provider page of the company Web site, www.bcbst.com or via the TennCare Pharmacy Benefits Manager, First Health Services Corporation Web site at http://tennessee.fhsc.com.

Reminder: Erythropoietin stimulating agents require prior authorization

Effective Feb. 1, 2008, BlueCare and TennCare*Select* began requiring prior authorization for self-administered and provider-administered erythropoietin stimulating agents before dispensing from a pharmacy or for outpatient administration.

Authorization is based on medical appropriateness criteria, such as hemoglobin and hematocrit levels, which can be found online in the *BCBST Medical Policy Manual* at <http://www.bcbst.com/UpcomingMPs/upcoming_mps.htm>. These medications, which include epoetin alfa (Procrit®; Epogen®) and darbepoetin alfa (Aranesp®) are available through the Bureau of TennCare's Pharmacy Benefits Manager, First Health Services Web site at https://tennessee.fhsc.com/.

Correction: National Provider Identifier (NPI) Reporting requirement letter

In a letter dated Feb. 21, 2008, to all institutional and professional providers we advised when submitting BlueCare institutional paper claims on the CMS-1450 claim form that Form Locator 75 should be used for the claim and line level attending provider and Form Locator 76 -78 should be used for all non-billing providers.

The letter should have stated that BlueCare institutional paper claims filed on the CMS-1450 claim form should use Form Locator 76 for the attending provider and Form Locator 77-78 should be used for all non-billing providers.

We apologize for any inconvenience this error may have caused.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Risk adjustment data validation

Annually, the Centers for Medicare and Medicaid Services (CMS) randomly selects Medicare Advantage (MA) Organizations for risk adjustment data validation. Data validation audits occur after risk adjustment data has been collected and submitted, and payments are made to the organizations. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is with in the data collection period, and ensuring the provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed on the organization.

At the recommendation of CMS, BlueCross BlueShield of Tennessee has developed its own independent Risk Adjustment Data Validation process by which medical records will be requested and reviewed by the Provider Audit department. This process includes validation of diagnoses and procedure codes through the identification of supporting documentation in the medical record.

Note: All requested records for data validation purposes should be provided promptly. Effective **July 1, 2008**, any claim payment associated with records not received will be recouped from the provider, since the claim cannot be substantiated by the medical record.

CoverTN

ADMINISTRATIVE

Filing diagnosis codes appropriately on rehabilitation therapy claims

When submitting claims for speech, occupational or physical therapy, it is imperative the first listed diagnosis is indicative of the reason for the visit. Providers should always list the first diagnosis as the reason they are seeing the patient.

For example, if a patient having Downs Syndrome is being seen for speech therapy, the provider would list the actual reason for the service first (i.e., 315.02 – developmental dyslexia) with Downs Syndrome listed as secondary diagnosis. The Downs Syndrome will be considered incidental to the visit, but should be listed as it gives a comprehensive picture of the case.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 2Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert
provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

May 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective June 14, 2008

- Esophageal pH Monitoring
- Genetic Testing for Congenital Cardiac Channelopathies
- Histrelin Acetate Implant (Supprelin LA)
- Nilotinib (Tasigna®)
- Sorafenib (Nexavar®)
- Ixempra (Ixabepilone)
- HepaGam B
- Intravenous Immune Globulin

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

Electronic safety alerts initiative launched

A new electronic service is being launched by iHealth Alliance and managed by Medem, a health IT firm founded by the American Medical Association (AMA) to furnish Federal Drug Administration (FDA) patient safety alerts to clinicians.

This new service will provide a more systematic and faster way for clinicians to receive important FDA notifications. We believe a more rapid delivery of FDA-mandated product recalls and warnings targeted to clinicians is an important way to improve patient safety.

This service is offered free of charge and will only be used for patient safety notices. To register and/or learn more about this important initiative, visit the Health Care Notification Network Web site, http://hcnn.net/.Providers may opt out of the service at any time.

New drugs added to commercial specialty pharmacy listing

Effective April 1, 2008, the following drugs have been added to our specialty pharmacy listing. These drugs do not require prior approval.

Self-administered via medical benefit

- Tasigna (step therapy)

Provider-administered via medical benefit

- Ixempra

MedSolutions head imaging requests

Tips from the desk of Dr. Diana Reed, Neurologist

One of the most frequent requests for prior authorization is for brain imaging due to headaches. Many requests require additional information. It is important to document:

- Duration and frequency
- Characteristic of onset: sudden and severe or gradual
- Headaches that awaken from sleep
- Onset (not exacerbation) with exertion
- Focal findings on neurological examination including papilledema, hyperreflexia, or other cranial nerve deficits.
- Failure of a 3-4 week trial of migraine specific treatment, including a preventive treatment if the headaches occur more than 2 times per week

MSI Head Imaging Guidelines support the following:

Worsening headaches despite treatment with a normal neuro exam: MRI brain without contrast. If there are focal neuro findings or symptoms: MRI brain with and without contrast. Head CT when there is concern for an acute bleed, stroke, or head trauma.

Migraines are commonly associated with nausea, vomiting, photophobia, phonophobia, non-specific blurred vision or dizziness, and often do not improve with over-the-counter analgesics. These symptoms are not indications for advanced imaging. Also, keep in mind that most brain tumors and aneurysms do not present with recurrent headaches, but with focal neurological signs or seizures.

ADMINISTRATIVE

Appropriate use of revenue code 0001*

When filing a CMS-1450 (UB-04) facility claim form, providers should not enter a line item total for Revenue Code 0001. This information was previously required on the old UB-92 facility claim form, which has been discontinued. The new UB-04 claim form has a specific line for entering Revenue Code 0001 total charges (FL 23). To help prevent future delays in claims payment, we encourage providers to reference the UB-04 Data Specifications Manual for detailed instructions on the appropriate use of Revenue Code 0001.

Changes to facility audit notification letter process

Effective June 1, 2008, all provider audit adjustment notifications will ONLY be mailed to the provider's remittance address stored in BCBST's claims processing system.

This change is a result of system changes and a move to a more "green planet" process. Providers will need to notify their staff to forward any audit communications as required.

Correction: Requesting benefits for nuclear stress testing

In the March issue of BlueAlert, we advised providers to have the procedure code available and/or indicate if the service is considered routine or non-routine when requesting benefits for nuclear stress tests. The article should only have directed providers to have the specific procedure code available for us to quote accurate benefits information.

We apologize for any inconvenience this matter may have caused.

BlueCard®

ADMINISTRATIVE

Clarification: Get faster, easier information electronically for Blue members

In the April issue of *BlueAlert*, we advised providers to call the BCBST Provider Service line† for more information on electronic services available for Blue members. Although providers can access this information via this line, we omitted to inform them they can also call the eBusiness Solutions Marketing department directly at 423-535- 3057, Monday through Friday, 8 a.m. to 4:30 p.m. (ET) or e-mail their inquiries to ecomm_marketing@bcbst.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Correction: National provider identifier (NPI) reporting requirement

Effective April 22, 2008, BlueCare and TennCare*Select* claims will not reject if filed with a provider name and no other provider identifier in the *Secondary Provider* fields. However, if any secondary provider identifier is filed on the claim, including but not limited to UPIN, license, legacy, tax ID, etc., then a valid NPI must be present for the claim to be adjudicated.

Any claims previously rejected due to only the provider name appearing in the secondary provider fields will be reprocessed and applicable member benefits applied. Processing of these claims should be completed by the end of April.

If you have any questions, please call the appropriate BlueCare or TennCare*Select* Provider Service line†.

CoverTN

ADMINISTRATIVE

You can assist your patients in getting the coverage they need

Providers can help enroll their patients in CoverKids, the State of Tennessee's comprehensive health insurance coverage for uninsured children and qualified pregnant women.

If you are aware of patients who have been released from TennCare, chances are they will be eligible for CoverKids. Application packets can be mailed to your office and/or a Policy Studies Inc. (PSI) Outreach Coordinator can visit your office to provide education on how the forms should be completed. The CoverKids application can also be found online at <http://www.covertn.gov/web/coverkids_app.html>.

If you have any questions about CoverKids eligibility, please call Policy Studies, Inc. at 1-866-620-8864 or contact the PSI Outreach Coordinator in your area:

West Tennessee
Shelton Knox - 901-679-5222
sknox@policy-studies.com

East Tennessee
Rae Clarke - 423-364-6388
rclarke@policy-studies.com

Middle Tennessee
Molly O'Neil - 615-794-3870
moneal@policy-studies.com

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Risk Adjustment: Complete ICD-9 coding and documentation*

The Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans based on the health status of their enrollees as determined through ICD-9-CM diagnosis coding. This process is called Risk Adjustment.

The primary source of data used by CMS to determine patient severity is claims and encounters from physicians and hospitals. If appropriate and complete diagnoses are not documented or submitted via claim, the risk score will reflect a healthier population than exists. Physicians and providers are asked to focus on complete diagnosis codes being reported to the highest level of specificity according to ICD-9-CM coding guidelines. All diagnosis codes reported should be supported by medical record documentation.

Provider's role in this process:

- Annually, restate chronic conditions being assessed or treated. Conditions such as quadriplegia, ostomies, ventilator dependency, and amputation status are often inconsistently documented.
- Document accurate and complete diagnosis. Documenting signs, symptoms or findings related to the disease is incomplete. Examples: "FBS 300" and "lipids" would accurately be coded as abnormal lab results rather than uncontrolled diabetes or hyperlipidemia, respectively.
- Code to the highest level of specificity possible. Comprehensive documentation should support the patient's complete medical picture. For example, "Bronchitis" is an example of non-specific documentation - coding would be limited to 490 or "bronchitis not specified as acute or chronic." Documenting "chronic obstructive bronchitis" or "chronic bronchitis" allows for more accurate coding and for risk score adjustment- further specificity could include 491.21 or "chronic obstructive bronchitis with acute exacerbation."

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; CoverKids; Access TN **1-800-924-7141**
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
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BlueAdvantage **1-800-841-7434**
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*These changes will be included in the appropriate 2Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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June 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective July 12, 2008

- Acoustic Immittance Measures for Hearing
- Gene Expression Profiling Assays as a Technique to Determine Prognosis for Managing Breast Cancer Treatment

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

New drugs added to commercial specialty pharmacy listing

The following drugs have been added to our specialty pharmacy listing. Drugs requiring prior approval are identified with a "PA".

Self-administered via medical benefit

- Acthar (HP) Gel (PA)

Provider-administered via pharmacy benefit

- Acthar (HP) Gel (PA)
- Somatuline

Changes to commercial preferred drug listing (PDL)

The following drug has been added to the PDL prior authorization list:

- Lamisil Oral Granules (for ages 4 years and older and for the diagnosis of Tinea Capitis).

The following drug has been added to the PDL quantity limitation list:

- Plavik 300mg, one tablet/30 days: primarily used for one-time initial dosing.

Clinical Practice Guidelines Adopted

BlueCross BlueShield of Tennessee has adopted the following guidelines as recommended best practice references:

ACC/AHA 2005 Guideline Update for the Dx and Mgt. of Chronic Heart Failure in the Adult
<http://www.acc.org/qualityandscience/clinical/guidelines/failure/update/index.pdf>
American Academy of Neurology Practice Parameter: Evidence-Based Guidelines for Migraine Headache (an Evidence-Based Review)
<http://www.neurology.org/cgi/reprint/55/6/754.pdf>

AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update
<http://circ.ahajournals.org/cgi/content/full/113/19/2363>

2008 Pediatric Immunization Schedules and Childhood, Adolescent and Catch-up Schedule
<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>

AHA/ASA Guidelines: Guidelines for the Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack
<http://stroke.ahajournals.org/cgi/content/full/37/2/577>

ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina/Non–ST-Elevation Myocardial Infarction
<http://www.cardiosource.com/guidelinefocus/gfc_acs.asp>

Hyperlinks to these guidelines are available within the *BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual*, which can be viewed in its entirety on the company Web site at http://www.bcbst.com/providers/hcpr/. Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

ADMINISTRATIVE

No Vaccines? – Remember your local health department

BCBST understands that not all providers maintain an inventory of, or administer vaccines such as Typhoid, Meningitis, Zostavax and Pneumonia in the office. As a reminder, patients needing vaccinations unavailable to them in your office should be referred to the local health department for these services.

Reminder: Submitting claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

DMEPOS claims must be billed on a CMS-1500 claim form using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers, i.e., NU, RR, and UE are required if published on the DMEPOS fee schedule. Fee schedules can be viewed online on Cigna's Web site under Coverage & Pricing at <http://www.cignagovernmentservices.com/partb/index.html>.

Some common supplies requiring pricing modifiers are blood glucose test strips and continuous positive airway pressure (CPAP) supplies. Pricing modifiers should be entered in the first modifier position in Block 24D and descriptive modifiers required by Medicare should be entered in the second and subsequent modifier fields. Claims filed without appropriate modifiers will be returned to the provider resulting in claims payment delays.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

BCBST adds new physician specialty*

BCBST now recognizes Hospital Medicine as a new BCBST approved specialty. In an effort to better direct BCBST members for health care, we will reflect this new specialty in our participating provider directory. Hospitalists, which are currently listed under Internal Medicine and new practitioners requesting hospitalist participation, will be listed under Hospital Medicine as their primary specialty.

Reminder: Health care debit cards

The number of Blue Cross and/or Blue Shield members carrying health care debit cards has substantially increased since their inception in 2005. These unique ID cards have value-added features to assist providers in collecting member cost-sharing amounts.

Some debit cards have the nationally recognized Blue Cross and/or Blue Shield logos, along with a major debit card logo such as MasterCard® or Visa®.

At the time services are rendered, the card should be debited for no more than the member copayment. If that amount is unknown, providers should **not** debit the card until the Remittance Advice is received reflecting member liability.

Reminder: Accessing physician quality and cost information

As previously communicated, the Physician Quality and Cost Information will be available for physician[1] review June 30, 2008. Prior to the release, physicians should have a BlueAccess user ID and password to access their quality and cost information.

First-time users can register by logging on to www.bcbst.com and clicking on "register now" in the BlueAccess section. Select "Provider" and follow registration instructions available at https://www.bcbst.com/secure/providers/.

YOU WILL NEED TO "REQUEST A SHARED SECRET"[2] FOR ALL PROVIDER ID NUMBERS THAT YOU NEED TO ACCESS.

After you have completed the registration process, you will be able to access the "Physician Quality and Cost Information link" on the main menu of BlueAccess.

For more information on BlueAccess registration, contact eBusiness Solutions at (423) 535-5717 or e-mail ecomm_marketing@bcbst.com.

[1] Hospital-based physicians and physicians who are in a specialty that is not board-eligible are excluded.
[2] A "Shared Secret" is required. Your staff may already have your "Shared Secret".

Reminder: Duplicate claims mean delays

What should you do if you haven't received a response to your initial claim submission?

- Don't automatically submit another claim
- Do wait 30 days
- Do check claims status online before re-submitting

Before you resubmit a claim because you haven't received your payment or a response regarding your payment, think again!

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.

If you resubmit a claim within 30 days, BlueCross BlueShield of Tennessee may deny the claim as a duplicate or suspend the claim for investigation. The member may also be confused and dissatisfied if they have to call customer service regarding a second Explanation of Benefits (EOB). After you have ensured all the necessary information is accurate, including the member's complete identification number, (which incorporates the three-character alpha prefix); we suggest that you wait at least 30 days before resubmitting a claim.

The next time you do not receive your payment or a response regarding your payment, please contact BlueCross BlueShield of Tennessee or visit our Web site, www.bcbst.com to check on the status of your claim, or submit electronic claims status inquiries.

If you have any questions, please call 1-800-705-0391.

~Claims filing tips~

In an effort to help alleviate some of the more common billing errors, we offer the following tips when filing claims for BCBST members:

- **Outlier and Threshold claims** require an occurrence **code** of **47** and the date the claim moved into this status.
- **Therapy claims** require a modifier if the services rendered are under a plan of care.
- When making a **correction** to a previously submitted CMS 1500 claim form, you must include all prior reimbursed line items plus the changes to be made in order to avoid a refund request on previously submitted charges.
- When **adjusting** a previously submitted **facility claim,** use the applicable bill type:
  XX7=Adjustment
  XX8=Cancel

Billing guidelines are outlined in the Billing and Reimbursement section of the *BCBST Provider Administration Manual* found on the Provider page on the company Web site, www.bcbst.com .

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Check your electronic confirmation report

If you file electronic claims to BlueCross BlueShield of Tennessee, please remember to review your EM735 Confirmation Report for errors. Providers should correct any errors identified on this report and resubmit the claims to us in order to ensure prompt payment.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Reminder: Risk adjustment medical record authentication

For purposes of risk adjustment data submission and validation, Medicare Advantage Organizations, such as BlueCross BlueShield of Tennessee, are required to ensure that the provider of service for face-to-face encounters is appropriately identified on the medical records via his/her signature and physician specialty credentials. All dates of service identified for review must be signed (with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner). This means that the credentials for the provider of services must be somewhere on the medical record—either
next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider.

Acceptable physician authentication includes handwritten signatures or initials, signature stamps, and electronic signature with authentication by the respective provider. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note.

For additional information related to Risk Adjustment visit the Centers for Medicare and Medicaid Web site <http://mcoservice.com/new/usergroup/traininginfo.html>.

For additional information related to Practice Site Standards/Medical Record Practices visit the Credentialing section of the BCBST Provider Administration Manual located online at http://www.bcbst.com/providers/manuals/.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Use of dedicated fax number helps expedite standard appeals

BlueCare/TennCare*Select* recently added a dedicated toll-free fax number, 1-888-357-1916 solely for use in faxing standard appeals for denied services. This enhanced process will help expedite standard appeals and ensure the most current information is available to providers when checking the status of an appeal.

When faxing a standard appeal, the following documentation must be provided:

- The principle reason for upholding the non-certification determination;
- Detailed clinical rationale; and
- Pertinent medical records for the specific case being appealed.

Reminder: LabOne no longer exclusively providing routine outpatient laboratory services

Effective March 1, 2008, providers may utilize any BlueCare/TennCare*Select* participating independent lab. Previously, LabOne exclusively provided routine outpatient laboratory services to BlueCare/TennCare*Select* members. Lab services provided by participating labs do not require prior authorization; however, authorization is required when services are provided by non-participating labs.

New name of TennCare*Select*'s Best Practice Network (BPN) Unit

Volunteer State Health Plan's BPN Unit, which provides assistance for children in custody of the Department of Children's Services, is changing its name to *Select*Kids.

Only the name is changing; the services provided by the *Select*Kids Unit will not change. Providers may verify eligibility by calling 1-800-451-9147, Monday through Friday, 8 a.m. to 6 p.m. (ET).

Reminder: Healthcare Effectiveness Data and Information Set (HEDIS®) global procedure code information letter

In a letter dated May 1, 2008, we advised the Amended and Restated Contractor Risk Agreement between the State of Tennessee and Volunteer State Health, Inc., (VSHP) requires VSHP to report HEDIS® performance measures developed by the National Committee for Quality Assurance (NCQA) annually for its BlueCare and TennCare*Select* populations. Performance measures that require medical record review in order to obtain required report data include prenatal/postpartum care.

Beginning June 1, 2008, global codes will not be considered for reimbursement unless the Category II codes have been submitted prior to receipt of the global code or the global code is accompanied by one of the Category II codes. Reimbursement of global obstetric delivery services may be recouped unless the postpartum care visits (0503F) are submitted within 21 to 56 days of delivery.

CPT® Codes and Descriptions

59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care.

59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Reminder: Healthcare Effectiveness Data and Information Set (HEDIS®) global procedure code information letter (cont'd)

59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.

59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

Category II Codes and Descriptions

0500F - Initial prenatal care visit.

0501F - Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum: blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period – LMP.

0502F - Subsequent prenatal care visit.

0503F – Postpartum care visit.

Current Procedural Terminology (CPT®) contains a set of supplemental tracking codes (Category II) that can be used for performance measures in patient management. These codes can be used for performance measurement purposes in lieu of sending medical records or scheduling an onsite medical record review.

Typically, the clinical component of these Category II codes may be included in the evaluation and management, or other clinical service codes, and does not have a relative value. The entire code description can be viewed in the *2008 CPT® Manual*. Providers should refer to the *CPT® Manual* and other CPT® coding resources for additional guidelines in effect for the date of service.

If you have any questions, please call the appropriate BlueCare or TennCare*Select* toll-free Provider Service line†.

BlueCard®

ADMINISTRATIVE

New BlueCard Web page up and running*

Visit our new BlueCard Web page located on the company Web site, www.bcbst.com. There you will find printable brochures, BlueCard tutorials, program description and much more. Watch for more information being added in the near future.

Reminder: How to identify BlueCard out-of-area plan members

There's an easy way to identify out-of-area members through BlueCard. When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

Each BlueCard member's identification number on the card may contain alphanumeric characters but will always begin with at least three alpha characters. The alpha prefix is key to facilitating prompt payments. The member ID is a combination of alpha and numeric characters.

Once you find the alpha prefix, you should call BlueCard *Eligibility*® at 1-800-676.BLUE (2583) to verify the patient's membership and coverage (*for faster processing, use electronic capabilities.)* Provide the member's alpha prefix and you will be routed to the member's Blue Plan.

In addition, the ID cards may have logos that appear on the front of Blue Plan member ID cards:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

When you see these logos, it means that the cardholder participates in the BlueCard Program, which provides health care coverage for members outside their Blue Plan's area.

When either the blank suitcase or "PPO in a suitcase" logo appears on a Blue Plan member ID card, you should submit claims to BlueCross BlueShield of Tennessee.

Note: You may also see ID cards without a suitcase logo from other Blue National Account Members; you should submit all Blue claims to BlueCross BlueShield of Tennessee. For more information, please call 1-800-705-0391.

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†Provider Service lines

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Commercial Lines; Cover Tennessee; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage 1-800-841-7434
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 3Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert

provider news flash

of Tennessee
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Please Route to all Providers & Office Staff

July 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective Aug. 9, 2008

- Hypertension Therapy Using Low Level Electrical Stimulation
- Laser Therapy for Psoriasis

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

Modified Milliman Care Guideline updates/changes

BlueCross BlueShield of Tennessee's Web site has been updated to reflect upcoming modifications to select Milliman Care Guidelines®. The Modified Milliman Care Guidelines can be viewed on the Utilization Management Web page at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm>.

Effective Aug. 29, 2008

The following as relates to Ambulatory Care:

- Ambulatory/Day Surgery Criteria

The following as relates to Home Care:

- Hyperemesis Gravidarum

The following as relates to Inpatient and Surgical Care:

- Hysterectomy

The following as relates to Rehabilitative Care:

- Speech Therapy

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

Xyzal® not added to BCBST commercial drug formulary

Xyzal® (generic name levocertirizine) is a prescription medication used to treat indoor and outdoor allergies.

Xyzal® was recently reviewed by the BlueCross BlueShield of Tennessee Corporate Pharmacy and Therapeutics (P&T) Committee. This committee is composed of clinicians, many of whom are community practicing physicians and pharmacists.

After review of the clinical information, the P&T Committee opted NOT to include this drug on the BCBST commercial formulary.

ADMINISTRATIVE

Reminder: Oral drugs in the practitioner's office not covered

BCBST does not cover any oral medications in the practitioner's office (administered in the office or dispensed for home use) and we do not reimburse for any medication (oral or injectable) dispensed from the office for the patient's home use.

Practitioners should be cautious of marketing tools promoting new software that allows the physician to dispense medications in his/her office rather than the member having the prescription filled at a participating pharmacy.

Some employers and employees in Tennessee are not subject to Tennessee's Workers' Compensation Law, T.C.A. 50-6-101, et al.

Most employers and employees in Tennessee are subject to Tennessee's Workers' Compensation Law and are, therefore, required to seek benefits for their on-the-job injury claims pursuant to T.C.A. §56-6-101, et al. However, pursuant to T.C.A. §50-6-106, there are certain employers and employees to whom the Workers' Compensation Law does not apply, including the State of Tennessee, counties thereof and municipal corporations.

On-the-job injury claims for these exempt employers and employees should be processed as any other medical claim by BCBST. Providers should provide treatment for these individuals in the same manner as any other BCBST Member's medical care in the network. If anything specific is required for an on-the-job injury patient, i.e., a special report, then those expenses will be handled directly by the employer or employee and not submitted to BCBST.

Notwithstanding, the State, any county or municipal corporation may accept the provisions of T.C.A. 50-6-101, et al, pursuant to the provision therein.

BlueCross BlueShield of Tennessee offices will be closed Friday, July 4, 2008, in observance of the Fourth of July Holiday.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Do you anticipate an overnight stay for your patient's scheduled surgery?

Same day surgery does not require prior authorization; however, 23-hour observation stays do require prior authorization. When a physician's office staff contacts BCBST to verify whether a same day surgical procedure requires prior authorization and the physician anticipates the patient will require 23-hour observation care after the surgery, the requester should inform us of the anticipated stay at that time. Surgeries requiring 23-hour observation and corresponding authorizations are outlined in the Modified Milliman Care Guidelines located on the Provider page of the company Web site, www.bcbst.com.

If the physician performs same day surgery and then converts to a 23-hour stay, the physician should contact BCBST's utilization management department at 1-800-924-7141 soon after the surgery to obtain the authorization. In this instance, the facility may not have the appropriate clinical information available to obtain the authorization. However, it is ultimately the physician's and the facility's responsibility to contact BCBST to request the authorization and to provide the clinical and demographic information that is required to complete the authorization.

Prior authorization requests for 23-hour observation stays can receive online approval via *BlueAccess*, the secured area on the company Web site, www.bcbst.com. 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. This service is available 24-hours-a-day, 7-days-a-week for all registered BCBST commercial providers.

Remember to use your National Provider Identifier (NPI) when updating *BlueAccess*

Effective May 23, 2007, the NPI became the only provider identifier on electronic transactions. With the NPI compliance date, BlueCross BlueShield of Tennessee began communicating to its new providers via their NPI number rather than the BCBST provider legacy number.

It is important providers use the NPI number when updating permissions information on *BlueAccess*, BCBST's secured page on its Web site, www.bcbst.com. If you need *BlueAccess* technical or training assistance, please call eBusiness Solutions at one of the following numbers:

Technical inquiries 423-535-5717
Training inquiries 423-535-3057

Reminder: Corrected bills: use block 19 for all lines of business - block 22 only for BlueCare and TennCare*Select*

BlueCross BlueShield of Tennessee identifies corrected bills submitted on paper CMS-1500 claim forms by either the "CC" (corrected claim) data in Block 22 or the "CORRECTED BILL" wording listed in Block 19. BlueCare and TennCare*Select* may use either Block 19 or Block 22 when submitting corrected bills; however, we will only retrieve corrected billing data in Block 19 for our commercial lines of business.

Below is our **preferred** method for submitting corrected claims on a CMS-1500 claim form:

- 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 on 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 (all lines of business) **OR** "CC" in Block 22 (this information only retrieved for BlueCare and TennCare*Select*).

Tips:

- Do not use red ink. Our Optical Character Recognition (OCR) equipment does not recognize red ink.
- Do not use a thick marker or crayon that may cover other form fields.

Reminder: Provider appeal processes

A provider or provider representative may request reconsideration or appeal of any adverse decision. The following outlines the utilization management and administrative appeal processes:

Utilization Management
Level 1 Inquiry (Reconsideration):

- Initial denial - In the initial review, if the nurse cannot approve the treatment/services, he/she automatically refers the request to a BCBST medical director for review/approval. Additional information may be submitted for review.
- If the denial is upheld, the provider may request a peer-to-peer telephone discussion‡ of the adverse decision.

Administrative
Level 2 Appeal:

- If the decision remains upheld, the provider or provider representative may submit additional relevant and pertinent clinical information supporting the medical necessity of the treatment/services for review by an outside specialty-matched consultant‡.

Note: Exhausting the above steps satisfies the Appeals levels of the BCBST Provider Dispute Resolution Procedure (PDRP).

If the provider is still dissatisfied with the decision, the next and final step is binding

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Provider appeal processes (cont'd)

arbitration. Binding arbitration is defined in the BCBST Provider Dispute Resolution Procedure. This procedure and UM appeals processes can be found in their entirety in the provider administration manuals located on the Provider page on the company Web site, www.bcbst.com.

‡A provider can request a specialty-matched appeal or peer-to-peer telephone discussion at any appeals level. The provider office staff should only initiate a peer-to-peer discussion when the attending or ordering physician requests and is aware of discussion. To arrange a peer-to-peer discussion with a BCBST medical director, office staff should call one of the following numbers:

BlueCare or TennCare*Select*
1-800-924-7141

All other lines of business
1-800-228-2096

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Completing "patient relationship information" claim fields appropriately

Effective for dates of service on or after April 1, 2008, all BlueCare and TennCare*Select* claims submitted on paper CMS-1500 and CMS-1450 Health Insurance Claim forms or submitted electronically in the ANSI-837 version 4010A1 format without the correct insured and patient relationship information will be returned to the provider unprocessed. The required data form content and field description format for completing these fields can be viewed in the Billing and Reimbursement section of the *BlueCare Provider Administration Manual* available on the Provider page of the company Web site, www.bcbst.com or on Blue*Source*, BCBST's quarterly provider information CD.

Additional reference sources include:

- *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual* for 08/05 Version and
- *National Uniform Billing Committee UB04 Data Specifications Manua*l

To help avoid delays in payment, please have someone review your billing system to ensure that all required information is being submitted correctly.

New edit for BlueCare and TennCare*Select* electronic (EDI) professional claims

Beginning Aug. 1, 2008, a new front-end edit, **650084** (UNITS NOT EQUAL IN DATE SPAN) will be implemented for BlueCare and TennCare*Select* electronic EDI professional claims.

For claims filed with procedure codes ranging 99201 to 99499, the edit will compare the "date of service span" on the DTP (qualifier 472) segment in the 2400 Loop with the "unit" field on the SV1 segment.

If the unit field does not equal the number of days in the date span, the claim will reject with edit **650084,** which will be reflected on the provider's confirmation report.

For technical questions, please call eBusiness Technical Support at 423-535-5717, Monday through Friday, 8 a.m. to 5:30 p.m. (ET) or e-mail Ecomm_TechSupport@bcbst.com.

VSHP partners with ValueOptions® of Tennessee to provide behavioral health services

Beginning Nov. 1, 2008, VSHP will partner with ValueOptions® of Tennessee, Inc., as their new behavioral health partner for administering services in East and West Tennessee for BlueCare members. The partnership is working diligently to ensure true, seamless integration of physical and behavioral health care, with wraparound support services that will eliminate disconnects, and prevent fragmentation of services.

ValueOptions® of Tennessee will be recruiting and contracting with providers in East and West Tennessee who offer behavioral health and consumer centered recovery services. Shortly, providers will be receiving materials related to credentialing behavioral health services and a ValueOptions® of Tennessee provider agreement or amendment that will include reimbursement rates for TennCare services. Upon receipt of these documents, it is critical that each provider review and complete the credentialing application as well as return the signed provider agreement or amendment in order to participate in the ValueOptions® of Tennessee TennCare Managed Medicaid Network.

If you have questions or need more information, please call ValueOptions® of Tennessee at 1-800-397-1630.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Risk adjustment helps ensure appropriate payment to providers

What is the purpose of risk adjustment?
Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage (MA) organizations based on the health status of their enrolled beneficiaries. Accurate payments to MA organizations help ensure that providers are paid appropriately for the services they provide to MA beneficiaries.

Why is risk adjustment important to physicians and providers?
Physicians and providers must focus attention on complete and accurate diagnosis reporting according to the official ICD-9-CM coding guidelines.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Risk adjustment helps ensure appropriate payment to providers (cont'd)

Why is medical record review conducted for Risk Adjustment?
Medicare Advantage plans, such as BlueCross BlueShield of Tennessee, conduct medical record review to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding.

Is a medical record release form needed when BCBST requests medical records?
Under CFR 164.502 (HIPAA) you are permitted to disclose the requested data for the purpose of healthcare operations, after you have obtained the "general consent" of the patient. A general consent form should be an integral part of your medical record file.

Medical Records can be **mailed** or **faxed** to:

BlueCross BlueShield of Tennessee
Attn: RAPS Department
P.O. Box 180205
Chattanooga, TN 37401-9943

Fax: 1-877-922-2963

Medical record reviews are conducted in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines.

CoverTN

ADMINISTRATIVE

Confirmation of pregnancy is a covered benefit

Although the CoverTN health benefit plan does not include maternity coverage, services for the confirmation of pregnancy are covered. The initial visit and laboratory charges to **confirm pregnancy** will be covered when billed with appropriate procedure/diagnosis codes in affect at the time of services:

Procedure Codes

81025 - Urine pregnancy test, by visual color comparison methods.
84702 - Gonadotropin, chorionic (hCG); quantitative.
84703 - Gonadotropin, chorionic (hCG); qualitative.
S3625 - Maternal serum triple marker screen including alpha-fetoprotein (AFP), estriol, and hcG.
S3626 - Maternal serum quadruple marker screen including alpha-fetoprotein (AFP), estriol, hcG & inhibin A.

Possible Diagnosis Codes

626.0 - Absence of menstruation.
V7240 - Pregnancy examination or test, pregnancy unconfirmed.
V7241 - Pregnancy examination or test, negative result.
V7242 - Pregnancy examination or test, positive result.

Maternity care that is needed after the confirmation of a pregnancy, i.e., the initial prenatal visit, is not a covered service under CoverTN. Pregnant members can receive coverage under the CoverKids program for prenatal, delivery and 60 days of postpartum care, if eligible.

CoverTN members with a physician-confirmed pregnancy should immediately request an application for CoverKids from Policy Studies Inc., by calling 1-866-620-8864 or apply online at http://covertn.gov/web/coverkids_app.html.

~Claims filing tips~

In an effort to help avoid delays in claims payment and alleviate some of the more common billing errors, we offer the following tips when filing claims for BCBST members:

Billing Orthotics –When billing the same orthosis code for bilateral items (left and right) for the same date of service, providers should submit both items on the same claim line using "LTRT" modifiers and 2 units of service. Additional guidelines available at http://www.cignagovernmentservices.com/. (See LCDL11517, Article A19885).

Billing Supplies – Providers must have a valid detailed order on file prior to submitting claims for supplies. Providers regularly submitting claims for supplies that exceed the normal usage guidelines may be asked to submit medical records for that member supporting the need.

A member or his/her caregiver must specifically request additional supplies before they are dispensed. The supplier cannot automatically dispense a quantity of supplies on a predetermined basis.

Additional guidelines are available at http://www.cignagovernmentservices.com/jc/pubs/supman/index.html.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; CoverKids; Access TN **1-800-924-7141**
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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August 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective Sept. 14, 2008

- High-Dose Chemotherapy with Autologous Stem-Cell Transplant for Primary Amyloid Light-chain (AL) Amyloidosis
- Hyperbaric Oxygen Pressurization/Therapy (HBO2)
- Tandem High-Dose Chemotherapy with Hematopoietic Stem Cell Support
- Genetic Testing for Tamoxifin Treatment
- Surgical Mesh System for Repair of Spinal Soft Tissue
- Adalimumab (Humira)
- Natalizumab (Tysabri)
- Sapropterin (Kuvan)
- Corticotropin Therapy
- Lanreotide Acetate (Somatuline Depot)
- Pegvisomant (Somavert)
- Rotavirus Vaccine (Rota Teq, Rotarix)

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

Endometrial ablation for treatment of menorrhagia

This procedure was placed on retrospective review for commercial lines of business effective Jan. 12, 2008. This is not a prior authorization change, but a contract supported retrospective chart audit to assure compliance with appropriateness criteria found in BCBST's medical policy. Full text of this medical policy can be viewed at <http://www.bcbst.com/mpmanual/Endometrial_Ablation.htm>.

The following codes apply:

- **58353** Endometrial ablation, thermal, without hysteroscopic guidance
- **58356** Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
- **58563** Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)

Federally mandated review for Medicaid (TennCare) patients to assure compliance with ASH (abortion, sterilization, and hysterectomy) payment rules remains unchanged.

Zyrtec® and MiraLax® now available without a prescription

The conversion of prescription drugs to over-the-counter (OTC) medications often generates questions and/or concerns about drug performance. The following is information that may be helpful to your patients about some recent changes. Two of the most recent prescription drugs to make the switch to OTC are the non-sedating antihistamine Zyrtec® (cetirizine hydrochloride) and the osmotic laxative MiraLax® (polyethylene glycol 3350). These drugs are the same quality, strength, dose, and dosage form as their prescription predecessor, and are just as safe and efficacious as they were before they became available without a prescription. While OTC medications are excluded from coverage for most BlueCross BlueShield of Tennessee members, now that these drugs no longer require a prescription, they are priced more competitively and may represent a cost savings to your patients.

Auralgan® formulation changes

The popular otic solution Auralgan® recently underwent a formulation change. Pharmacies can no longer substitute the traditional A/B otic solution when a prescription is written for Auralgan® since there are no Federal Drug Administration (FDA)-recognized generic equivalents to the new formulation. There is no proof that the reformulated product offers any benefits over the standard antipyrine/benzocaine product and has not been submitted to the FDA for approval. The new formulation costs $150 per bottle compared to an average of $2 for a bottle of generic A/B otic solution. To reduce calls to your office and save your patients money remember to write "antipyrine/benzocaine otic solution" or "A/B otic solution" on your prescriptions when this is the desired product. This will allow pharmacists to dispense the generic product and result in significant savings for your patients.

Source: The New Auralgan Formulation. *Pharmacist's Letter/Prescriber's Letter* 2008;24(5):240502.

New drug added to commercial specialty pharmacy listing

Effective July 1, 2008, the following drug has been added to our commercial specialty pharmacy listing. This drug does not require prior approval.

Provider-administered via medical benefit

- Cimzia®

Claims Tip

Facility claims filed with Type of Bill 89X are considered inpatient and require a Room & Board Revenue Code. Claims filed without a Room & Board code will reject back to the provider.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Changes to PPO and HDHP benefits plans*

Beginning Sept. 1, 2008, several changes will be implemented to most BlueCross BlueShield of Tennessee PPO benefits plans. These changes will take place over the next year as group customers renew their benefit plans. Self-funded groups may choose to adopt these changes, or keep their plans as they are today.

Changes to PPO benefits plans:

- **Well Care Rider** – Limit to $750 per calendar year
- **Flu Immunization** – Will be covered in medical benefit
- **Physical, Speech, Occupational and Manipulative Therapy** – Will have 20 visits per therapy type per calendar year
- **Office Surgery** – Subject to deductible/ coinsurance (Applies to only deductible/ coinsurance with office visit copay. Does not apply to straight deductible/ coinsurance, copay preventive, or copay PPO)
- **ER Copay –**
  - $250 ER Copay OR
  - Deductible/Coinsurance
- **Pharmacy**
  - Member pays the cost difference between the brand and generic equivalent when they or their doctor request the brand drug. (MAC A)
  - Step Therapy for Celebrex added (member must try and fail on traditional NSAID, otherwise prior authorization is required)
  - Remaining large groups with maintenance list will be encouraged to discontinue
- **Specialty Drug Copay** – Equal to 2 times the highest RX Plan copayment, or$100 in plans with drug percentage copayments
- **4th Quarter Deductible Carryover** – Optional

Changes to HDHP benefits plans:

- TMJ: non-surgical treatment – limited to $1500 per calendar year

Changes to both the PPO and HDHP benefits plans:

- **Physical, Speech, Occupational and Manipulative Therapy** – Now 20 visits per therapy type per calendar year
- **Durable Medical Equipment** – $2,500 calendar year maximum
- **Medical Supplies** – $2,500 calendar year maximum
- **Prosthetics**–$2,500 calendar year maximum
- **Genetic Testing**–$2,500 calendar year maximum
- **High-Tech Imaging** – Prior authorization required for **all** providers. When using out-of-network providers or providers outside Tennessee, whether in- or out-of-network, member is responsible for ensuring provider receives prior authorization, or benefit penalties will apply.
- **Pharmacy** – Prescription drugs for which there is an Over-the-Counter equivalent in both dosage and strength, except for insulin are not covered.
- **Extraction of Impacted Teeth** – Not covered. However, if group has both medical and dental insured with BlueCross BlueShield of Tennessee under the same group number, medical will pay secondary benefits after dental.

New benefit exclusions:

- Complications of cosmetic procedures or complications of Bariatric surgery
- DME exclusions: Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts, auto-tilt chairs
- Patient lifts, air fluidized beds and air flotation beds, unless approved by Case Management
- Treatment for benign gynecomastia (breast enlargement in males)
- Treatment for hyperhidrosis (excessive sweating)
- Re-operation or surgery related to bariatric surgery, including but not limited to complications or Bariatric surgery or body remodeling following weight loss
- Cranial orthosis for treatment of plagiocephaly**
- Maintenance care**
- Methadone/buprenorphine maintenance therapy**
- Orthognathic surgery**
- Pharmacogenetic testing**
- Artificial intervertebral disc
- Balloon sinuplasty for treatment of chronic sinusitis***
- Chelation therapy except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilsonn's disease (hepatolenticular degeneration); and (5) lead poisoning***
- Percutaneous intradiscal electrothermal annulplasty and percutaneous intradiscal radiofrequency thermocoagulation to treat chronic discogenic back pain. These procedures allow controlled delivery of heat to the intervertebral disc through an electrode or coil***
- Vagus nerve stimulation for treatment of depression***

Providers are encouraged to verify member eligibility and benefits by calling our toll-free Provider Service Line 1-800-924-7141 or logging on to BlueAccess, the secure section of our company Web site, www.bcbst.com.

**New to HDHP only. Exclusions in PPO, but not in the original HDHP product.
***These services are currently excluded as Investigational through Medical Policy. They are being added as coverage exclusions for clarification to the member.

What is Medigap?

Some Medicare patients may also have other health care coverage to help supplement the costs of services that are not covered under Original Medicare.

You may see a number of BlueCross BlueShield of Tennessee member ID cards reflecting "**Medigap**" on the front of the card. A Medigap policy is simply a Medicare supplemental policy intended to fill gaps in Original Medicare Plan coverage. Claims for BCBST members having Medigap/Medicare Supplement coverage should be filed to Medicare for primary payment. Effective Jan. 1, 2008, all Blue Plans, including BlueCross BlueShield of Tennessee began crossing over Medicare claims for services covered under Medigap and Medicare Supplement products. This process results in automatic claims submission of Medicare claims to the Blue secondary payer reducing or eliminating the need for the provider's office to submit additional claims to the secondary carrier. See more about the Medicare crossover process by visiting the company Web site at http://www.bcbst.com/providers/news/.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Appropriate coding and billing information for oxygen contents and supplies

Oxygen contents is included in the reimbursement for rental of oxygen equipment and should only be billed separately when the patient owns his/her stationary system/concentrator or when the patient has a portable tank as their only oxygen equipment. Accessories/supplies, including but not limited to, transtracheal catheters, cannulas, tubing, mouthpieces, face tent, masks, oxygen conserving devices, oxygen tent, humidifiers, nebulizer for humidification, regulators, and stand/rack are included in the allowance for rented systems. For appropriate coding and billing, providers are encouraged to review the guidelines in the LCD L11446 *Oxygen and Oxygen Equipment* and the associated Article A33750. These guidelines can be found via the Jurisdiction C DME MAC link located on Cigna Government Services' Web site, http://www.cignagovernmentservices.com/

Cultural competency provider tool kit accessible online

Cultural competency is an important issue facing health care providers. Health care organizations need to have and utilize policies in this area and take steps to ensure their employees possess the necessary skills to anticipate, recognize and respond to various expectations (language, cultural and religious) of members and health care providers.

BCBST is pleased to offer the *Cultural Competency Provider Tool Kit*, which provides health care professionals additional resources to better manage members with diverse backgrounds. This provider tool is a collaborative effort by BCBST and the State of Tennessee Bureau of TennCare developed to help address cultural competency.

The tool kit contains links to a compilation of resources and educational materials for practitioners' office staff and can be found online via the Provider page on the company Web site, www.bcbst.com.

Reminder: Appropriate coding and billing information for Transcutaneous Electrical Nerve Stimulator (TENS)

For appropriate coding and billing, providers are encouraged to review the guidelines in the LCD L5031 Transcutaneous Electrical Nerve Stimulator (TENS) and the associated Article A37064. These guidelines can be found via the Jurisdiction C DME MAC link located on Cigna Government Services' Web site, http://www.cignagovernmentservices.com/

Inappropriate use of code A4556, Electrodes, e.g., apnea monitor, per pair when billing supplies for member-owned TENS may result in return of the claim for corrected billing.

Real-time claims adjudication application just keeps getting better!

The Real Time Claims Estimation/Adjudication application is a Web-based tool accessible to physician offices at no charge through BlueAccess, BlueCross and BlueShield of Tennessee's secure area on its Web site, www.bcbst.com.

This tool provides the capability to 1) determine and share with the patient true patient liability at or before the point of care, and 2) adjudicate the claim to completion before the patient leaves the physician's office. Most recent enhancements to the application include 1) Outpatient facilities are now able to generate estimates and submit claims, and 2) Transactions may be entered for additional lines of business.

Log on to www.bcbst.com and try the Real Time application, today!

Reminder: Billing appropriately for observation services

Observation services billed with Revenue Code 0762 do not require a HCPCS/CPT® code in form locator 44 on a CMS-1450 claim form unless the provider is billing for fetal stress and non-stress tests. Adding an evaluation and management code with the observation code may result in delayed or denied payment of the service.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Volunteer State Health Plan (VSHP) announces new transportation contract with Southeastrans, Inc.*

Beginning Sept. 1, 2008, Southeastrans, Inc., will manage all non-emergency transportation services across the state of Tennessee for TennCare members enrolled in BlueCare and TennCare*Select*. Southeastrans Inc., specializes in Medicaid non-emergency medical transportation ensuring Medicaid members receive quality transportation services in a prompt and safe manner.

Effective Sept. 1, 2008
BlueCare and TennCare*Select* Members should contact Southeastrans, Inc. to request non-emergency transportation for medical services only. Non-emergency transportation to behavioral health services should be arranged through Tennessee Behavioral Health Inc. or via Premier Behavioral Health.

Effective Nov. 1, 2008
BlueCare Members located in the West Grand Region should contact Southeastrans, Inc. to arrange transportation for both medical and behavioral health services.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Volunteer State Health Plan (VSHP) announces new transportation contract with Southeastrans, Inc. (cont'd)*

Effective Jan. 1, 2009, BlueCare Members located in the East Grand Region should contact Southeastrans, Inc. to arrange transportation for both medical and behavioral health services.

Note: For TennCare*Select* Members, only non-emergency transportation to medical services should be arranged through Southeastrans, Inc. Transportation to behavioral health services for TennCare*Select* Members should continue to be arranged through Tennessee Behavioral Health Inc. or Premier Behavioral Health.

Benefits for non-emergency transportation claims or services may be provided as long as they are scheduled through Southeastrans, Inc., prior to actual transport, and the services for which the member is being transported is a covered TennCare service. All non-emergency claims with a date of service on or after Sept, 1, 2008, should be billed directly to Southeastrans, Inc. All member-related non-emergency transportation complaints will be referred to VSHP for tracking and resolution.

Providers and members and/or their representatives may request non-emergency transportation services by contacting Southeastrans, Inc., at one of the following toll-free telephone numbers:

BlueCare
- East Grand Region 1-866-473-7563
- West Grand Region 1-866-473-7564

TennCare*Select*
- Statewide 1-866-473-7565

These toll-free numbers are available 7-days-a-week, 24-hours-a-day.

Reminder: Important changes to TENNderCare billing guidelines

Effective Jan. 1, 2008, claims for preventive services must be filed using the appropriate CPT® code with diagnosis codes V20-V20.2, V70.0-V70.0, V70.3-V70.9. Use of these codes is required in order for the encounter to be considered a complete TENNderCare screening reimbursable at the enhanced rate. Previously, providers were not required to use a "V" diagnosis code in conjunction with preventive procedure codes.

When a TENNderCare screening reveals the need for further diagnostic and treatment services, one of the following referral codes should be used in Block 24D on the CMS-1500 professional paper claim form:

- UA – Medical follow-up needed
- UB – Behavioral follow-up needed
- UC – Dental follow-up needed

Although the above codes are for informational use only, we encourage you to use them as they assist in better coordination of the member's care.

Preventive codes and guidelines for billing preventive services with evaluation & management codes are defined in the *BlueCare Provider Administration Manual* located on the company Web site, www.bcbst.com.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Coding for co-existing conditions

Risk Adjustment is based upon the member's total health status: reporting co-existing and chronic conditions is essential. In cases where co-existing conditions are present, remember to code all documented conditions that co-exist at the time of the visit and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist.

Exception: History codes V10 through V19 may be used as secondary codes if the historical condition or family history has an impact on current care, or possibly influences treatment.

Additionally, avoid coding diagnoses documented as "probable", "suspected", "questionable", "rule out", or "working diagnosis." Examples:

Co-existing Chronic Conditions
- 250.42 Diabetes with renal manifestations-type II or unspecified: uncontrolled
- V58.67 Long-term use of insulin
- 401.9 Essential hypertension

Historic V-code
- V02.62 Hepatitis C, carrier
- 780.79 Malaise and fatigue

BlueCard®

ADMINISTRATIVE

Reminder: Blue Network "S" added to BlueCard Program

The BlueCard Program allows out-of-area members who travel or live in another state to receive in most instances participating benefits for health care services even when their membership is through another Blue Cross and/or Blue Shield Plan.

Effective Jan. 1, 2008, BlueCross BlueShield of Tennessee added Blue Network S to the BlueCard Program allowing members access to more provider choices for their health care services.

For more information on the BlueCard Program, please call 1-800-705-0391.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 3Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert
provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

September 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective Oct. 12, 2008

- Adoptive Immunotherapy
- Drug-Eluting Lung Stents for Emphysema
- Genetic Testing for Helicobacter Pylori Treatment
- Vulvectomy

Effective July 21, 2008

- Endometrial Ablation for Treatment of Menorrhagia
  Note: A hyperlink to an evaluation tool/documentation form to facilitate post service claims, and documentation/predetermination requests are attached to this policy for provider use. Effective Aug. 29, 2008, CareAuthQI, a BlueCross BlueShield of Tennessee online authorization application located on our company Web site, www.bcbst.com , may also be used to submit information electronically.

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

Clinical Practice Guidelines Adopted

BlueCross BlueShield of Tennessee has adopted the following guidelines as recommended best practice references:

ST-Elevation Myocardial Infarction: 2007 Focused Update of the ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction
<http://circ.ahajournals.org/cgi/content/full/117/2/296>
ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction
<http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm>
Standards of Medical Care in Diabetes – 2008
<http://care.diabetesjournals.org/cgi/content/extract/31/Supplement_1/S12>

The 7th Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
<http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf>

High Cholesterol: Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines
<http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04.pdf>

Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III Final Report)
<http://www.nhlbi.nih.gov/guidelines/cholesterol/profmats.htm>

Perinatal Care: ACOG: Guidelines for Perinatal Care, Sixth Edition
<http://www.acog.org/bookstore/Guidelines_for_Perinatal_Care,_Fifth_Edition_P262.cfm>

ICSI: Health Care Guideline: Routine Prenatal Care
<http://www.icsi.org/prenatal_care_4/prenatal_care__routine__full_version__2.html>

Asthma: Guidelines for the Diagnosis and Management of Asthma (EPR-3)
<http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>

Working Group Report on Managing Asthma during Pregnancy: Recommendations for Pharmacologic Treatment - Update 2004
<http://www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg.htm>

The following reflect adopted clinical practice guidelines for behavioral health:

Clinical Practice Guideline for Assessing & Managing the Suicidal Patient and Tip Sheet
<http://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/>

<https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_prac_guidelines/prov_suic_tipsheet.pdf>

American Psychiatric Association's (APA) Guideline for treatment of patients with Panic Disorder
<http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>

APA Guidelines for treatment of patients with Bipolar Disorder - 2nd edition
<http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>

Hyperlinks to these guidelines are available within the *BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual*, which can be viewed in its entirety on the company Web site at http://www.bcbst.com/providers/hcpr/ Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

ADMINISTRATIVE

Changes to PPO and HDHP benefits plans updated

In the August issue of *BlueAlert*, we advised providers of several changes being implemented Sept. 1, 2008, to most fully insured BlueCross BlueShield of Tennessee PPO benefits plans.

For changes to both the PPO and HDHP benefits plans we communicated Prosthetics would have a $2,500 calendar year maximum. The actual limit for Prosthetics is $20,000 per calendar year.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Access and availability for urgent care

In accordance with applicable regulatory and accrediting bodies, BlueCross BlueShield of Tennessee maintains and monitors access and availability standards for its members. Providers are reminded that urgent care appointments must be scheduled within 48 hours for both new and existing BlueCross BlueShield of Tennessee patients.

A copy of the BlueCross BlueShield of Tennessee *Member Access and Availability Standards* for routine and urgent care can be found in both the BlueCross BlueShield of Tennessee and BlueCare provider administration manuals, which are available on *BlueSource*, our quarterly provider information CD, online at www.bcbst.com and also on Volunteer State Health Plan, Inc.'s Web site, www.vshptn.com.

Non-compliance with these standards shall be addressed through our Medical Management Corrective Action Plan, which is also published on our Web site.

Reminder: Be aware of member rights and responsibilities

As a BlueCross BlueShield of Tennessee 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, we periodically remind 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 and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and BlueCare provider administration manuals, which are available on *BlueSource*, BCBST's quarterly provider information CD, online at www.bcbst.com and also on Volunteer State Health Plan, Inc.'s Web site, www.vshptn.com.

Clarification: Subrogation recovery

The BlueCross BlueShield of Tennessee Subrogation Department utilizes Explanation Codes AD3 and XSA for identifying subrogation adjustments on the provider's Explanation of Payment (EOP). These adjustments should not be confused with coordination of benefits. BCBST does not coordinate benefits with a payment from a third party payor such as an automobile insurance carrier. Subrogation adjustments in no way increase the patient's liability from the original claim and will be reflected in the *Contract Write-off* column of the EOP.

New online Web authorization presentation available on Blue*Source* third quarter CD

BlueCross BlueShield of Tennessee providers having Internet capability can submit authorizations for inpatient confinement, 23-hour observation, outpatient procedures, specialty pharmacy, global obstetrics and clinical updates via *BlueAccess*, the secure area on our Web site, www.bcbst.com.

In an effort to help educate providers in the online authorization submission processes, we have developed two Web authorization presentations, 1) *Authorization Submission* and, 2) *Specialty Pharmacy Submission*. Access to these educational tools are being made available on the Provider page on the company Web site, www.bcbst.com and also on Blue*Source*, BlueCross BlueShield of Tennessee's provider information CD mailed quarterly to all BCBST contracted providers.

Watch for these helpful presentations on the third quarter edition of Blue*Source* scheduled for release Sept. 30, 2008.

Note: *These authorization processes are applicable for all BlueCross BlueShield of Tennessee lines of business, except BlueCard®.*

Blue*Source* CD is a single source tool for accessing important medical and administrative information

Blue*Source*, BlueCross BlueShield of Tennessee's provider information CD is mailed quarterly to all BCBST contracted providers. This CD is a single source tool developed for provider use in accessing important billing and reimbursement information, reviewing upcoming medical policies, locating other network providers, verifying covered medications, and much, much more.

Internet access is not required to view documents on the CD. Simply place the CD into your computer's CD-ROM drive and all this important information is at your fingertips. For those providers having Internet capability, we included a convenient link to the company Web site, www.bcbst.com.

In recent months, we have had a number of providers request to be removed from the Blue*Source* mailing list. Even though we are sure this is due to the fact that you are accessing the information via our Web site, we are unable to honor this request. Both the BlueCare and the BlueCross BlueShield of Tennessee provider administration manuals along with quarterly updates are included on the Blue*Source* CD. As these administrative manuals are considered extensions of the provider Agreements between BlueCross BlueShield of Tennessee and its Providers, BCBST is obligated to supply each contracted provider with this information.

We encourage all our providers to accept and utilize the CD to assist you in your health care administrative needs.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Important changes to home health and private duty nursing services*

Effective Sept. 8, 2008‡, TennCare will implement changes to the home health and private duty nursing benefits. Specifically, these changes in benefits will only affect adult TennCare members age 21 years and over; Children under the age of 21 years will not be affected. These changes will include coverage for private duty nursing benefits **only** when they are ventilator dependent for at least 12 hours-a-day **OR** have a functioning tracheostomy requiring suctioning and need other specified types of nursing care, which include the following:

- Oxygen (nebulizer or cough assist);
- medication via G-tube, PICC line or central port;
- TPN; or
- nutrition via G-tube

For specifics of the home health changes, please visit http://www.bcbst.com/providers/news/ where a complete listing of all changes can be found.

A notice of the benefit change was mailed to all adult enrollees on Aug. 8, 2008. Beginning Sept. 8, 2008, we will be mailing an additional letter to any patient who is currently receiving amounts of care in excess of the new limits providing 10-day advance notice before TennCare stops payment on services exceeding the limits.

It is critical that you work with your patients currently receiving amounts of care in excess of the limits to determine the best course of action.

‡Changes will be effective for all **new** orders Sept. 8, 2008, and as early as Sept. 18, 2008, for **existing** orders.

TennCare contracts with new pharmacy benefits manager*

The Bureau of TennCare announced it has contracted with SXC® Health Solutions, Inc., to begin serving as its new Pharmacy Benefits Manager (PBM).

Effective Oct. 1, 2008, SXC® Health Solutions, Inc., will begin processing all pharmacy claims and respond to prior authorization requests. The full press release is available on the Bureau of TennCare's Web sit at <www.tennessee.gov/tenncare/news-250408.html>.

Reminder: Admitting diagnosis code edit

Volunteer State Health Plan reviews all potential payable codes. Sometimes the Symptom Code (780.0 – 799.0) indicates the need for emergency evaluation while the Discharge Code does not indicate emergent care necessity.

Providers are encouraged to include the Symptom Code in Form Locator 69 (*Admitting Diagnosis*) on the CMS-1450 paper claim or in Segment H102-2 of Loop 2300 (*Admitting Diagnosis or Patient Reason for Visit*) when filing claims electronically.

Providers may view the BlueCare and TennCare*Select* Medical Emergency Code listing on the company Web site, www.bcbst.com.

Reminder: New provider appeal toll-free fax number now available for BlueCare and TennCare*Select*

We recently added a new toll-free fax number, **1-888-357-1916**, solely for use in faxing a standard appeal for denied services. Provider use of this dedicated fax number helps ensure all faxed standard appeals are imaged into our system in a timely manner. This enhanced process will help expedite standard appeals and ensure the most current information is available to you when checking the status of your appeal.

When faxing a standard appeal the following documentation must be provided:

- The principle reason for upholding the non-certification determination;
- Detailed clinical rationale, and
- Pertinent medical records for the specific case you are appealing.

Note: This fax number applies ONLY to BlueCare and TennCare*Select* lines of business.

If you have any questions, please call the appropriate BlueCare or TennCare*Select* Provider Service line.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Reminder: Risk adjustment: coding to the highest specificity-fourth and fifth digits

The Centers for Medicare & Medicaid Services (CMS) utilizes the Hierarchical Condition Category payment model for Medicare Advantage plans. For risk adjustment purposes, CMS refers to disease groups as HCCs. Disease groups contain major diseases and are broadly organized into body systems. The HCC assigned to a disease is determined by the ICD-9-CM diagnosis codes submitted during a data collection period. Only selected diagnosis codes are included in the CMS-HCC model.

ICD-9-CM codes have three, four, or five digits. Diagnoses should be reported to the highest level of code available for that category. In selected cases, the fifth digit may impact whether the code is in the HCC models, but at a different HCC level.

Example 1:
Diabetes (250.XX) codes group into HCC 15, 16, 17, 18, or 19 depending on the fourth digit applied. The fourth digit designates manifestations or complications of diabetes such as neurological conditions, eye disorders, or diabetic ulcers. At a minimum, the submitted ICD-9-CM codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model.

Example 2:
Myocardial infarction (MI) (heart attack, 410.XX) is unspecified or subsequent

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE (cont'd)

Reminder: Risk adjustment: coding to the highest specificity-fourth and fifth digits (cont'd)

episode fifth digits 0 and 2 are in HCC 82. All initial care for a new MI (from physician office to emergency room to hospital) should have the fifth digit of "1" and group to HCC 81.

Documentation and Coding Resources

- Official Coding Guidelines on CDC Web site, www.cdc.gov/nchs/icd9.htm
- American Health Information Management Association (AHIMA), www.ahima.org
- American Academy of Professional Coders (AAPC), www.aapc.com
- American Hospital Association (AHA), www.aha.org

BlueCard®

ADMINISTRATIVE

Reminder: Call BlueCard *Eligibility* ® for easy access to membership and coverage information

Not sure how to verify eligibility and benefits for out of area Blue members? First, look for the three-character alpha prefix that precedes the identification number on the member's ID card. Once you have located the alpha prefix, call BlueCard *Eligibility* at 1-800-676-BLUE. Provide the member's alpha prefix and you will be routed to the member's Blue Plan where eligibility and coverage can be verified

Remember to submit claims for out of area Blue members to BlueCross BlueShield of Tennessee.

For more information on BlueCard eligibility, call 1-800-705-0391.

Cover Tennessee

ADMINISTRATIVE

Reminder: Diagnostic imaging services performed in an office setting

Diagnostic imaging services performed in an office setting are considered an exclusion to the CoverTN benefits. Claims for diagnostic imaging services will only be reimbursed when performed in an outpatient diagnostic imaging center. These services include but may not be limited to, CAT scan, MRI, and nuclear imaging.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; CoverKids; Access TN **1-800-924-7141**
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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BlueCross BlueShield of Tennessee offices will be closed Monday, September 1, 2008 in observance of Labor Day

*These changes will be included in the appropriate 4Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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Please Route to all Providers & Office Staff

October 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Enhanced and Expanded Disease Management Support for Members

Introducing Healthy Focus Health Coaching

Since 2001, BlueCross BlueShield of Tennessee has provided disease management services to members with chronic conditions. Now, that service is enhanced to include 24/7/365 availability for inbound health questions and outreach for certain other conditions such as back pain, women's health, men's health and more.

Our new Healthy Focus Health Coaching helps improve patient health with integrated, personalized coaching services that support a broad spectrum of medical conditions and physician treatment plans. Health coaches do not provide medical advice or clinical care. They do provide evidence-based, unbiased information and support, including tools and resources to help patients make the most of each office visit. Our aim is to help patients become more engaged in their health care and work more effectively with their physicians.

Every Day, Round-the-Clock Support
Health Coaches give members and their families 24/7/365 access to specially trained health care professionals such as nurses, dieticians and respiratory therapists. Coaches provide evidence-based information and support to help patients work with their physicians to address a wide range of issues, such as managing their chronic conditions, evaluating different treatment options, finding the best way to care for an injury and understanding symptoms. This information does not replace physician care. Rather, it prepares patients to make health care decisions in partnership with their physician.

Health Coaches provide whole-person support that helps your patients:

- understand their diagnoses
- become motivated to actively manage their health
- learn important self-care skills
- increase their compliance with physician treatment plans

Health Coaches also provide additional health education support through award-winning videos, materials, tools and resources. Health Coaching supports total population health management, ensuring that members receive the right support at the right time.

Consider Health Coaching for your patients who:

- have chronic conditions
- are at high risk for ER and hospital visits
- are non-adherent with care plans or medication
- need decision support

To refer a patient for Health Coaching, call 1-800-225-8698.

ADMINISTRATIVE

Reminder: You can submit corrected claims electronically

Providers are reminded that medical and dental corrected claims can be submitted electronically. Please see guidelines for submitting corrected claims on the company Web site at <www.bcbst.com/providers/ecomm/ElectronicCorrectedClaims.pdf>.

Reminder: Reporting Modifier 50

Historically, BlueCross BlueShield of Tennessee required claims for bilateral procedures be submitted on two separate lines for both facility claims (CMS-1450) and professional claims (CMS-1500). As a reminder, bilateral procedures billed by facility and professional providers should be filed as a **single** line item using the appropriate procedure code with Modifier 50 and **one** unit. This guideline applies to all BlueCross and BlueShield of Tennessee products and is necessary to comply with mandates of the Health Insurance Portability and Accountability Act (HIPAA).

At times, it is appropriate to bill a bilateral procedure with:

- a single line with no modifier and 1 unit
- a single line with modifier 50 and 1 unit
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples include, but are not limited to:

- a bilateral procedure performed on different areas of the right and left sides of the body (e.g. lesion removal performed on the right arm and a lesion removal on the left arm);
- the procedure code description specifically includes the word "bilateral"; and
- the procedure code description specifically indicates the words "one or both" (e.g. CPT® code 69210 – removal of cerumen, one or both ears).

For more information, please refer to Billing Guidelines published in the provider administration manuals located at www.bcbst.com/providers/manuals.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Reporting preventive medicine services

Preventive medicine services are routinely performed to promote wellness and for disease prevention. Depending on the age of the patient, these visits usually include services such as vaccinations, screening laboratory services, counseling and even management of medical problems. Often, during the course of a preventive medicine visit, a significant and/or separate problem may need to be addressed. When this occurs, it is important for providers to report the additional services appropriately, since benefits for preventive medicine services can vary between individuals. Examples:

1. When a preventive medicine service is reported in Block 24d of the CMS 1500 claim form, a routine exam diagnosis code should be reported in Block 24e.
2. When a non-preventive medicine service is reported in Block 24d of the CMS 1500 claim form, a non-routine exam diagnosis code should be reported in Block 24e.

Effective Dec. 1, 2008, when a non-preventive medicine service is reported in Block 24d on the CMS 1500 claim form with a routine exam diagnosis code (V70.0 or V20.2) in Block 24e, the line item will be returned to the provider for a more appropriate diagnosis code.

Reminder: Correct usage of code E1028

Code E1028 is appropriately submitted for swing-away, removable or retractable hardware only (e.g. joystick, headrest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g. hardware for seat, back or tray). A separate claim line is required for each item billed with E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.

Consult the Pricing, Data Analysis and Coding Contractor (PDAC) located on the Noridian Administrative Services, LLC (NAS) Web site: www.dmepdac.com for specific products billable with code E1028.

Reminder: Claims filed without POA codes will be returned

As previously communicated, effective Jan. 1, 2008, BlueCross BlueShield of Tennessee began accepting present on admission (POA) indicator codes on inpatient hospital claims.

The Centers for Medicare & Medicaid Services (CMS) will begin rejecting claims filed without the POA codes Oct. 1, 2008. BCBST will begin rejecting these claims for discharge date Nov. 1, 2008, and after.

BlueCare/TennCare*Select*

Clinical

Reminder: Case management and disease management programs available

Case management services are available to members having complex chronic conditions, a major trauma, or complicated care needs in which extensive interaction is necessary to connect with all the parties involved in the member's healing process. Members enrolled in a case management program are assigned a Volunteer State Health Plan Case Manager (registered nurse) to coordinate their complex needs.

Disease management services are available to members with diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease, coronary artery disease and pregnancy.

Members enrolled in a disease management program are assigned a Clinical Health Coach (registered nurse) who supports and coaches members in adopting and maintaining healthy habits. When these nurses recognize changes or lifestyle issues that may affect the member's health, they work with the member and provider to address the issues and coordinate appropriate treatment, services and medications.

Members may self refer to either program by calling the Customer Service number listed on their ID card and providers may refer patients to either program by calling one of the following numbers:

Case Management	1-800-225-8698
Disease management	1-888-416-3025

ADMINISTRATIVE

Prior authorization required for select radiology procedures*

Beginning Nov. 1, 2008, for members in the West Grand Region and Jan. 1, 2009, for members in the East Grand Region, Volunteer State Health Plan will require prior authorization for select high tech imaging procedures performed in an outpatient setting. These services will not require an authorization if they are performed when a patient is receiving treatment in an emergency room or in an inpatient setting.

Procedures requiring prior authorization include, but are not limited to: CT, CTA, MRI, MRA, MR Spectroscopy, PET Scans, and Nuclear Cardiology.

At this time, TennCare*Select* members and individuals who qualify as dually eligible for Medicare and Medicaid will be exempt from the prior authorization requirement. More information will be available in future *BlueAlert* newsletters, on our Web sites, www.bcbst.com, and www.vshptn.com, and other communications.

Prior authorization information on member ID card

As reported above, effective Nov. 1, 2008, prior authorization will be required for select high tech imaging services for BlueCare Members in the West Grand Region. Because a BlueCare member from the West Grand Region may seek services in the East Grand Region on or after November 1, providers should verify if prior authorization is required for their patients. If the words "Medical/Behavioral" appear on the front of the member ID card, please check the back of the card for information regarding prior authorization. The number to call for prior authorization is located on the back right (Advanced Radiological Imaging Auth. 1-888-693-3211).

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Volunteer State Health Plan (VSHP) announces new transportation contract with Southeastrans, Inc.*

Providers are reminded that beginning Sept. 1, 2008, Southeastrans, Inc., began managing all non-emergency transportation services across the state of Tennessee for TennCare members enrolled in BlueCare and TennCare*Select*.

Effective Sept. 1, 2008, BlueCare and TennCare*Select* Members should contact Southeastrans, Inc. at **1-423-893-8282** to request non-emergency transportation for **medical** services only.

Effective Nov. 1, 2008, for BlueCare Members in the West Grand Region and **Jan. 1, 2009,** for BlueCare Members in the East Grand Region, non -emergency transportation to and from their **behavioral health care** appointments will be provided by Southeastrans. (Prior to this date these members should continue to use their existing BHO to arrange this service.)

Non-emergency transportation for TennCare*Select* Members to and from their **behavioral health care** appointments will continue to be arranged through Premier Behavioral Health Systems or Tennessee Behavioral Health, Inc.

Changes to benefit limits for home health and private duty nursing services*

Effective Sept. 8, 2008, TennCare began applying benefit limits to adults age 21 and over for both Home Health and Private Duty Nursing services. This is a positive change to help to curtail over-utilization and gain control of very costly services. TennCare's private duty nursing and home health costs have grown from $54 million to $243 million in a four year period. The annual growth rate of 53 percent is unsustainable in a taxpayer funded program. This change will assist us in keeping the TennCare program stable as we move back into an at-risk arrangement with the Bureau. The Bureau of TennCare mailed letters August 8 to members and providers announcing this change and also held a provider training forum in Nashville on August 13, which was well attended.

Important claims information pertaining to these changes follows:

- Providers will bill for a benefit week – which is defined as Monday – Sunday.
- Billing must occur on one claim per defined benefit week per patient.
- If second claim is billed for same week, claim will be denied.
- Providers must bill each day and service as a single line item on the claim.
- Fee schedule amounts for services did not increase or decrease with these limit changes – although the billing units for revenue codes 551/G0154, 571/G)156 and 589/T1000 are to be reported in 15 minute increments.
- Billing guidelines are the same for both adult and pediatric claims. All claims must be billed using HCPCS and revenue codes beginning Sep. 8, 2008. Both the revenue and the HCPCS code are required – if not included, the claim will be denied for the provider to refile using the correct billing guidelines.

For a detailed listing of the benefit changes, please visit our Web site at <http://www.bcbst.com/providers/news/HH%20PDN%20PDF%20Prov%20Notice.pdf>.

Reminder: The Federal Deficit Reduction Act of 2005

The Federal Deficit Reduction Act of 2005 (DRA) sets forth new requirements and penalties designed to reduce and control Medicaid costs through the reduction of fraudulent and erroneous claims. The False Claims Act (Title 31, Section 3729) includes provisions for liability for certain acts for any person who knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Claims may include, but are not limited to overcharges, or charging for a product or service delivered to someone other than the covered party.

Organizations receiving Medicaid payments for fraudulent or erroneous claims will:

- have to repay those funds;
- be subject to numerous penalties; and
- be excluded from Medicare reimbursements and from participation in federal health care programs.

BlueCross BlueShield of Tennessee cooperates with all state and federal agencies in the investigation of fraud and abuse.

Reportable fraud and abuse includes fraud and abuse in the administration of the TennCare program, in addition to provider and member fraud and abuse. Providers and subcontractors acknowledge that as a condition of receiving any amount of TennCare payment, they must comply with the applicable Fraud and Abuse section of the TennCare Contractor Risk Agreement, the DRA, the False Claim Act and all other federal and state regulations. Also, providers are required to educate staff on the DRA and the False Claims Act including the requirement to report potential fraud and abuse.

Complete fraud and abuse information can be found in the *BlueCross BlueShield of Tennessee* and *BlueCare* provider administration manuals, available on the company Web sites, www.bcbst.com and www.vshptn.com, or if you have questions regarding fraud and abuse please call the appropriate provider service line. Additionally, a Web based fraud and abuse training tutorial will be available on the Blue*Source* Provider Information CD during the fourth quarter.

Behavioral health referral services available around the clock*

Effective Nov. 1, 2008, behavioral health care services are available 24-hours-a-day, 7-days-a-week for BlueCare members in the West Grand Region. Members, behavioral health providers and primary care practitioners can call BlueCare at 1-888-423-0131 to find out about available behavioral health resources in their areas.

In a crisis situation they may also call the State of Tennessee crisis hotline at 1-800-809-9957 for direction to their local crisis team for assistance. For urgent situations, members will be referred to providers in their community that can see them within 48 hours.

TennCare*Select* members and providers statewide should continue to call Premier Behavioral Health Systems of Tennessee at 1-800-325-7864 for all their behavioral health care needs.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

TennCare Pharmacy preferred drug list (PDL)*

Beginning Oct. 1, 2008, SXC® Health Solutions, the new TennCare Pharmacy Benefits Manager, will assume pharmacy management responsibilities. Additionally, on this date new PDL changes will be implemented including the addition of diabetic supplies (blood glucose meters and test strips) with some products preferred and some non-preferred. Providers are encouraged to review the revised PDL at one of the following online locations:

- Provider page of the company Web site, www.bcbst.com or www.vshptn.com
- SXC® Health Solutions, Inc. via the Bureau of TennCare's Web site, <www.tennessee.gov/tenncare/pro-pharmacy.html>.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Risk Adjustment: Medical record documentation reminder

For purposes of risk adjustment data submission and validation, Medicare Advantage Organizations, such as BlueCross BlueShield of Tennessee are required by the Centers of Medicare & Medicaid Services (CMS) to ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider.

All dates of service that are identified for review on the record must be **signed** (with credentials) and **dated** by the physician or an appropriate physician extender (e.g., nurse practitioner). The physician must authenticate each note for which services were provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signature. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note.

ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

Type	Acceptable
• Hand-written signature or initials, including credentials	• Mary C. Smith, MD; or MCS, MD
• Electronic signature, including credentials	• Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by") • Must be password protected and used exclusively by the individual physician

UNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

Type	Unacceptable unless…
• Typed name	• Authenticated by the provider
• Non-physician or non-physician extender (e.g., medical student)	• Co-signed by acceptable physician
• Provider of services' signature without credentials	• Name is linked to provider credentials or name on physician stationery

Reminder: Editing of hospital Part B inpatient services

It is important to remember that only certain services (ancillary and physician charges) will be reimbursed when submitting an inpatient facility claim with a Bill Type 121. The complete guideline can be viewed online in the Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual (Section 240.1) located at <http://www.cms.hhs.gov/manuals/downloads/clm105c04.pdf>.

BlueCard®

ADMINISTRATIVE

BlueCross BlueShield of Tennessee discontinues Blue Network C*

Effective Jan. 1, 2009, BlueCross BlueShield of Tennessee will discontinue marketing benefit packages through Blue Network C (BlueClassic℠). As a result of this action, BlueCard Traditional and BlueCard PPO members will begin utilizing Blue Network P as their BlueCard provider network. The discontinuation of Blue Network C will not affect any other network agreements under which a provider may be contracted.

We appreciate your participation in the BlueCross BlueShield of Tennessee provider networks and your continued support in providing its members with the best of care. If you have any questions, please contact your provider network manager.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; CoverKids; Access TN **1-800-924-7141**
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 3Q or 4Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert
provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

November 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective Dec. 13, 2008

- Abatacept
- Dalteparin Sodium
- Rilonacept
- Certolizumab Pegol
- Daily Hemodialysis in the Home
- Home Spirometry

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

Modified Milliman Care Guideline updates/changes

BlueCross BlueShield of Tennessee's Web site has been updated to reflect upcoming modifications to select Milliman Care Guidelines®. The *Modified Milliman Care Guidelines* can be viewed on the Utilization Management Web page at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm>.

Effective Dec. 5, 2008

The following as relates to Inpatient and Surgical Care:

- Pediatric Adenotonsillectomy for Obstructive Sleep Apnea Syndrome (OSAS): Observation Care

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

Cultural competence and health care disparities

An article published in the March 26, 2008, edition of the *Journal of the American Medical Association* states that despite decades of effort in the United States, significant health care disparities continue to exist. Drawing from research conducted by the Agency for Healthcare Research and Quality, the article points out that compared to Caucasians, African Americans have significantly more new AIDS cases and pediatric asthma hospitalizations, while Native Americans are less likely to receive prenatal care and Asian women have significantly lower mammography rates. Addressing such disparities is particularly important as the country becomes more culturally diverse.

One of the first steps is learning how to communicate in a culturally sensitive way with patients from different backgrounds. BlueCross BlueShield of Tennessee is currently exploring ways to assist health care providers in this endeavor. Over the coming months we will provide updates on this effort as well as links to helpful information on this topic.

Reminder: Synagis® effective in reducing hospitalizations

Respiratory Syncytial Virus (RSV) season is approaching. Synagis® (palivizumab) has been shown to be effective in reducing hospitalizations for children at high risk for RSV infection. BlueCross BlueShield of Tennessee recognizes the beginning of Synagis® season on November 1 and its duration through the end of March.

Our medical policy on Synagis® can be viewed online at <http://www.bcbst.com/mpmanual/!SSL!/WebHelp/Palivizumab.htm>.

A downloadable Synagis® enrollment form is also available on the Provider page on the company Web site, www.bcbst.com under "Pharmacy".

For commercial members, Synagis® should be billed directly to BlueCross BlueShield of Tennessee using CPT® code 90378. Synagis® requires prior authorization for both medical and pharmacy benefits. To request prior authorization, call the appropriate Provider Service line or contact one of the following Preferred Specialty Pharmacy vendors listed below:

Caremark Specialty Pharmacy
Phone: 1-800-237-2767
Fax: 1-800-323-2445

CuraScript Pharmacy
Phone: 1-888-773-7376
Fax: 1-888-773-7386

Accredo Health Care
Phone: 1-888-239-0725
Fax: 1-866-387-1003

BCBST initiative for improving diabetic screening scores

The initiative designed to improve diabetic screening scores is planned for last quarter 2008

BlueCross BlueShield of Tennessee will implement an Interactive Voice Response outreach initiative promoting diabetic screenings for fully insured and City of Knoxville, TN members having diabetes and meeting at least one of the following elements:

- Non adherent to medications:
  - Diabetes with nephropathy: ACE-I or ARB.
- Missing at least one of the following tests:
  - Diabetes-Eye exam (retinal) testing;
  - Hemoglobin A1C testing;
  - Microalbuminurea; **or**
  - LDL-cholesterol screening performed.

This initiative does not apply to BlueCare or TennCare*Select*. If you have questions, please call our Provider Service line†.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

BCBST focuses on improved quality care and service

The BlueCross BlueShield of Tennessee Quality Improvement Program (QIP) focuses on improving the quality and safety of clinical care and service received by its commercial and TennCare members. As part of the QIP, BlueCross BlueShield of Tennessee conducts member education and other activities to improve rates on clinical initiatives.

These initiatives have shown some positive results. For example, a BlueCare member notified us that after receiving several reminder letters, she finally scheduled her mammogram. The results revealed the early stages of breast cancer which can now be treated. She explained that without the reminders, she would never have scheduled an exam.

However, despite such efforts by BlueCross BlueShield of Tennessee and our network providers to increase screenings, several rates continue to be below the national benchmark. The following HEDIS® 2007 results show that more emphasis is needed to increase rates for the following measures:

Product	HEDIS Measure		
	Retinal Eye Exam	Mammo gram	Pap Test
BlueCare	39.17%	48.71%	69.21%
TennCare*Select*	34.31%	30.03%	49.14%
Commercial	36.50%	67.52%	76.14%

The Quality Improvement and Outreach Departments at BlueCross BlueShield of Tennessee are planning new initiatives to specifically promote these screenings. Heath care providers, due to their direct patient contact, also play an essential role in actively encouraging patients to undergo appropriate screenings.

The Preventive Services section on the Provider page on the company Web site, www.bcbst.com, offers links and resources to assist providers in performing and promoting preventive care. For additional information on the BlueCross BlueShield of Tennessee Quality Improvement Program, please call 423-535-6221.

ADMINISTRATIVE

Billing guideline clarification for CPT® code 92250

CPT® code 92250, Fundus Photography, is not typically considered a routine vision benefit. BlueCross BlueShield of Tennessee has determined that benefits are available for CPT® code 92250 when reported on a CMS-1500 claim form and linked in Block 24E, to one or more of the following diagnosis codes:

When filing CPT® 92250, use DX code:		
115.92	362.76-363.15	743.51-743.59
130.2	363.20	743.66
190.5-190.6	363.30-363.33	758.1
190.9	363.40	759.5-759.6
224.5-224.6	363.43-363.61	794.11-794.14
225.1	363.63	871.0-871.9
249.00-250.93	363.70-363.9	921.0-921.9
360.00-360.33	364.24	950.0-950.9
360.44-360.50	365.00-365.89	996.53
360.54-360.55	377.00-377.16	998.82
360.60	377.21-377.49	V10.84
360.64-360.69	379.00	V58.71
361.00-361.81	379.07-379.09	V80.2
362.01-362.37	379.14-379.39	
362.41-362.57		
362.74	743.20-743.22	

Reminder: Real Time Claims Estimation/Adjudication available to outpatient facilities

Outpatient facilities are able to generate estimates and submit claims through *BlueAccess*. Log on to BlueCross BlueShield of Tennessee's secure area on its Web site, www.bcbst.com and try the Real Time application, today!

Reminder: Submitting paper CMS-1500 claims forms

To help expedite claims submitted on paper CMS-1500 claim forms, providers are reminded to:

1. type all alpha characters in upper case (capital letters);
2. align all print in appropriate blocks; and
3. keep within the boundaries of the form field; and
4. use the same font size throughout the claim form. Our scanning equipment will not recognize use of both typed and handwritten information on the same line item.

Enhanced provider service line

BlueCross BlueShield of Tennessee recently enhanced its toll-free Provider Service line, 1-800-924-7141, bringing more consistency to the available menu options offered on the "touch tone" and "voice response" features.

If you experience any problems when calling this number, please advise the Customer Service Representative.

When use of taxonomy code is appropriate

BCBST does not require electronic or paper claims be submitted with the provider's taxonomy code. However, to help ensure multi-specialty provider claims, such as transportation, durable medical equipment, home infusion, or pharmacy provider claims are processed correctly, a taxonomy code must be reported along with the NPI and tax ID at the applicable billing and/or rendering level.

BlueCare/TennCare*Select*

Clinical

Is it strep or just pharyngitis?

Measures have indicated the BlueCare and TennCare*Select* population of children between ages 2 and 18 years are being prescribed antibiotics for pharyngitis without the confirmation of a positive strep test.

Providers are encouraged to perform these quick and easy strep tests to confirm the actual need for prescription. Strep tests detect approximately 80 to 90 percent of all strep throat cases each year.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Correction: Arranging non-emergency transportation services with Southeastrans, Inc.

In the October issue of *BlueAlert*, we published an incorrect telephone number for use in arranging non-emergency transportation services. The correct numbers are:

For BlueCare:

East Grand Region	1-866-473-7563
West Grand Region	1-866-473-7564

For TennCare*Select*:

Statewide	1-866-473-7565

We apologize for any inconvenience this may have caused.

Changes to hospice billing guidelines*

Effective Dec. 1, 2008, providers should begin filing BlueCare and TennCare*Select* claims for Inpatient Room and Board for nursing home residents using Revenue Code 0658 instead of Revenue Code 0654. In addition to this change, claims will no longer be accepted with both inpatient and outpatient charges on the same claim.

Claims filed on or after the effective date with Revenue Code 0654 and claims filed with **both** outpatient and inpatient charges on the same claim form will be rejected.

Hospice and patient liability billing changes*

Some TennCare enrollees receiving TennCare-reimbursed Nursing Facility care may elect to receive hospice benefits. Providers should file CMS-1450 claims with a value code of 23 (recurring monthly income), 24 (Medicaid rate code), 31 (patient liability amount) or C3 (estimated responsibility payer c) in Form Locators 39-41 along with the patient liability amount.

We encourage you to review the billing guidelines available in the *VSHP Provider Administration Manua*l located on the Provider page of our company Web sites, www.vshptn.com and www.bcbst.com or on the Blue*Source* Provider Information CD.

If you have questions, please call the appropriate BlueCare or TennCare*Select* Provider Service number.

BlueCare provider administration manual getting new name

Because the BlueCare and TennCare*Select* products are administered by Volunteer State Health Plan, Inc. (VSHP), it only seems appropriate the provider administration manual should reflect the VSHP name.

You can be assured only the name is changing. The manual is updated on a quarterly basis and will continue to advise providers of any changes to policies, benefits, medical management and claims processing guidelines as they relate to the BlueCare and TennCare*Select* programs.

The *Volunteer State Health Plan Provider Administration Manual* can be viewed on our Web sites, www.vshptn.com and www.bcbst.com or on Blue*Source*, BlueCross BlueShield of Tennessee's quarterly information CD.

Reminder: Billing process for Medicare/Medicaid dual eligible members

Claims filed electronically for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed to Medicare for primary payment. Medicare should crossover to the State of Tennessee for Medicare coinsurance amounts.

Paper claims filed for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed with Medicare for primary payment. After Medicare pays, providers should file the paper claims along with the Medicare Summary Notice to the State of Tennessee for reimbursement of Medicare coinsurance amounts. Mail paper claims for secondary payment to:

Tennessee Bureau of Medicaid
P.O. Box 460
Nashville, TN 37202-0460

Uninsured/Uninsurable members (Eligibility Class 77 with Medicare) should be billed directly for any deductible/coinsurance amounts due after Medicare pays primary. BlueCare will not pay these amounts; however, the member is liable for their Medicare deductible/coinsurance.

Claims filed for non-Medicaid members after Medicare has paid primary will show patient liability as zero (0) on the BlueCare/TennCare*Select* Remittance Advice. However, the member may be billed for any Medicare deductible/coinsurance amounts. Medicare/Medicaid dual eligible members should not be billed for any Medicare deductible/coinsurance amounts, as these should crossover to the Tennessee Bureau of Medicaid for secondary payment.

Eligibility classification may be determined by the last two digits of the group number or by reviewing the classification listing in the *VSHP Provider Administration Manual* available on the Provider page on our Web sites, www.vshptn.com and www.bcbst.com, or on Blue*Source*, BlueCross BlueShield of Tennessee's quarterly information CD.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Reminder: Prior authorization required for select radiology procedures

As communicated to you earlier, please remember that beginning Nov. 1, 2008, for members in the West Grand Region and Jan. 1, 2009, for members in the East Grand Region, Volunteer State Health Plan will require prior authorization for select high tech imaging procedures performed in an outpatient setting (emergency room services and inpatient services will not require prior authorization). At this time, TennCare*Select* members and individuals who qualify as dually eligible for Medicare and Medicaid will be exempt from the prior authorization requirement.

Procedures requiring prior authorization include, but are not limited to: CT, CTA, MRI, MRA, MR Spectroscopy, PET Scans and Nuclear Cardiology.

To contact MedSolutions to request a prior authorization, you can phone them at 1-888-693-3211 or fax them at 1-888-693-3210.You can also submit your prior authorization request online at www.medsolutionsonline.com.

Additional information is available on our company Web sites, www.bcbst.com and www.vshptn.com.

Clarification of HomeHealth/Private Duty Nursing benefits

Private duty nursing is a covered benefit for those members who are either:

a. Under age 21
b. Ventilator dependant at least 12 hours per day
c. Have a functioning tracheostomy (additional criteria required)

These services should be billed using Revenue Code 0589 and T1000 HCPCS code per 15 minute increments. Intermittent skilled nursing visits requiring up to one hour of time should be billed using Revenue Code 0551 and G0154 HCPCS code in 15 minute increments, regardless of the age of the member. Extended skilled nursing visits requiring greater than an hour of time should be billed using Revenue Code 0552 and either S9123 or S9124 HCPCS codes in one hour increments, regardless of the age of the member.

BlueAdvantage (BlueCross BlueShield of Tennessee's Medicare Advantage Product)

ADMINISTRATIVE

Reminder: Risk Adjustment Data Validation

Annually, the Centers for Medicare and Medicaid Services (CMS) randomly select Medicare Advantage (MA) Organizations for risk adjustment data validation. Data validation audits occur after risk adjustment data has been collected and submitted, and payments are made to the organizations. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is with in the data collection period, and ensuring the provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments could potentially be imposed on both the organization and the provider submitting the claim.

At the recommendation of CMS, BlueCross BlueShield of Tennessee has developed its own independent Risk Adjustment Data Validation process by which medical records are requested and reviewed by the Provider Audit department. This process includes validation of diagnoses and procedure codes through the identification of supporting documentation in the medical record.

All requested records for data validation purposes should be provided promptly. Effective July 1, 2008, BCBST began recouping any claim payment from the provider associated with records not received, since the claim cannot be substantiated by the medical record.

Referring members to BCBST participating providers*

It is always important to remember to refer your patients to other BlueCross BlueShield of Tennessee contracted providers, which includes sending patients for lab work. BCBST contracts with laboratories just as we do with physicians and hospitals.

If you are not sure of other participating providers in your area, please refer to the *BCBST Referral Directory of Network Providers* on the company Web site, www.bcbst.com or call our Provider Service line† for assistance. Establishing a pattern of always referring to other participating providers will greatly reduce any unnecessary costs to the patient, as well as maintain compliance with your BCBST Provider Agreement.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

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

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

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*These changes will be included in the appropriate 4Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert

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Please Route to all Providers & Office Staff

December 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

Full text of the following BCBST medical policy changes can be viewed online under "Upcoming Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.

Effective Jan. 10, 2009

- Electrical Bone Growth Stimulation
- Keratoprosthesis

Note: Effective dates also apply to BlueCare and TennCare*Select* pending state approval.

New FDA Web site offers health care professionals safety information

The U.S. Food and Drug Administration (FDA) has launched a new, improved marketed unapproved drug Web site with a section particularly for health care professionals. The site, found at <www.fda.gov/cder/drug/unapproved_drugs/default.htm>, explains the risks posed by unapproved drugs and gives helpful information on how to protect patients. The site includes:

- Video and audio programs, given by FDA physicians and regulators that can be accessed online or downloaded;
- Questions and answers, public health advisories, and other documents;
- Enforcement actions taken by FDA (by drug class and by firms); and
- Background information about marketed unapproved drugs.

New drugs added to commercial specialty pharmacy listing

Effective Oct. 1, 2008, the following drugs have been added to our commercial Specialty Pharmacy medication list. Those requiring prior approval are identified by a (PA).

Provider-administered via medical benefit

- Adagen
- Aralast NP
- Arcalyst
- Arranon
- Cystadane
- Cytovene IV
- epoprostenol (Flolan) (PA)
- Hylenex
- HyperRho S/D
- mitoxantrone (Novantrone)
- Prialt
- Privigen
- Supprelin

Self-administered via pharmacy benefit

- Kuvan
- leuprolide (Lurpon SQ)

A complete listing of Specialty Pharmacy medications can be viewed online at <http://www.bcbst.com/pharmacy/Specialty/Program/SpecialtyPharmacyDrugList.pdf>.

ADMINISTRATIVE

Consumer-Directed Health Care (CDHC): Important facts to remember

As the New Year begins, providers will see more patients with a Consumer-Directed Health Care (CDHC) plan. As a reminder, we offer the following important facts:

The primary components under the CDHC plans are High Deductible Health Plans (HDHPs) and financial components. Providers participating in the member's assigned network may collect any applicable deductible, copayment and coinsurance amounts. We do encourage you to work with members on payment of services.

Under the HDHP, there are three financial account possibilities that can also provide reimbursement to the provider:

- Health Savings Account (HSA);
- Health Reimbursement Arrangement (HRA); or
- Flexible Spending Account (FSA).

Some employers provide funding to pay the member's deductible and coinsurance through HRA or HSA accounts. If a member pays at the time of service, you will be responsible for refunding any overpayment.

Our HDHP uses the standard BCBST PPO ID card. The ID cards reflect the member's participating provider network. With our new HRA Plan, the member's ID card will also indicate if he/she has an HRA Plan.

When checking member eligibility, you will be able to see whether the member has an HRA with his/her health plan. Remember, ID cards are for identification purposes only; they do not guarantee eligibility, or payment of your claim. ***You should always verify eligibility***.

With Real-Time Adjudication, you can see if the member has an HRA and what payments will be made directly to you from that HRA.

With our automatic payment feature, any HRA funds are paid directly to you from BCBST. There may also be HRA payments paid after the claim is submitted. If you collect the full amount from the member at the point of service, you will be responsible for refunding those overpayments. It may be more appropriate to wait until you receive the benefit reimbursement before billing the member in order to avoid an overpayment.

For more information on CDHC, please visit our Web site, www.bcbst.com. There you can find brochures, tutorials and information on other BlueCross BlueShield of Tennessee health plans.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

TRICARE managed care program update

As previously reported (October 2007 *BlueAlert*), BlueCross BlueShield of Tennessee participated in the bidding process in response to the U. S. Department of Defense request for proposal to serve the health care needs of approximately 9.2 million active and retired members of the Uniformed Services.

While the official TRICARE contract for the South Region will not be effective until June 2009, and the delivery of health care for the next contract period will not begin until early 2010, we anticipate some notification of the Department of Defense's intent in the near future.

We view this opportunity as a privilege to be able to serve a most deserving population. Providers play an integral role in this endeavor and through your participation TRICARE beneficiaries will have access to one of the broadest and strongest provider networks in the nation.

When we hear more from the Department of Defense, we will be in close and timely communication. In the meantime, thank you for your commitment and your willingness to join in this critically important endeavor.

Reminder: Submitting medical records to BCBST

Occasionally, medical records are sent to BCBST without a clear indication of who requested the information or complete member identification. Because we are interested in serving you in the most efficient manner possible, providers are encouraged to submit medical records using the following guidelines:

1. Submit medical records via hardcopy along with a cover letter stating what is being requested.
2. Submit any request letters from us as the **first** page of your medical record.
3. If submitting multiple records for a single patient or multiple records for multiple patients, ensure the individual records are secured with a clip or other indicator if mailed in the same envelope.
4. Medical records must be legible with all appropriate information pertinent to the presenting case.
5. Include all member information in a clear, legible format. We must be able to identify the patient and the relationship to BCBST.
6. Attach claims **behind** the medical record. If attached to the front, the submission will be mistaken for a claim needing adjudication rather than a medical record needing review.

The above guidelines and appropriate mailing addresses can be found in the BCBST and the VSHP provider administration manuals located on the company Web site, www.bcbst.com.

BlueCare/TennCare*Select*

CLINICAL

Hearing and vision screenings for members under 21 years of age

The AAP Recommendations for Preventive Pediatric Health Care currently include a preventive visit at 3 to 5 days of age and a new 30 month early childhood preventive visit. Routine hearing and vision screening should be included in every preventive visit for BlueCare and TennCare*Select* members under age 21 in accordance with American Academy of Pediatrics periodicity guidelines.

A comprehensive periodicity schedule that includes, but is not limited to age/risk appropriate recommendations for Measurements (including BMI assessment), Sensory screenings, Procedures, and Developmental/Behavioral assessments is available for viewing, printing or ordering from the *Practice Toolkit* tab at AAP.org.

Vision and hearing screening guidelines are available for viewing on the following Web sites:

Bureau of TennCare
<www.state.tn.us/tenncare/tenndercare/screeningguid.html>

TENNderCare Tool Kit
<www.bcbst.com/providers/preventive-services.shtml>

Reminder: Case management and disease management programs available

Case management services are available to members having complex chronic conditions, a major trauma or complicated care needs in which extensive interaction is necessary to connect with all the parties involved in the member's healing process. Members enrolled in a Case Management Program are assigned a BlueCross BlueShield of Tennessee Case Manager (registered nurse) to coordinate their complex needs.

Disease management services are available to members with diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease, pregnancy and coronary artery disease.

Members enrolled in a Disease Management Program are assigned a BlueCross
BlueShield of Tennessee Clinical Health Coach (registered nurse) who supports and coaches members in adopting and maintaining healthy habits.

When these nurses recognize changes or lifestyle issues that may affect the member's health, they work with the member and provider to address the issues and coordinate appropriate treatment, services and medications.

Members may self refer to either program by calling the Customer Service number listed on their ID card and providers may refer patients to either program by calling one of the following numbers:

Case Management	1-800-225-8698
Disease Management	1-888-416-3025

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder – Don't forget to submit your disclosure form

Federal Regulations require that Volunteer State Health Plan (VSHP), maintain disclosure of ownership and controlling interest information on all contracted providers receiving Medicaid payments.

If you have not completed the *Disclosure of Ownership and Control Interest Statement* form, please call Provider Service at 1-800-924-7141, Monday through Friday, 8 a.m. to 5 p.m. (ET) and choose the "Network Contracting" option. The form is also available at <http://www.bcbst.com/providers/Disclosure.pdf>.

VSHP is required to report any non-compliance to the Bureau of TennCare who will then report to the Centers for Medicare & Medicaid Services (CMS). Non-compliance with the disclosure information can result in payment delays and possible recoupment of previously paid Medicaid monies.

BlueCare member ID card gets new look*

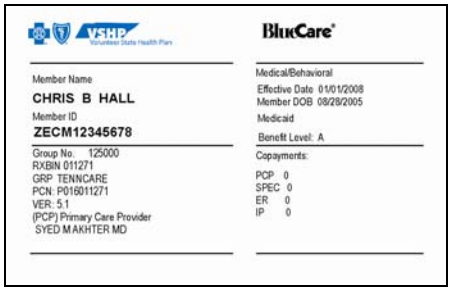
BlueCare members are being issued new ID cards for use in obtaining covered BlueCare services.

The new ID cards reflect important member information to include:

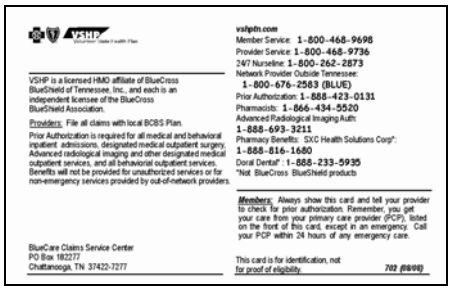
- Name;
- ID number;
- Assigned PCP name;
- Effective date of coverage;
- Benefit level;
- Copay amounts;
- Prior Authorization requirements; and
- Contact numbers.

A sample copy of the new member ID card follows:

Front



Back



Remember, ID cards are not a guarantee of benefits. Providers should always check eligibility by:

- Calling the BlueCare/TennCare*Select* Provider Service line†; or
- Accessing e-Health Services® via BlueAccess on the company Web site, www.bcbst.com.

Reminder: High tech imaging prior authorizations

As communicated to you earlier, effective Nov. 1, 2008, prior authorization is required for select high tech imaging services for BlueCare members in the **West Grand Region.**

Effective Jan. 1, 2009, prior authorization will be required for these services for BlueCare members in the **East Grand Region.**

When submitting prior authorization requests for BlueCare members for high tech imaging services via the MedSolutions Web site, www.medsolutions.com, please select the VSHP health plan section and provide the member ID **without** the "ZEC" prefix. By doing this, you will help ensure your authorization request is processed without delay.

Reminder: Use of dedicated fax number helps expedite standard appeals

BlueCare/TennCare*Select* has a dedicated toll-free fax number, 1-888-357-1916 solely for use in faxing standard appeals for denied services. This enhanced process helps expedite standard appeals and ensures the most current information is available to providers when checking the status of an appeal.

When faxing a standard appeal, the following documentation must be provided:

- The principle reason for upholding the non-certification determination;
- Detailed clinical rationale; and
- Pertinent medical records for the specific case being appealed.

BlueCard®

ADMINISTRATIVE

Reminder: BCBST discontinues Blue Network C

Effective Jan. 1, 2009, BlueCross BlueShield of Tennessee will discontinue marketing benefit packages through Blue Network C (BlueClassic℠). As a result of this action, BlueCard Traditional and BlueCard PPO members will begin utilizing Blue Network P as their BlueCard provider network. The discontinuation of Blue Network C will not affect any other network agreements under which a provider may be contracted.

We appreciate your participation in BlueCross BlueShield of Tennessee provider networks and your continued support in providing its members with the best of care. If you have any questions, please contact your provider network manager.

BlueCard®

ADMINISTRATIVE (cont'd)

BlueAccess enhances BlueCard and FEP provider online experience

Effective Dec. 31, 2008, providers will see new and enhanced features when accessing *BlueAccess* for BlueCard and FEP claims status and eligibility information.

Some key enhancements are:

- More benefit information when checking eligibility;
- More detailed out-of-pocket information;
- More user-friendly claims status process (reducing number of "Claim Not Found" experiences); and
- Easier process for checking multiple claims or multiple benefit types.

Key new features are:

- Capability to check status of submitted inquiries; and
- Ability to correct information for claim resubmission.

We are confident these enhancements will allow for an easier online claims status and eligibility inquiry experience. For more information or suggestions, please call eBusiness Service Center at 423-535-5717.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

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

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

BlueAdvantage **1-800-841-7434**
(Monday – Friday, 8 a.m. to 5 p.m. ET).

~Claims filing tip~

Screening Colonoscopy

If, during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as "a colonoscopy with biopsy or removal" should be reported rather than "screening colonoscopy procedure".

Note: *This guideline applies for all BCBST lines of business.*

Season's Greetings

BlueCross BlueShield of Tennessee offices will be closed Dec. 24 & 25, 2008 and Jan. 1, 2009 in observance of the Holiday Season

*These changes will be included in the appropriate 4Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.