BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

January 2009

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. 8, 2009

- Browplasty
- Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk
- Reverse Shoulder Arthroplasty

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

Modified Milliman Care Guidelines 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 February 20, 2009

The following as relates to Ambulatory Care:

- Colonoscopy
- Mandibular Osteotomy and Genioglossal Advancement with Hyoid Myotomy and Suspension (GAHM)

The following as relates to Inpatient and Surgical Care:

- Hysterectomy, Abdominal - Laparoscopic Procedures, Supracervical

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

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 Diagnosis and Management of Chronic Heart Failure in the Adult
<http://www.acc.org/qualityandscience/clinical/guidelines/failure/update/index.pdf>

Guide to Clinical Preventive Services
http://www.ahrq.gov/clinic/cps3dix.htm

Practice parameter: Evidence-based Guidelines for Migraine Headache (an evidence-based review): Report of the Quality Standards Subcommittee of the AAN
<http://www.neurology.org/cgi/reprint/55/6/754.pdf>

Global Initiative for COPD. Global Strategy for the Diagnosis, Management, and Prevention of 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.

Changes to commercial preferred drug listing

The Pharmacy and Therapeutics Committee attempts to minimize annual changes to the BlueCross BlueShield of Tennessee Commercial Preferred Drug List (PDL), but changes are necessary due to availability of generics, pricing changes and changes to market availability.

Changes for 2009 follow:

Drugs moving from Tier 3 to Tier 2:

- Androderm
- Avapro/Avalide
- Azor (moved 10/1)
- Micardis/Micardis HCT
- Opana ER
- QVAR
- Simcor

Drugs moving from Tier 2 to Tier 3:

- Accolate
- Cozaar
- Hyzaar

New generic equivalent drugs available

Generic drugs are safe, effective and affordable. The generic equivalent is now available for the following drugs, moving them from Tier 2 to Tier 3 on the BlueCross BlueShield of Tennessee commercial Preferred Drug List (PDL):

- Depakote (divalproex)
- Estrastep Fe (Tillia FE and Tri-Legest FE)
- Fosamax (alendronate)
- Fosamax D (alendronate plus OTC Vitamin D)
- Imitrex (sumatriptan tabs, injectable, nasal spray)
- Mircette (Kariva)
- Tri-Norinyl (Aranelle, Leena)
- Yasmin (Ocella)

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

Reminder: Case management and disease management programs available

Case management services are available to members with complex chronic conditions, a major trauma or complicated care including, but not limited to, transplantation and high-risk maternity care in which extensive interaction is necessary to connect with our members, their health care providers and all other 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.

Healthy Focus is our Disease Management Program, which now includes a fully integrated 24/7 nurse-line demand management service. Healthy Focus is designed to support the provider - patient relationship and to help you provide high quality, evidence-based care to our members with certain chronic conditions. Through Healthy Focus, services are available to members with conditions such as, but not limited to diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease, and coronary artery disease.

In our primary coach model, participants work with the same Health Coach over time.
Health Coaches are specially trained health professionals such as nurses, respiratory therapists, and dietitians, who support and coach members in adopting and maintaining appropriate self-care habits. When the Health Coach recognizes status or compliance changes that may affect the member's health, that Health Coach will work with the member to address the issues. Via this process, members are provided with information and guidance and may be encouraged to discuss their health care needs with their physician. The Health Coach is available to the members by phone anytime, 365 days a year, at no cost.

Through Healthy Focus, providers will receive a monthly report identifying their patients who have spoken with a Health Coach for the first time.

Members may self refer to either of these programs by calling the Customer Service number listed on their ID card. Providers also may refer patients to either program by calling one of the following numbers:

Case Management	1-800-225-8698
Healthy Focus	1-888-818-8581

ADMINISTRATIVE

Reminder: Flu season is here!

Flu season can begin as early as October and last as late as May. However, in Tennessee, flu activity is typically worse in February and March.

Providers are reminded not all BlueCross BlueShield of Tennessee health care benefits plans cover influenza immunizations. Benefits can be verified by calling the appropriate Provider Service line†. The following influenza immunization guidelines apply:

Commercial

- ***Vaccine and administration***
  Covered if member's health care plan has a Well care rider

- ***FluMist® nasal spray*** (recommended for healthy individuals ages 2-49)
  Entire cost may not be covered and member may be responsible for any charges that exceed the standard reimbursement amount

If your commercial patients elect to have the *FluMist®* nasal spray, a *FluMist®* acknowledgement form is available online for provider use at http://www.bcbst.com/providers/forms/FluMist.pdf.

Note: If you utilize the waiver form, you are still required to file a claim with BlueCross BlueShield of Tennessee for the services.

BlueCare or TennCare*Select*

- ***Vaccine and administration***
  - Covered

  Note: Providers who normally receive influenza vaccine through the Vaccine for Children (VFC) program may use their purchased supply and submit claims using a Modifier 32 to receive fee for service reimbursement **only** when the VFC supply is depleted or delayed.

- ***FluMist® nasal spray*** (recommended for healthy individuals ages 2-49)
  - Covered

  Note: *FluMist®* is available under the Vaccines for Children (VFC) Program for children ages 5 through 18 years.

Changes to durable medical equipment (DME) repair billing guidelines*

Effective Jan. 1, 2009, providers should bill labor charges for DME repairs to member-owned equipment using the most appropriate 5-digit HCPCS code, e.g., E1340 **without** a modifier. Previously, Modifier "RP" was required when filing these charges.

The Centers for Medicare & Medicaid Services (CMS) deleted this modifier requirement Dec. 31, 2008.

Real Time Claim Estimation/Adjudication now available for BlueCare and TennCare*Select*

Have you used BlueCross BlueShield of Tennessee's Real-Time Claims Adjudication application? This Web-based tool enables claim submission and claim estimation to gain true patient liability at or before the point-of-care for Commercial and BlueCare/TennCare*Select*. The tool also provides the capability to adjudicate the claim to completion before the patient leaves the provider's office.

Access to this free Web-based tool is available through *BlueAccess*, BCBST's secure area of our Web site, www.bcbst.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

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ADMINISTRATIVE

Health Research Insights, Inc. contracting with several large BCBST employer groups

Several of our large self-funded employer groups have retained the claim review services of Health Research Insights, Inc. (HRI). It is the understanding of BlueCross BlueShield of Tennessee that HRI will be reviewing historical data incurred by the employees of these groups in an effort to analyze their medical claims payments. It is possible that your office or organization may be contacted by them concerning these historical payments.

It is very important for us to stress the fact that BlueCross BlueShield of Tennessee is in no way affiliated with HRI or their claim reviews and have no position in the contract between the employer group and HRI. It must also be understood that as a self-funded employer group, they own the sole rights to the information contained within the claims data.

BlueCross BlueShield of Tennessee assumes no responsibility, nor have we assisted HRI in any way with these reviews and therefore will not be able to provide any information regarding these reviews if inquiries are received. Our representatives have been instructed to inform callers they must contact HRI directly with any questions. A document has been placed on our company Web site, www.bcbst.com to help providers understand this situation.

Duplicate payments made on lab charges

Recently we identified a number of claims submitted to BlueCross BlueShield of Tennessee in which the physician and an independent lab billed for the same lab work performed on the same patient.

Because payment was made to both providers for the same procedure, we will be initiating overpayment recovery efforts where applicable. Those providers affected by the overpayments will receive a refund request.

Changes to billing guidelines for moderate conscious sedation*

Effective for date of service April 1, 2009, and after, BlueCross BlueShield of Tennessee will reimburse moderate conscious sedation when appropriate for all lines of business in accordance to the Centers for Medicare & Medicaid Services (CMS) and CPT® Guidelines in Appendix G. Appendix G, Summary of CPT® Codes That Include Moderate (Conscious) Sedation, lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself.

CPT® Codes 99143-99145

- Physician can bill the conscious sedation codes as long as the procedure billed with it is not listed in Appendix G of CPT® Guidelines;
- Physician should not bill CPT® codes 99143 to 99145 in conjunction with codes listed in Appendix G;
- BlueCross BlueShield of Tennessee has adopted the National Correct Coding edits that bundle CPT® codes 99143 and 99144 into the procedures listed in Appendix G.

CPT ® Codes 99148 to 99150

- In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate conscious sedation in the facility setting for the procedures listed in Appendix G or other procedures, the second physician can bill.
- Facility settings considered are inpatient hospital - place of service 21, outpatient hospital - place of service 22, emergency room-hospital - place of service 23, ambulatory surgery center - place of service 24, or skilled nursing facility - place of service 31.
- When these services are performed by the second physician in the non-facility setting, CPT® codes 99148 to 99150 should not be reported.

Reminder: Consumer-Directed Health Plans rise in popularity

As the New Year begins, providers will see more patients having a Consumer-Directed Health Care (CDHC) Plan. CDHC is a term used to describe new health care options designed to make consumers aware of the true costs of health care and to become more responsible for consumption of these services.

The primary components under the CDHC plans are High Deductible Health Plans (HDHP) and financial options.

Key elements under an HDHP plan:

- 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);
- Providers are reimbursed via Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), or Flexible Spending Account (FSA);
- Members issued a standard BCBST ID card;

CDHC is gaining popularity as a way to offer health care coverage and help offset rising health care costs. Watch for more information in future BlueAlerts or visit our company Web site, www.bcbst.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Calling the appropriate provider service line helps shorten phone time

Calling the appropriate VSHP provider service line can help reduce the amount of time you spend on the phone. If you need information regarding your BlueCare patient, call the **BlueCare Provider Service line at 1-800-468-9736**. If your patient is a TennCare*Select* member, you should call the **TennCare*Select* Provider Service line at 1-800-276-1978.**

These provider service lines are open Monday through Friday, 8 a.m. to 6 p.m., (ET).

Reminder: Prior authorization required for select radiology services

VSHP requires prior authorization for select outpatient advanced imaging services. A listing of these services can be found in the *VSHP Provider Administration Manual* located on the company Web site, www.vshptn.com. To arrange prior authorization for these services:

For BlueCare members in the West Grand Region (effective Nov. 1, 2008) and in the East Grand Region (Jan. 1, 2009) contact MedSolutions:

Phone: 1-888-693-3211
Fax: 1-888-693-3210
Online: www.medsolutionsonline.com,

For TennCare*Select* members call VSHP Utilization Management Department, Monday through Friday, from 8 a.m. to 6 p.m. or online submission:

Phone: 1-888-423-0131
Fax:
- West Grand Region 1-800-919-9213
- East Grand Region 1-800-292-5311

Online: www.vshptn.com

Home health care services dedicated fax lines established*

Effective Feb. 1, 2009, all requests for home health care services for BlueCare or TennCare*Select* members should be faxed to one of the numbers listed below. Use of these dedicated fax lines will help expedite your requests for home health care services. For members residing in:

East Grand Region	1-865-588-4663
West Grand Region	1-800-919-9213

Use of these dedicated fax lines will help expedite your requests for home health care services.

Change to prior authorization requirement for outpatient therapy evaluations*

Effective Feb. 1, 2009, VSHP will no longer require prior authorization for evaluations for physical therapy, occupational therapy or speech therapy. **Note**: *This guideline applies for BlueCare members only.*

BlueCare behavioral health provider initiated notice fax line established*

The Bureau of TennCare requires that all members being discharged from any behavioral health service be notified of their rights to appeal that discharge decision. Providers are required through the Grier Process to notify the Managed Care Organization (MCO) of any provider initiated discharge by submitting a "Provider Initiated Notice (PIN)" form within 2 days of the discharge. The MCO is responsible for providing the member with a letter that outlines their appeal rights. An electronic copy of the PIN is available on the company Web site, www.vshptn.com.

To help ensure this process is handled expeditiously, VSHP established the following dedicated fax lines for use by behavioral health providers caring for BlueCare members residing in the East and West Grand Regions:

East Grand Region	1-800-859-2922
West Grand Region	1-866-320-3800

VSHP's "In-the-Know" well care pilot program launched

A new well-care pilot program is being launched by VSHP to encourage teens, ages 15 to 20 years old who are not up-to-date on TENNderCare screenings to get a checkup.

Scheduled to be launched during the first quarter of 2009 in Gibson and Tipton counties in West Tennessee and Bledsoe County in East Tennessee, the pilot will focus on increasing the screening rates for this population of our membership. Teens and/or their parents are being asked to make an appointment for a well-care checkup. When you are contacted please remember these appointments must be scheduled in accordance with the Primary Care Provider (PCP) *Access and Availability Standards* outlined in the *Volunteer State Health Plan Provider Administration Manual*. The manual can be found on the VSHP company Web site, www.vshptn.com.

BlueCard®

ADMINISTRATIVE

Reminder: High-tech imaging (HTI) procedures may require prior authorization for out-of-state members

Out-of-state members may require a prior authorization for certain HTI procedures. Checking benefits and eligibility can determine if a prior authorization is required.

Ordering physicians having direct access to a member's clinical information can easily obtain a prior authorization. This can help the facility and radiologists avoid denials and loss of revenue. Eligibility and benefits for out-of-state members can be verified on the company Web site, www.bcbst.com or by calling **1-800-676-BLUE (2583)**. We encourage you to check eligibility prior to rendering services.

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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).

*These changes will be included in the appropriate 1Q 2009 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 12, 2009

- Enoxaparin Sodium
- Bendamustine
- Bevacizumab
- Photodynamic Therapy (PDT) for the Treatment of Actinic Keratoses
- Botulinum Toxin
- Romiplostim

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

New drugs added to commercial specialty pharmacy listing

Effective Jan. 1, 2009, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by a (PA).

Provider-administered via medical benefit:
Camptosar
Hycamtin
Nplate
Treanda

Self-administered via pharmacy benefit:
Xenazine (PA)

ADMINISTRATIVE

Reminder: Always include correct phone and fax numbers when submitting online Web authorization

Effective mid March, provider fax numbers will be required information when submitting online Web authorizations. It is important to always include the correct provider contact phone number and fax number in the event a nurse reviewer needs to contact you regarding the authorization request.

Clarification for reporting Present on Admission (POA) Indicator Option "1"*

Effective April 1, 2008, for all inpatient admissions to general acute care hospitals, BlueCross BlueShield of Tennessee began requiring the "Present on Admission" code on diagnoses for discharges on or after Dec. 31, 2007. Based on National Coding Standard guidelines, BlueCross BlueShield of Tennessee offers the following clarification for utilizing POA Indicator Option "1":

When filing electronic ANSI 837 inpatient facility claims, providers should enter Indicator Option "1" in the POA field if:

- the diagnosis code is exempt from POA reporting; OR
- the facility‡ is exempt from POA reporting.

When filing paper CMS-1450 (UB04) inpatient facility claims, the POA field should be left blank if:

- the diagnosis code is exempt from POA reporting; OR
- the facility‡ is exempt from POA reporting.

‡Exempt facilities are critical access hospitals, Maryland waiver hospitals, LTC hospitals, cancer hospitals, and children's inpatient facilities.

When any other POA Indicator Options apply, they should be reported in the POA field on **both** electronic and paper claims.

Claims will reject if:

- POA "1" is submitted on a paper CMS-1450 (UB04) inpatient claim;
- POA is left blank on an electronic inpatient claim; or
- POA is required, but not submitted.

No change to BCBST reimbursement guidelines for oxygen rental

Although Medicare implemented the 36-month cap on oxygen rental beginning Jan. 1, 2009, BCBST will continue to handle all oxygen systems as a continuous rental for its Commercial, BlueAdvantage and TennCare members.

All supplies and oxygen contents will continue to be included in the rental of the oxygen equipment and will not be reimbursed separately.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Billing guidelines for behavioral health licensure levels

To receive appropriate reimbursement, BlueCare Behavioral Health providers are advised to bill the correct modifier code in accordance with their licensure levels.

The modifiers are:

- UA= MD Level
- HP = Doctoral Level
- HO = Masters Level
- SA = Nurse Practitioner Rendering Service In Collaboration With a Physician

Note: This guideline does not apply for TennCare*Select*.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Home health/Private duty nursing billing guidelines

Billing of home health (HH) intermittent visits must be billed in 15 minute increments, rounded to the nearest hour and filed with the appropriate procedure code GO154 and GO156.

Extended visit codes, S9122, S9123 and S9124 should be filed for services 2 hours or more per day when the member does not qualify for private duty nursing. Private duty nursing (PDN) services are for members who require continuous skilled nursing care (eight or more hours during a 24-hour period) provided by a registered nurse or licensed practical nurse under the direction of the recipient's practitioner.

HH/PDN coding for members under age 21 years:

For purposes of billing, home health agencies have been instructed to use private duty nursing codes (T codes) for patients who meet the adult criteria for PDN care (i.e. vent/trach patients), all other nursing care that is not provided as a visit, would be coded using the skilled nursing/hour codes (S Codes).

As a reminder, children are eligible to have aides and nurses accompany them outside the home under certain circumstances defined by rule. The coding decision described above does not in any way drive the determination of whether a nurse may accompany a child outside the home.

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

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

Continuation of benefits for members over age 21 years*

On Sept. 9, 2008, Volunteer State Health Plan began the implementation of home health/private duty nursing benefits in accordance with the Bureau of TennCare guidelines.

When an enrollee over age 21 files an appeal and requests continuation of benefits and it is determined the current services will continue, the appeal will be expedited and a decision made quickly. As an expedited appeal, it is important for home health agencies to work with VSHP in obtaining a new physician order that can be used in the event the appeal is upheld.

The approval criterion for continuation of benefits requests for members over the age of 21 for Private Duty Nursing and/or Home Health Aide is available on the company Web sites, www.vshptn.com and www.bcbst.com.

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

ADMINISTRATIVE

Online Web authorization available for BlueAdvantage

Have you submitted Web authorization or advanced determination requests for your commercial members? If so, we would like for you to know this service is now available for your BlueAdvantage patients. If you have not used this service before and would like to know more, please log on to *BlueAccess*, the secure area on the company Web site, www.bcbst.com and visit the e-Health Services section. Providers can also review our online Web Authorization Submission tutorial located at <http://www.bcbst.com/providers/training/CareAuth/player.html>.

BlueCard®

ADMINISTRATIVE

BlueCross BlueShield of Mississippi announces its new wellness program – *Healthy You!*

BlueCross BlueShield of Mississippi (BCBSMS) developed its *Healthy You!* wellness program to help identify potential health risks before they become serious. This wellness benefit covers annual health screenings and immunizations for a number of BCBSMS members based on age and gender.

Some BlueCross BlueShield of Tennessee providers may be seeing these out-of-state members for their *Healthy You!* wellness examinations. Providers can verify eligibility and benefits for members from other Blues plans via *BlueAccess* on our company Web site, www.bcbst.com or by calling **1-800-676-BLUE (2583)**. We encourage you to check eligibility prior to rendering any services.

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

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
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CLINICAL

Medical policy update/changes

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Effective April 9, 2009

- Radiofrequency Ablation for Treatment of Tumors
- Balloon-based Radiofrequency Ablation for Barrett's Esophagus
- Targeted Phototherapy (UVB Therapies) for Psoriasis

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

Leuprolide Acetate claims may be subject to medical appropriateness

Providers are reminded to review the current medical appropriateness indications for Leuprolide Acetate in the *BCBST Medical Policy Manual* located on the company Web site at <http://www.bcbst.com/mpmanual/!SSL!/WebHelp/Leuprolide_Acetate.htm>.

These claims may be subject to retrospective review to ensure medical appropriateness criteria are met.

ADMINISTRATIVE

Online Web authorization system enhanced

If you have recently utilized our online Web Authorization process you probably know what services are available to providers. However, if you have not submitted a prior authorization request online, we would like to make you aware that authorization requests for the following services can now be submitted through *BlueAccess*, BCBST's secure area on its Web sites, www.bcbst.com and www.vshptn.com:

- Inpatient Admissions
- 23-Hour Observation
- Specialty Pharmacy
- Clinical Updates (facility requests for additional days)
- Outpatient Procedures (BlueCare Only)
- Global Obstetrics (BlueCare Only)

For more information on how to get started with the online authorization process, see the tutorial at <http://www.bcbst.com/providers/training/CareAuth/player.html>.

Select hospitals exempt from "Present on Admission" reporting requirement

BlueCross BlueShield of Tennessee will be following The Centers for Medicare & Medicaid Services (CMS) Guidelines for Present on Admission (POA) Indicator Reporting for all lines of business. The Present on Admission Indicator Reporting requirement applies **only** to Acute Inpatient Prospective Payment System (IPPS) hospitals. Facilities (as indicated by CMS) that are exempted from the POA Indicator Requirements will **not** be required to submit the POA Indicator Option "1".

At this time, the following hospitals are **EXEMPT** from the POA indicator requirement:

- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Facilities
- Rural Health Clinics
- Federally Qualified Health Centers (FQHCs)
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities (IRFs)
- Veterans Administration/Department of Defense Hospitals

Changes to medical management program corrective action plan*

Effective April 1, 2009, BlueCross BlueShield of Tennessee's Medical Management Program Corrective Action Plan (MMCAP) has been revised to:

- differentiate between applicant and participating provider reviews;
- remove non-credentialing activity provisions;
- indicate "Practice Improvement Plan" as only one element of the Plan;
- reflect modified appeal processes; and
- identify responsibilities of Chief Medical Officer and the Credentialing Committees.

The revised document can be viewed online in its entirety at <http://www.bcbst.com/providers/corrective-action-plan.shtml>.

Reminder: Submitting electronic secondary claims appropriately

BlueCross BlueShield of Tennessee accepts professional and institutional secondary claims in the ANSI-837 electronic format. The ANSI-837 format, version 4010A1 is the required format for electronic transmissions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Electronic submitters are encouraged to

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Submitting electronic secondary claims appropriately (cont'd)

review the standard ANSI-837 Implementation Guides for specific requirements regarding these electronic claims types. Implementation Guides containing specific secondary electronic claim information can be found at <http://www.bcbst.com/providers/ecomm/technical-information.shtml>.

Providers should **not** submit secondary to Medicare claims electronically. For secondary to Medicare payments, Group Health Incorporated (GHI), Medicare's coordination of benefits contractor, will coordinate transfer of the claim to the supplemental or retiree group insurers for the payment of secondary benefits.

For questions, please contact our eBusiness Service Center at 423-535-5717, Monday through Friday from 8 a.m. to 5:30 p.m. (ET).

Change to DME labor codes*

Effective April 1, 2009, HCPCS Code E1340 will become invalid for claim submission to the Centers of Medicare & Medicaid Services (CMS). Service-specific codes K0739 and K0740 will replace the generic labor code.

At this time BCBST will continue to accept E1340 but providers are encouraged to use the more specific labor codes for DOS April 1, 2009, and after. For further information, providers can review this publication on the CMS Web site at http://www.cms.hhs.gov/.

Note: Labor billing code selection for BlueAdvantage should follow CMS guidelines.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Prior authorization fax requests no longer accepted on weekends and holidays*

Effective April 1, 2009, fax requests **will not** be accepted on weekends or holidays.

Fax transmissions may be submitted to the Utilization Management Department Monday through Thursday, 24-hours-a-day and Friday until 6 p.m. (ET).

Fax requests to: 1-800-292-5311

Urgent concurrent reviews for inpatient stays and emergent admissions must be submitted within 24 hours or the next business day. These requests can be submitted to the:

- prior authorization number listed on the member's VSHP ID card
- VSHP UM department:
  - BlueCare 1-888-423-0131
  - TennCareSelect 1-800-711-4104

  Or
- Via *BlueAccess* on www.vshptn.com

MedSolutions creates exclusive prior authorization phone number for use in authorizing high tech imaging services for BlueCare members*

To help expedite prior authorization requests for high tech imaging services for BlueCare members, MedSolutions created the following dedicated phone number:

1-877-791-4101

Please use this number when requesting high tech imaging services for your BlueCare patients.

Note: At this time, prior authorization for high tech imaging services is **not** required for TennCare*Select* members.

Home health and private duty agencies must report changes in services*

Effective Jan. 30, 2009, all home health and private duty agencies are required to submit weekly status reports to Volunteer State Health Plan reporting any change(s) in services to its members. Agencies should complete and return the VSHP-supplied forms indicating such changes as:

- Increase/Decrease in service;
- Hospitalizations;
- Facility transfers;
- Discharge from service;
- Death; and/or
- Missed appointments

Reminder: Reporting PDN missed shifts helps promote continuity of care

The *Private Duty Nursing Missed Shift* fax form is readily available online at <http://www.bcbst.com/providers/forms/PDN_Missed_Shift_doc_2_.pdf> and should be **faxed** to Case Management at the appropriate number below within 24 hours to promote continuity of care for our members.

East Tennessee 1-800-292-5311
West Tennessee 1-901-544-2490

Providers may also request the form by calling the BlueCare or TennCare*Select* Provider Service lines†.

Clear Claim Connection online tool being discontinued*

Effective March 20, 2009, Clear Claim Connection, a BlueCare and TennCare*Select* interactive online code auditing disclosure tool is being discontinued. Commercial and Medicaid Code Bundling will be utilized for all claims. Bundling rationale can be found on the Provider page of the company Web site, www.bcbst.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Clarification: Prior authorization required for select radiology services

In the January 2009 issue of *BlueAlert* we advised VSHP requires prior authorization for select outpatient advanced imaging services. The article was confusing in that we provided contact information for arranging prior authorizations for both BlueCare and TennCare*Select* members, which made it appear authorization for high tech imaging services is also required for TennCare*Select*.

At this time, VSHP only requires prior authorization for high tech imaging services for its BlueCare population. We apologize for any inconvenience this may have caused.

Reminder: Filing claims for preventive services

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 *VSHP Provider Administration Manual* located on the company Web site, www.bcbst.com.

Correction: Billing guidelines for behavioral health licensure levels

In the February 2009 issue of BlueAlert we advised in order for BlueCare behavioral health providers to receive appropriate reimbursement, they must bill the correct modifier in accordance with their licensure level. We inadvertently included modifier UA (MD level) in the listing. Medical doctors are **not** required to bill the UA modifier. We apologize for this inconvenience.

VSHP begins 2009 HEDIS medical record review project

Volunteer State Health Plan will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS) project in March 2009 to meet National Committee for Quality Assurance (NCQA) accreditation and the Bureau of TennCare reporting requirements for BlueCare and TennCare*Select*.

Measures requiring additional information from medical record documentation to report results include:

- Childhood immunizations;
- Prenatal and postpartum care;
- Cervical cancer screening;
- Controlling high blood pressure;
- Comprehensive diabetes management; and
- Two new measures:
  - Adult BMI assessment; and
  - Weight assessment and counseling for nutrition and physical activity for children/adolescents.

A representative form VSHP will be calling your office in the near future to request documentation or schedule an onsite review of medical records for data abstraction. All information should be received prior to May 15, 2009, to meet strict reporting timeframes for this project.

Providers are reminded that VSHP and providers **can** continue to share information related to a member's protected health information (PHI) without the member's authorization when the information is needed for health care treatment or payment activities. The Privacy element of the Health Insurance Portability and Accountability Act of 1996, (HIPAA) works to protect members' PHI, but also allows use by providers and insurers in the course of normal business when related to Treatment, Payment or Health Care Operations (TPO).

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

ADMINISTRATIVE

A number of employer groups choose to include end stage renal disease coverage

It is important to remember that although **Individual** Medicare Advantage plans are not open to End Stage Renal Disease (ESRD) patients (except for very limited circumstances); **Employer** Group Medicare Advantage plans are allowed to include ESRD patients in their employee coverage (regardless of the circumstances). Because of this Employer Group exception and to prevent any unnecessary member cost, BlueCross BlueShield of Tennessee urges Dialysis Clinics to verify benefits by calling the BlueAdvantage Provider Service line† prior to rendering services.

New look for Medicare Advantage terms and conditions

You may have noticed that the BlueAdvantage Terms and Conditions for private-fee-for-service (PFFS) has a different look. This is because the BlueCross BlueShield Association in conjunction with the Centers for Medicare & Medicaid Services (CMS) developed a standard model template for all Blue Plans to facilitate. The intent is to diminish confusion for providers trying to locate their patient's specific document. All Blue Plans are required to publish the document on their respective Web site. You can locate the BlueAdvantage Terms and Conditions by visiting <http://www.bcbst.com/providers/bcbst-medicare/pdfs/terms/pdf>.

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

ADMINISTRATIVE

Shared Health online records now available for BlueAdvantage members

The secure online health record of Medicare Advantage members is now available through Shared Health. Beginning Jan. 1, 2009, providers can access Medicare Advantage members' Clinical Health Record (CHR) and manage the care of their Medicare Advantage patients on the Shared Health Web site, www.sharedhealth.com.

Shared Health allows doctors to write prescriptions from their own computers and send them directly to any Medicare Advantage patient's pharmacy through the Shared Health ePrescribe® feature.

ePrescribe® gives providers critical information about prescriptions for Medicare Advantage patients such as:

- Covered medicines;
- Medicines requiring prior authorization or quantity limits' approval;
- Medication claims history; and
- Drug interactions that could potentially harm a patient.

Key Benefits of Shared Health:

- Allows more time for patient care and less time for administrative paperwork.
- Protects valuable medical information in the case of a catastrophic event such as Hurricane Katrina.
- Improves preventive care by giving a more holistic view of your patient.
- Helps emergency departments quickly access relevant patient information when time is crucial.

If you have additional questions, or would like to become a registered clinician with Shared Health, please call 1-888-283-6691, or visit www.sharedhealth.com for more information.

Real Time Claim Estimation/Adjudication available for BlueAdvantage

Real Time Claims Adjudication application is now available for use with your BlueAdvantage patients. If you have not used this online application before and would like to know more, please log on to BlueAccess, the secure area on the company Web site, www.bcbst.com and view the educational tutorial located in the eHealth Services® section, or contact eBusiness Solutions by:

Calling:
Technical Support 423-535-5717
Marketing Team 423-535-3057
Or
e-mail:
eComm_Marketing@bcbst.com

BlueCard®

ADMINISTRATIVE

2009 BlueCard Program

Your feedback helps improve our processes making your daily interactions with us an easier experience.

In first quarter 2009, you may receive a call on behalf of BlueCross BlueShield of Tennessee seeking feedback on your experiences when treating members from other Blue plans. Our research vendor may invite you to participate in a phone or electronic survey. If your office is contacted, we encourage you to participate in the survey or provide your e-mail address for participation at a more convenient time.

If you need information about the BlueCard Program or wish to offer suggestions for improvements, please consider:

- talking to your provider relations representative;
- visiting us online at www.bcbst.com; or
- calling us at 1-800-705-0391.

Thank you in advance for your participation. We appreciate your feedback.

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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 Contracts or Credentialing**" 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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Happy St. Paddy's Day
March 17, 2009

*These changes will be included in the appropriate 2Q 2009 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

April 2009

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 9, 2009

- Intraepidermal Nerve Fiber Density Testing
- Vagus Nerve Stimulation for the Treatment of Medically Refractory Movement Disorders, Headache, and Obesity
- Late Lyme Disease Treatment
- Natural Orifice Transluminal Endoscopic Surgery
- Outpatient Pulmonary Rehabilitation
- PET for Miscellaneous Applications

Note: Effective dates also 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:

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>

2009 Pediatric Immunization Schedules *and* Childhood, Adolescent and Catch-up Schedule
<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable>

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

Change in pharmacy benefits for State of Tennessee members

Effective May 1, 2009, State of Tennessee employee health benefits plan will only cover **generic** Proton Pump Inhibitors (PPIs). Brand name PPIs, including the following, will no longer be covered:

- Aciphex
- Nexium
- Prevacid
- Prilosec
- Protonix
- Zegerid

State employees were recently notified these medications are covered for members 18 years and under without prior authorization and 19 years and over with prior authorization if there is a diagnosis of:

1. Grade III Erosive Esophagitis;
2. Grade IV Erosive Esophagitis; or
3. Zollinger-Ellison Syndrome.

Note: Providers can call Caremark at 1-877-916-2271 to request prior authorization.

New tools available for clinicians with Shared Health®

Smart tools. Healthy outcomes. Smart business

Shared Health is pleased to announce the recent addition of *Clinical Insight* and *Clinical Tracker*, two new tools designed to provide a means for clinicians to operate their practice more efficiently while providing the best outcomes for their patients.

These two new products are quality enhancements to Shared Health's offering, providing macro-and micro-views to help clinicians transform care.

Shared Health's Condition Insight allows clinicians a view of the care delivered across their patient population. It allows clinicians to generate reports that help them evaluate their adherence to quality and program-specific measures.

Shared Health's Condition Tracker provides a patient-centric view of a patient's adherence to evidence-based guidelines for specific medical conditions, regardless of who administered the care.

With these tools, providers will be able to reduce costs, have more time to manage and treat patients, identify care opportunities, and provide quality health care.

These products work in conjunction with Shared Health's existing Clinical Xchange™ system and are provided at no charge to clinicians. To learn more call 1-888-283-6691 or visit Shared Health online at www.sharedhealth.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Health reimbursement arrangement (HRA) and flexible spending account (FSA) programs

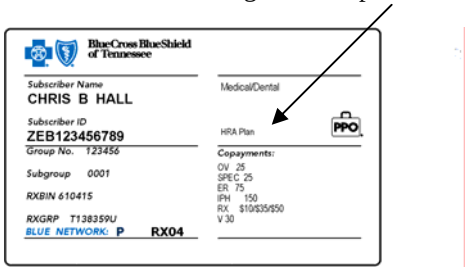
Effective Jan. 1, 2009, BCBST introduced its internally administered HRA and FSA programs, previously administered by a third party. Due to significant interest in these programs you may see more patients with these types of arrangements. A few things to remember:

- **Checking eligibility and real time**. When checking member eligibility online, you will be able to see whether the member has an HRA or FSA account with his/her health plan. If a member has an HRA account, it will be indicated on the front of the member's ID card. With our Real Time Claims Estimation/Adjudication system, (a free Web-based tool available through *BlueAccess*, BCBST's secure area of our Web site, www.bcbst.com) you can see the actual patient liability as well as what payments will be made directly to you from the HRA. You can also call BCBST's provider service line to check eligibility and find out if HRA funds are available for that member.

- **Collecting patient liability vs billed charges.** With or without these types of financial arrangements, it is important to only collect patient liability – **not** billed charges at the point-of-service. Members having an HRA or FSA are only allowed to use those monies for qualified medical expenses. If members pay billed charges, any dollars paid above the allowed amounts are considered non-qualified and must by law be returned to the financial arrangement account.

  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.

The below sample ID card represents a BCBST member having an HRA plan:



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 (LEP) is 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 and 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 info@accessproject.org.

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

Changes in pharmacy benefits for AccessTN members

Effective April 1, 2009, AccessTN members will move to BlueCross BlueShield of Tennessee's Limited Formulary. In addition to the formulary change, members receiving self-administered specialty medications will be required to use one of BCBST's three preferred specialty pharmacy vendors.

AccessTN members have received notification of these changes. Information on BCBST formularies and its Specialty Pharmacy Program can be found at http://www.bcbst.com/providers/pharmacy/.

Oncotype DX™ test for breast cancer

Oncotype DX™ is a diagnostic test that quantifies the likelihood of breast cancer and assesses the benefits of chemotherapy. Currently, BCBST medical policy considers the Oncotype DX™ test Medically Necessary if the appropriate criteria are met. Test samples are sent to a California lab, Genomic Health, for the performance of this service, but the member is not always being made aware that the service is subject to Medical Appropriateness review. Since Genomic Health does not participate in any of BCBST's provider networks, this leaves the member liable for the full charge for the service if deemed not Medically Necessary. Additionally, not all benefit plans cover genetic testing, which would also leave the member liable for the full charge of this service.

If you plan to send a specimen from a patient with BCBST coverage to Genomic Health, please submit a predetermination request for review of benefits and Medical Necessity prior to services being received. If you do not submit a predetermination for this service, medical records will be requested upon receipt of the claim. We appreciate your cooperation in helping ensure your patients and our members are fully informed about the potential cost of their care.

Please note this policy does not apply for BlueCare or TennCare*Select*.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Changes to BCBST commercial durable medical equipment and medical supply networks

Effective April 6, 2009, BCBST will implement new quality standards for participation in its Commercial DME and Medical Supply networks resulting in changes within those networks. Facilities and providers are reminded of the requirement to verify suppliers are contracted with BCBST prior to referring members to those suppliers. We encourage you to review the provider referral directory located on the Provider page of our company Web site, www.bcbst.com.

If you have questions, please call the Provider Service line†.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Home health/Private duty nursing billing guidelines

Billing of home health (HH) intermittent visits must be billed in 15 minute increments rounded to the nearest hour and filed with the appropriate procedure code GO154 and GO156.

Extended visit codes S9122, S9123, and S9124 should be filed for services two (2) hours or more per day when the member does not qualify for private duty nursing. Private duty nursing (PDN) services are for members who require continuous skilled nursing care (eight (8) or more hours during a 24-hour period) provided by a registered or licensed practical nurse under the direction of the recipient's practitioner.

HH/PDN coding for members under the age of 21 years:

For purposes of billing, home health agencies have been instructed to use private duty nursing codes (T1000) for patients who meet the adult criteria for PDN care (i.e. vent/trach patients), all other nursing care that is not provided as a visit, would be coded using the skilled nursing/hour codes (S Codes). According to TennCare Rule 1200-13-14-01 (88), children under the age of 21 may receive Medically Necessary PDN services that are dependent upon technology-based medical equipment requiring constant nursing supervision. The Medical Necessity review process includes reviewing the need for nursing supervision, visual assessment, and monitoring of the child as well as the equipment used in association with the services requested. For children up to age 21, the T1000 code may be billed for PDN Medically Necessary services for the eight (8) or more hours of continuous skilled nursing care during a 24-hour period.

As a reminder, children are eligible to have aides and nurses accompany them outside the home under certain circumstances as defined by rule. The coding decision described above does not in any way determine whether a nurse may accompany a child outside the home.

We encourage you to review the billing guidelines 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 Blue*Source*, our provider information CD mailed quarterly to all BCBST contracted providers.

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

Reminder: Hospice billing guidelines

Effective with claims filed on or after Dec. 1, 2008, BlueCare and TennCare*Select* inpatient hospice claims filed with Revenue Codes 0655, 0656, or 0658 should not be filed with outpatient Type of Bill 81X.

Claims filed with an "inpatient" Revenue Code and an "outpatient" Type of Bill will be returned to the provider.

Reminder: Verifying member eligibility via BlueAccess

When verifying eligibility through BlueAccess for BlueCare and TennCare*Select* members, it is important to remember to enter the date you wish to verify eligibility. Some members may have multiple eligibility records in our processing system, which means the member's coverage may not have ended on the term date being displayed.

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

Reminder: BlueCare and TennCare*Selec*t prior authorization information

Requesting prior authorization for 23-hour observation

Neither BlueCare nor TennCare*Selec*t requires prior authorization for a 23 hr observation stay unless any of the following apply:

- the physician or hospital is out of network;
- the request is for a hysterectomy or a bariatric surgery; or
- the request is for a potentially cosmetic/investigational/non-covered procedure, an arthroscopy, an upper or lower endoscopy, laparoscopic cholecystectomy, or transplant.

Clarification to prior authorizations for Colonoscopy and Endoscopy

BlueCare and/or TennCare*Select* requires prior authorization for all **upper** endoscopies. **Lower** endoscopies (colonoscopies, flexible sigmoidoscopies, etc) do **not** require prior authorization.

Colonoscopies do not require prior authorization unless the physician or facility is out of network or unless the procedure is to be performed as a 23 hour observation or as an inpatient procedure.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: BlueCare and TennCare*Select* prior authorization information (cont'd)

The BlueCare and TennCare*Select* prior authorization list is available in the *VSHP Provider Administration Manual*, located on the company Web sites, www.VSHPTN.com and www.bcbst.com.

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

Change to prior authorization requirements for home health therapy*

Effective March 1, 2009, Volunteer State Health Plan (VSHP) no longer requires prior authorization for home health therapy for BlueCare and TennCare*Select* members under the age of 21 years.

BlueCard®

ADMINISTRATIVE

Get information faster, easier services electronically

Want a faster and easier service that reduces the time your office 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 to:

- **verify eligibility and benefits** for members of other Blue Plans;
- **check claims status** electronically for Blue members; and
- **get faster responses to inquiries** for local members and members from other Blue Plans.

BlueCross BlueShield of Tennessee is your single point of contact for submitting claims electronically. Reduce your time completing claims forms and get faster, more accurate claims processing.

For more information on electronic services, call eBusiness Solutions Marketing Department at 423-535-3057, Monday - Friday, 8 a.m. to 4:30 pm (ET) or e-mail inquiries to ecomm_marketing@bcbst.com.

Reminder: Blues move to automatic crossover for all Medicare claims

Effective Jan. 1, 2008, all Blue Plans began crossing over Medicare claims for services covered under Medigap and Medicare Supplemental products. This resulted in automatic claims submission of Medicare claims to the Blue secondary payer, reducing or eliminating 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 crossover in the same manner nationwide.

Some key steps to remember when submitting Medicare primary/Blue Plan secondary claims:

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to the Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential to enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member ID card for additional verification.
- Be sure to include the alpha prefix as part of the member identification number. The member ID will reflect the alpha prefix in the first three (3) positions in the ID number. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payment.

The claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by Medicare. This process may take up to fourteen (14) business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time the provider receives the Medicare Summary Notice. As a result, it may take an additional 14-30 business days for the provider to receive payment from the Blue Plan.

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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 2009 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert

provider news flash

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Please Route to all Providers & Office Staff

May 2009

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 13, 2009

- Rufinamide
- Plerixafor
- Fludarabine
- C1 Esterase Inhibitor
- Capecitabine
- Eltrombopag
- Autologous Chondrocyte Implantation (ACI)†
- Osteochondral Autografting (OCG) †
- Positional Magnetic Resonance Imaging (MRI)

†A predetermination is encouraged to assure compliance with the Medical Appropriateness criteria found in BCBST's Medical Policy Manual; otherwise, claims for these services will be subject to retrospective review. Predetermination forms can be found online at <www.bcbst.com/providers/forms/predetermination_form.pdf>.

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

New drugs added to commercial specialty pharmacy listing

Effective April 1, 2009, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by a (PA).

Provider-administered via medical benefit:
Cinryze (PA)
Mozobil

Self-administered via pharmacy benefit:
Promacta (PA)
Mozobil

Reminder: How to identify a BCBST member

Each BlueCross BlueShield of Tennessee member is issued an ID card. These ID cards contain much of the information providers need to submit claims and coordinate patient care.

While BCBST ID cards differ depending on the member's health care benefit plan, there are some standard elements common to most BCBST ID cards. These are:

- Member name;
- Member ID card (including three-letter alpha prefix);
- Group number (if applicable);
- Health Reimbursement Arrangement (HRA) Plan designation (if applicable);
- Member copayment amount:
  - OV=office visit
  - SPEC=specialist
  - ER=emergency room
  - IPH=inpatient hospital
  - RX=prescription tier
  - V=vision
- Prior authorization toll-free number;
- Mailing address for claims & inquiries
- Behavioral health services telephone number (if applicable);
- Participating provider network; and
- RX Network (if applicable).

If a member presents without his/her ID card, providers should verify health care coverage by calling the Provider Service line, 1-800-924-7141 or logging on to BlueAccess, the secure area on the company Web site, www.bcbst.com.

ADMINISTRATIVE

Reminder: Electronic funds transfer (EFT)

A safe, secure and cost-effective way to receive your payments

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

Sign up today 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

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) 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. **Note:** when you begin to receive EFT payments, you will no longer receive a paper remittance advice as this information is made available online for viewing and printing.

We also support and provide the remittance information in the ANSI 835 format which for many providers facilitates automated posting of claims payment information.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Electronic funds transfer (EFT) (cont'd)

For technical support please contact the eBusiness Service Center at (423) 535-5717 or via e-mail at ecomm_techsupport@bcbst.com. Technical support is available Monday through Friday, from 8 a.m. to 6:30 p.m. (ET).

Reminder: Interim bill guidelines

Interim bills are claims filed for a portion of a large inpatient hospital stay. All interim billing submitted by a facility is required in no less than thirty (30)-day increments, with the exception of final billing. Any interim bill, with the exception of that associated with final billing, which contains fewer than thirty (30) days, is subject to denial or recovery.

Interim bills are identified by the last digit of the Type of Bill (TOB) codes found in field locator #4 on the CMS-1450 (UB-04) claim form. When billing electronically, the ANSI-837I (Institutional) format must be used.
Example:

If claim is:	use TOB:
First Claim, TOB=**2**	11**2** or 12**2**
Continuing Claim, TOB=**3**	11**3** or 12**3**
Last Claim, TOB=**4**	11**4** or 12**4**

Reminder: Changes to DME billing guidelines

With the Medical Supplies and Durable Medical Equipment (DME) Amendment effective April 6, 2009, for Blue Networks P and S, providers are encouraged to review the Centers for Medicare & Medicaid (CMS) guidelines for pricing modifier usage. Some codes may require dual pricing modifiers.

Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule are required for correct claim adjudication. Providers can view this document on the CIGNA Government Services Web site, www.cignagovernmentservices.com. Claims billed with an inappropriate code and modifier combination will be returned to the provider for submission of a corrected claim resulting in reimbursement delays.

Note: There are no changes to the guidelines for BlueAdvantage, CoverTN, BlueCare or TennCare*Select* lines of business.

Enhanced support for Web services

Support for BlueAccess and eHealth Services® has been enhanced offering providers a more user-friendly experience. The Provider Service Organization has formed a new department geared to responding to your questions regarding benefits, eligibility and claims status obtained on BlueAccess, the secure area of www.bcbst.com. The Provider Outreach Department (POD), in conjunction with eBusiness Solutions, uses the latest in technology to recreate your Web experience allowing for quick resolution to Web inquiries and offering in-depth instruction on navigating the site. Come and take another look at www.bcbst.com. We are surfing with you!

Claims, Eligibility or Benefits Questions?
Please call the Provider Service line at 1-800-924-7141 and ask the customer service representative for the "POD". You will be connected with a knowledgeable staff member who will help enhance your Web experience.

Technical Support?
Please call the eBusiness Service Center at (423) 535-5717 or e-mail ecomm_techsupport@bcbst.com.

State of Tennessee employee health plan now has expanded coverage of tobacco quit aids, tobacco surcharge, and quitter refund

The health plans covering State of Tennessee members are expanding their pharmacy coverage of tobacco quit aids, including some over-the-counter items, with a physician's prescription.

Effective **May 1, 2009**, state plan members can obtain certain quit aids for a $5 copay. These covered products include Chantix (varenicline), bupropion, nicotine inhaler, nicotine nasal spray, lozenges, gum, and patches. The plans will cover up to two (2) courses of treatment for a maximum of twelve (12) weeks per treatment, per calendar year for each type of treatment. Additionally, no benefits limits apply to bupropion.

In addition to covering certain quit aids, the plans are allowing members to participate in ongoing tobacco quit classes at work and/or get telephonic coaching from 1-800-QUIT-NOW (1-800-784-8669).

Members who quit on or before **July 1, 2009,** will not have to pay a new tobacco use surcharge in 2010. Members that use tobacco after **July 1, 2009,** must pay the $50 monthly surcharge, but they can get a refund if they quit. More information about the new benefits, the surcharge, and the Quitters Refund is available at http://www.state.tn.us/finance/ins/tobacco.html.

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

ADMINISTRATIVE

Retrospective reviews for BlueAdvantage members available online*

Effective May 1, 2009, requests for BlueAdvantage retrospective reviews of non-emergent, elective services may be submitted via the online Web Authorization process located on *BlueAccess*, the secure area on the company Web site, www.bcbst.com.

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

ADMINISTRATIVE

Changes to prospective medical necessity reviews*

Effective June 1, 2009, BlueAdvantage will no longer conduct prospective Medical Necessity reviews for:

- Home Health Skilled Nursing visits,
- Home Health Aide visits, or
- Home Health claims‡ with fewer than fourteen (14) therapy visits.

‡These claims will be subject to a focused, retrospective post claims review similar to Original Medicare.

For any providers who have previously called and have a concern that their claims may be denied due to our original effective date of April 1, 2009, please know that our internal processes have been in place since April 1, therefore, only claims for fourteen (14) or more therapy visits will be denied "INF" (requesting additional information) and subject to medical review.

Note: Advance Determinations continue to be performed upon request.

Verification requirement implemented for provider service line*

Effective April 6, 2009, in accordance with guidelines set forth by the Centers for Medicare & Medicaid (CMS), BlueAdvantage began requiring providers to provide three identification elements when calling the BlueAdvantage Provider Service line, 1-800-841-7434. In addition to correctly providing member information, this new guideline requires providers to verify their:

- PTAN (Provider Transaction Access Number);
- NPI (National Provider Identification); and
- the last 5 digits of their tax ID.

If the provider has never been assigned an NPI, the customer service representative will require two additional data elements for authentication purposes, such as the mailing address reflected on the provider remittance advice and the provider's master address.

BlueCare/TennCare*Select*

CLINICAL

BlueCare's Depression Disease Management program promotes healthy lifestyle

Through intervention and empowerment, our members with depression are able to adopt healthy behaviors.

BlueCare's CareSmart Major Depression Disease Management program enables members with depression to access health education in a way they can understand. Depression can often be a co-occurring disorder with other medical conditions, such as diabetes and heart disease that frequently interfere with healthy lifestyle choices. Through education and intervention, CareSmart staff helps members increase their knowledge of depression and self-care management.

Our disease management and outreach staff coordinates with both medical and behavioral health providers to maximize the opportunity to engage members with co-occurring medical conditions through an integrated approach. BlueCare's mission is to provide a fully integrated health solution that provides education, coaching, support and empowerment for individuals who want or need to assume responsibility for their own health.

Members may self refer to the program by calling the Customer Service number listed on their ID card and providers may refer patients to the program by calling 1-888-416-3025. For more information on the Depression Disease Management program visit our company Web site, www.vshptn.com.

ADMINISTRATIVE

Reminder: Prior authorization requirements for physical, occupational, and speech therapy services

VSHP requires prior authorization for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services rendered to adults regardless of place of service including the nursing home setting. No prior authorization is required for PT, OT, and ST services when billed by the skilled nursing facility.

Providers are reminded prior authorization is **not** required for PT, OT, and ST services rendered to children under age 21 years, regardless of place of service.

VSHP requesting notification on maternity-related admissions

Help us improve the health and birth outcomes of our BlueCare and TennCareSelect pregnant members

Beginning June 1, 2009, BlueCare and TennCare*Select* requests that facilities let us know when a mother delivers her baby or when there are any other maternity-related admissions. Early notification will help us begin discharge planning and/or case management services as needed.
The preferred method for submitting notification is through *BlueAccess*, the secure area on our company Web sites, www.bcbst.com and www.vshptn.com, which are available 24-hours-a-day. Notification may also be reported by calling the appropriate number below:

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

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Reporting home health missed shifts

Home health agencies are reminded to notify VSHP Case Management of any missed shifts. When providing home health care for BlueCare and TennCare*Select* members the agency should fax a copy of the monthly scheduled shift for hourly skilled and aide services to VSHP Case Management at:

East Tennessee 1-800-292-5311
West Tennessee 901-544-2490

Additionally, home health agencies are required to notify VSHP Case Management:

- in advance, of any planned missed shift; or
- if a nurse/aide is going to be late and the agency is unable to staff the shift.

Missed shifts should be reported on the *VSHP Private Duty Nursing Missed Shift Report* provided on the company Web site at <http://www.bcbst.com/providers/forms/PDN_Missed_Shift_doc_2_.pdf.>. If the home health agency is not able to staff a shift after normal business hours, the agency should call VSHP NurseLine at one of the following numbers:

BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978

Note: It is considered a missed shift if the home health agency is authorized to provide a shift, but no services are provided for that shift. The home health agency should only submit claims for services actually rendered.

Reminder: VSHP high-tech imaging prior authorization

Prior authorization is required for select high-tech imaging procedures for Volunteer State Health Plan (VSHP) members. These procedures include, but are not limited to:

- CT,
- CTA,
- MRI,
- MRA,
- MR Spectroscopy,
- PET Scans, and
- Nuclear Cardiology.

At this time, the following members are exempt from this prior authorization requirement:

- TennCare*Select* members
- BlueCare members who qualify as dually-eligible for Medicare and Medicaid (Eligibility class 17 and 77)
- Dually eligible members with Medicare Part A only (no Part B coverage)

To request prior authorization for a high-tech imaging services for VSHP members, call MedSolutions at 877-791-4101.

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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 May 25, 2009 in observance of Memorial Day

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

June 2009

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 11, 2009

- Osteochondral Allografting
- Saliva Testing for Hormone Levels
- Bariatric Surgery for Morbid Obesity

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

BCBST continues to monitor H1N1 influenza outbreak

For some time, BlueCross BlueShield of Tennessee has had a pandemic response plan in place to ensure it is prepared in serving our members' needs while working in concert with our network physicians and other providers.

With the recent outbreak of the H1N1 influenza virus, we are continuing to cover flu tests and treatments as we normally do. Prescription medications such as Tamiflu® and Relenza® are covered by many of our lines of business; however, we encourage you to verify benefits and prior authorization requirements prior to prescribing these medications to your BCBST patients.

We will continue to monitor the H1N1 influenza and will work to ensure that you have access to the appropriate resources to provide necessary treatment to our members.

Reminder: Prescribing for oneself and one's family

The Tennessee Board of Medical Examiners adopts the following guidelines as policy for self-prescribing, and for one's immediate family:

Self-prescribing

1. A physician cannot have a bona fide doctor/patient relationship with himself or herself.
2. Only in an emergency should a physician prescribe for himself or herself schedule IV drugs.
3. Prescribing, providing, or administering of schedule II and III drugs to himself or herself is prohibited.

Immediate Family

1. Treatment of immediate family members should be reserved only for minor illnesses or emergency situations.
2. Appropriate consultation should be obtained for the management of major or extended periods of illnesses.
3. No schedule II, III, or IV controlled substances should be dispensed or prescribed except in emergency situations.
4. Records should be maintained of all written prescriptions or administration of any drugs.

ADMINISTRATIVE

All Blue 2009 provider workshops

Coming Soon to a City Near You!

The annual state-wide *All Blue* provider workshops, designed for office staff of specific providers as determined by BlueCross BlueShield of Tennessee, have been scheduled and are coming soon to a city near you. The workshops will feature Ancillary, Facility and Professional breakout sessions.

At our workshops, you will have access to dedicated BlueCross BlueShield of Tennessee professionals who will share important information on current issues and answer your questions.

Watch for your invitation announcing upcoming dates, times and locations.

Reminder: Billing guidelines for glucose monitoring systems

Effective April 6, 2009, BlueCross BlueShield of Tennessee no longer requires a manufacturer's information/supplier's invoice when billing the following codes:

- **A9276 -** Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply;
- **A9277** – Transmitter; external for use with interstitial continuous glucose monitoring system; and
- **A9278** – Receiver (monitor); external, for use with interstitial continuous glucose monitoring system.

Consult Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the proper use of the Healthcare Common Procedure Coding System (HCPCS) for products. Providers are also encouraged to review the description of the codes to file claims appropriately, e.g., A9276 1 unit = 1 day supply.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Supplies and equipment included in procedure reimbursement

Under the Resource Based Relative Value Scale (RBRVS) reimbursement methodology, the relative value unit for the practice expense portion of the procedure code includes an allowance for supplies that are necessary to assist or perform the procedure.

Providers can review supplies and equipment included in the reimbursement for a particular procedure code on the CMS Clinical Practice Expert Panel files at http://www.cms.hhs.gov.

Reminder: Appropriate claims filing for providers practicing in contiguous counties

Is your practice located in a bordering county of one of the eight (8) states Tennessee touches? If so, there is a good chance you hold contracts with **both** your home state's Blue Plan and BlueCross BlueShield of Tennessee.

In those instances, you should file all claims for **BlueCross BlueShield of Tennessee members** with BlueCross BlueShield of Tennessee, **not** with your home Blue plan.

This will help ensure claims for BlueCross BlueShield of Tennessee members are adjudicated in accordance with your contract with the Tennessee plan.

Please visit the ***News*** section on the Provider page on our company Web site, www.bcbst.com for more information and responses to frequently asked questions.

If you have additional questions, please call us at 1-800-705-0391.

Reminder: Negative pressure wound therapy services

Benefits are provided for Negative Pressure Wound Therapy for our commercial members when provided by a BlueCross BlueShield of Tennessee participating provider.

When arranging these services for our Blue Network P and Blue Network S members, please refer to the *BlueCross BlueShield of Tennessee Provider Directory* located on the Blue*Source* Provider Information CD or visit our company Web site, www.bcbst.com

Reminder: Correct reporting of infusion and drug administration services

According to Current Procedural Terminology (CPT®), physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff. CPT® codes 96360-96549 include evaluation and management services.

If a significant, separately identifiable evaluation and management service is performed on the same day, the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549. This billing guideline is also in accordance with Evaluation and Management Guidelines located in the Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual, Chapter 12, Section 30.6.7D.

BlueCross BlueShield of Tennessee billing guidelines state that 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. Providers are reminded to follow these guidelines to help ensure prompt adjudication of claims.

BlueAccess receives new feature

With the focus on "going green" and in response to provider community feedback, another change has been implemented to *BlueAccess*, the secure area on the company Web site, www.bcbst.com.

Effective immediately, providers can make demographic changes online. BlueAccess enables registered providers to view information in a secure online environment, just as it appears ***right now*** in our customer service computer system.

If you have not yet registered, visit www.bcbst.com ; click on "Register now" and follow the prompts.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Coding claims appropriately

The National Uniform Billing Committee (NUBC) and National Uniform Claim Committee (NUCC) periodically make and publish revisions to their manuals, which are available online at www.nubc.org/ and www.nucc.org/.

Providers are reminded of their responsibility to ensure codes filed are valid for the dates of service when submitting claims for BCBST and VSHP members. To avoid delays in receiving payments, unnecessary overpayments, and to help ensure the most appropriate member benefit is applied, it is important that all codes submitted are valid for the date of service on the claim. Please check your claims to ensure all codes, including but not limited to the following are reflected accurately:

- ICD-9-CM Procedure codes
- ICD-9-CM Diagnosis codes
- HCPCS/CPT® codes
- Revenue codes
- Type of Bill codes
- Place of Service codes
- Admission Source codes
- Occurrence codes
- Value codes
- Modifier codes

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

ADMINISTRATIVE

Reminder: CMS auditing tool required for all BlueAdvantage ED/EM claims

The BCBST Provider Audit Team may include BlueAdvantage Private Fee-for-Service (PFFS) and Preferred Provider Organization (PPO) claims during audits. For BlueAdvantage Acute Care Hospital Emergency Department claims the ED Evaluation and Management visit level tool mandated by the Local Centers for Medicare & Medicaid Services (CMS) Fiscal Intermediary will be used. This tool can be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506P_Draft_AHA_AHIMA_Guidelines.pdf>.

CMS does not require providers to utilize the *Draft Visit Guidelines*; each facility is free to develop its own guidelines. However, the use of this tool is required for the medical review of all BlueAdvantage ED E/M claims. Please note this tool differs from the sample tool reflected in the BCBST and VSHP provider administration manuals, which is used to audit non-BlueAdvantage ED claims.

BlueCard®

ADMINISTRATIVE

Improved BlueCard/FEP provider online experience

In mid-May, you may have noticed some additional enhancements made to the Remittance Advice (RA) information for BlueCard/FEP section on *BlueAccess*, the secure area on the company Web site, www.bcbst.com. These new enhancements give providers the ability to:

- View remittance number on the claim status response page if the remittance is available.
- Click a hyperlink on the remittance number to access the actual RA

The payment information is more clear and user-friendly by the addition of these new features:

- The check number will show "N/A" when the claim has been denied or allowed payment is zero.
- View the remit information when payment is paid through Electronic Fund Transfer.

We are confident these enhancements will allow for an easier online remittance and payment inquiry experience. For more information or suggestions, please call eBusiness Service Center at 423-535-5717.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Avoid claims processing delays on 276/277 transactions

Beginning July 1, 2009, providers using the standard 276/277 Claim Status and Response Time format must use the identification number exactly as it appears on the member's ID card. Following the three-character alpha prefix, the member ID should not include any spaces or special characters for a maximum of 17 characters.

Standard 276/277 transactions that do not reflect this requirement will be returned to the provider for correction.

Changes to CMS-1450 (UB04) inpatient and outpatient billing guidelines*

Effective with claims filed on or after July 1, 2009, the following changes will apply to BlueCare and TennCare*Select* institutional inpatient and outpatient hospital claims filed on a CMS-1450 (UB04) Health Insurance Claim form or submitted electronically in the ANSI-837 version
4010A1 format:

- An Admitting Diagnosis Code is required for claims filed with type of bills **11x**, **12x, 18x,** and **21x**.
- A Patient's Reason for Visit Diagnosis Code is required for type of bills **13x** and **85x**, when filed with Type of Admission codes 1, 2, or 5 and revenue codes 045x, 0516, 0526, or 0762.

Claims filed without an "Admitting or Patient Reason for Visit" diagnosis code as specified above will be returned to the provider.

Reminder: Hospice and patient liability billing changes

Some TennCare enrollees receiving TennCare-reimbursed Nursing Home Facility care may elect to receive hospice benefits.

Claims for these members should be filed on a CMS-1450 claim form reflecting one of the following appropriate Value codes along with the patient liability amount in Form Locators 39-41:

- 23 (recurring monthly income);
- 24 (Medicaid rate code);
- 31 (patient liability amount); or
- C3 (estimated responsibility payer c).

We encourage you to review the Hospice billing guidelines available in the *VSHP Provider Administration Manual* located on the Provider page of the company Web sites, www.vshptn.com or www.bcbst.com, and on *BlueSource*, BCBST's provider information quarterly CD.

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

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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 2009 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 2009

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 8, 2009:

- Allergy Testing- Provocative Tests for Food or Food Additives and Food Challenge Testing

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

Clinical practice guidelines adopted

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

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>

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>

ATP III Guidelines: 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>

Standards of Medical Care in Diabetes – 2009:
<http://care.diabetesjournals.org/cgi/content/full/32/Supplement_1/S13>

Seventh Report of the Joint National Committee (JNC) on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure:
http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf

ACOG: Guidelines for Perinatal Care, Sixth Edition:
<http://sales.acog.com/acb/stores/1/product1.cfm?SID=1&Product_ID=242>

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

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>

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.

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's Web site has been updated to reflect upcoming modifications to select Modified Utilization Management Guidelines. The *Modified Utilization Management 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. 21, 2009:

The following as relates to Ambulatory Care:

- Esophagogastroduodenoscopy (EGD), UGI Endoscopy
- LOOP Electrosurgical Excision Procedures (LEEP, LLETZ) Cervix

The following as relates to Home Care:

- Hyperemesis Gravidarum

The following as relates to Inpatient and Surgical Care:

- Cesarean Delivery

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

Reminder: Leuprolide Acetate claims may be subject to medical appropriateness

Providers are reminded to review the current medical appropriateness indications for Leuprolide Acetate in the BCBST Medical Policy Manual located on the company Web site at <www.bcbst.com/mpmanual/!SSL!/WebHelp/Leuprolide_Acetate.htm>. These claims may be subject to retrospective review to ensure medical appropriateness criteria are met.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

BlueCross BlueShield of Tennessee to host educational seminar

BCBST in partnership with Tennessee End of Life Care (TELP) is offering an educational seminar, *Fundamentals of Advance Care Planning*, August 6 and August 7, 2009, with providers having the option of attending either day.

The seminar is being held at:

BlueCross BlueShield of Tennessee
One Cameron Hill Circle
Bldg 1 – Community Auditorium
Chattanooga, TN 37402
8 a.m. to 4:30 p.m. (ET).
$75.00 per person

Objectives of the seminar are to help participants:

- Understand the major components of the 2004 Tennessee Health Care Decisions Act;
- Differentiate between Advance Care Planning, Advance Directives, Do Not Resuscitate Orders and the Physician's Orders for Scope of Treatment (POST);
- Complete an Advance Care Plan or other Advance Directive; and
- Initiate conversations with adults about their wishes for end of life care.

Agenda Topics:

- A Patient's Rights – An Overview of the 2004 Tennessee Health Care Decisions Act;
- Advance Care Planning and Advance Directives – Understanding the Concepts, Language, and Tools;
- Medicine & Ethics – Advance Care Planning and Life Sustaining Treatment;
- "Let's Talk" – How to Skillfully Facilitate the Process of Advance Care Planning; and
- Problem Solving Scenarios – Small Group Sessions.

To register to attend one of the sessions, please contact Lacy Phillips, RN, PMP at 423-296-8813 or e-mail, Shanna_Phillips@bcbst.com.

eBusiness hours of operation extended*

The BlueCross BlueShield of Tennessee eBusiness Service Center extended its hours of operation from 8 a.m. to 6:30 p.m., ET. This change provides an extension of urgent BlueAccess and EDI transaction support in a limited capacity.

If you have an urgent BlueAccess or EDI transaction support need, please call the eBusiness Service Center at 423-535-5717.

Non-urgent requests can be e-mailed to ecomm_techsupport@bcbst.com 24-hours-a-day, 7-days-a-week.

Providers are reminded to check out our newest marketing and technical information online at www.bcbst.com/providers/ecomm.

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 (LEP) is to be provided by the entity at the level at which the request for service is received. For example, if your office is providing medical services to a non-English speaking member and you feel an interpreter is needed, the cost of these services will be the responsibility of the entity where the services are received. The member, at no time is liable for the cost of LEP services.

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 or 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 tips may offer some cost-effective language assistance:

- train bilingual staff;
- utilize telephone and video conference services;
- use qualified translators and interpreters; and/or
- 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 info@accessproject.org.

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

Accessing Physician Quality and Cost Reporting Program 2009

The Physician Quality and Cost Information, including 2009 program updates, will be available for physician[1] review starting in August 2009. 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, selecting "Provider" and following 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 through *BlueAccess.*

For more information or *BlueAccess* training, contact eBusiness Solutions at (423) 535-5717 or email at Ecomm_TechSupport@bcbst.com

[1] Hospital based physicians excluded
[2] *A "Shared Secret" is required. Your staff may already have your "Shared Secret".*

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Clarification: Filing automobile or other accident-related claims

When your patient is a BlueCross BlueShield of Tennessee member who has been involved in an automobile accident, you are contractually required to file your claim with BCBST, even if the member's own automobile insurance carrier provides medical payment coverage. By filing your claims with BCBST first, you are ensuring that your claims will not be denied as untimely. If you do not file your claim with BCBST and attempt to do so after the timely filing period has expired, your claim will be denied as untimely. In such event, you cannot pursue the BCBST member for payment and are contractually required to hold the member harmless.

You are allowed to file a claim with both BCBST and the automobile insurance carrier. In the event that BCBST pays the member's claim and you also receive a check for medical payments from the automobile insurance carrier, you must reimburse BCBST those funds as to not receive any overpayments.

If the member has med-pay coverage available and you receive a payment prior to receiving payment by BCBST, you should file your claim with BCBST and attach a copy of the check and any explanation of benefits or letter of exhaustion from the automobile insurance carrier. BCBST will process the claim and provide benefits up to the allowed amount, according to your contractual agreement with BCBST. Any overpayment created due to payments being made by both BCBST and the automobile insurance carrier should be returned to BCBST.

Reminder: Changes to billing guidelines for moderate to conscious sedation

Effective for date of service April 1, 2009, and after, BlueCross BlueShield of Tennessee will reimburse moderate conscious sedation when appropriate for all lines of business in accordance to the Centers for Medicare & Medicaid Services (CMS) and CPT® Guidelines in Appendix G. Appendix G, Summary of CPT® Codes That Include Moderate (Conscious) Sedation, lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself.

CPT® Codes 99143-99145

- Physician can bill the conscious sedation codes as long as the procedure billed with it is not listed in Appendix G of CPT® Guidelines;
- Physician should not bill CPT® codes 99143 to 99145 in conjunction with codes listed in Appendix G;
- BlueCross BlueShield of Tennessee has adopted the National Correct Coding edits that bundle CPT® codes 99143 and 99144 into the procedures listed in Appendix G.

CPT ® Codes 99148-99150

- In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate conscious sedation in the facility setting for the procedures listed in Appendix G or other procedures, the second physician can bill.
- Facility settings considered are inpatient hospital - place of service 21, outpatient hospital - place of service 22, emergency room-hospital - place of service 23, ambulatory surgery center - place of service 24, or skilled nursing facility - place of service 31.
- When these services are performed by the second physician in the non-facility setting, CPT® codes 99148 to 99150 should not be reported.

BlueCard®

ADMINISTRATIVE

Reminder: How to avoid out-of-area claim issues

BlueCross BlueShield of Tennessee strives to process your claims quickly and accurately.

To help ensure your claims are processed timely and accurately, please follow these steps:

1. Submit **all** claims for your BlueCross BlueShield of Tennessee patients to BlueCross BlueShield of Tennessee.

2. Ensure **all services** for the same patient, same date of service, same place of service, and same provider are billed on a single claim **submission**. Claims not complying with this billing guideline are at risk for recoupment due to post-pay edits. Providers billing such claims may also be identified for focused audits.

3. Verify member ID cards frequently. Ensuring the most current ID and alpha prefix are being used will help avoid processing delays related to prefix or ID changes.

4. Include member's complete identification number, including the current three-character alpha prefix. Submit claims with only ***valid*** alpha-prefixes; claims with incorrect or missing alpha prefixes and/or member identification numbers cannot be processed correctly.

5. In cases where there is more than one payer and a Blue Cross and/or Blue Shield Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim. Upon receipt, BlueCross BlueShield of Tennessee will electronically route the claim to the member's Blue Plan. The member's Plan will process the claim and approve payment; BlueCross BlueShield of Tennessee will reimburse you for services.

6. Avoid sending duplicate claims. Sending another claim, or having your billing agency resubmit claims

BlueCard®

ADMINISTRATIVE

Reminder: How to avoid out-of-area claim issues (cont'd)

automatically slows down the claims payment process and creates confusion for the member.

7. Check claim status by calling BlueCross BlueShield of Tennessee at 1-800-705-0391 or submit an electronic HIPAA 276 transaction (claim status request) to BlueCross BlueShield of Tennessee.

If you encounter an issue with a claim, we are here to help. Please contact us at:

- www.bcbst.com;
- 1-800-705-0391; or
- submit an electronic inquiry to www.bcbst.com.

Reminder: High-tech imaging (HTI) procedures may require prior authorization for out-of-state members

Out-of-state members may require a prior authorization for certain HTI procedures. Checking benefits and eligibility can determine if a prior authorization is required.

Ordering physicians having direct access to a member's clinical information can easily obtain a prior authorization. This can help the facility and radiologists avoid denials and loss of revenue. Eligibility and benefits for out-of-state members can be verified on the company Web site, www.bcbst.com or by calling **1-800-676-BLUE (2583)**. We encourage you to check eligibility prior to rendering services.

CoverTN

ADMINISTRATIVE

When should you refer to a 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, CoverKids members should **ONLY** be referred to the local health department when vaccinations are needed and unavailable to them in your office.

BlueCare/TennCare*Select*

ADMINISTRATIVE

New behavioral health consultation line available*

Volunteer State Health Plan (VSHP) can assist you in obtaining referrals for your **BlueCare** patients having mental health and substance abuse treatment needs. The behavioral health staff is available to consult with you and share ideas regarding clinical treatment approaches, management of difficult cases (e.g., eating disorders and ADHD), and utilization of new treatment modalities.

We recently established a toll-free primary care provider consultation line staffed by ValueOptions® Peer Advisors who are Board Certified Psychiatrists. The staff will be available to you for telephone consultation regarding all aspects of mental health and substance abuse treatment, including medications.

This service is currently available Monday through Friday from 9 a.m. - 5 p.m., ET. Please call 1-877- 241-5575 and identify yourself as a TennCare primary care provider seeking psychiatric consultation services.

We encourage you to visit our company Web site, www.vshptn.com where you can find useful information including treatment guidelines for many mental disorders.

Reminder: Calling the appropriate provider service line helps expedite phone time

Calling the appropriate VSHP provider service line can help reduce the amount of time you spend on the phone. If you need information regarding a BlueCare patient, call the **BlueCare Provider Service line, 1-800-468-9736**. If your patient is a TennCare*Select* member, you should call the **TennCare*Select* Provider Service line, 1-800-276-1978.**

The phone lines are available Monday through Friday, 8 a.m. to 6 p.m., ET.

• • • • • • • • • • • • • • • • • • •

†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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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).

BlueCross BlueShield of Tennessee offices will be closed Friday, July 3, 2009, in observance of the Fourth of July Holiday

*These changes will be included in the appropriate 2Q 2009 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

August 2009

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. 13, 2009

- Alemtuzumab
- Leuprolide Acetate
- Temozolomide
- Zoledronic Acid (Reclast®)
- Cetuximab
- Erlotinib
- Interferon Alfa (Systemic)
- Paclitaxel (Protein Bound)
- Bone Mineral Density Studies
- Magnetoencephalography & Magnetic Source Imaging of the Brain

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

New drugs added to commercial specialty pharmacy listing

Effective July 1, 2009, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by a (PA).

Provider-administered via medical benefit:
Cimzia Vials
Synvisc One
Vantas

Self-administered via pharmacy benefit:
Afinitor (PA)
Cimzia Syringes
Simponi

ADMINISTRATIVE

BCBST implementing CMS guidelines for serious reportable adverse events ("never events")*

Effective Dec. 1, 2009, in an effort to encourage greater patient safety and reduce "never events" -- preventable medical errors that result in serious consequences for the patient, BCBST will apply the Centers for Medicare & Medicaid Services (CMS) guidelines to all participating acute care inpatient hospitals and ambulatory surgery centers.

"Never events" are defined as errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.

Participating providers are required to populate Present on Admission (POA) indicators on all acute care inpatient hospital claims.

BlueCross BlueShield of Tennessee will require all participating providers to hold members harmless for any services related to "never events" in any clinical setting and reimbursement will not be issued. BCBST will follow CMS guidelines for billing and reimbursement of "never events".

For more information please review the "never events" policy scheduled for inclusion in the 3rd quarter update to the BlueCross BlueShield of Tennessee and Volunteer State Health Plan provider administration manuals to be published September 2009, on the company Web sites, www.bcbst.com, www.vshptn.com.

Review process implemented for Xeloda

A recent study on 600 women with early stage breast cancer demonstrated that those who were 65 years of age or older, and received Xeloda (capecitabine), were twice as likely to relapse and almost twice as likely to die compared to those receiving standard chemotherapy.

Effective July 1, 2009, in response to this study, a review process was added for Xeloda for members 65 years or older who have prescription benefits through BCBST **commercial** lines of business.

Reminder: Billing guidelines for bilateral procedures

Per HIPAA guidelines, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported. However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples are when, but not limited to:

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

Therefore, sometimes 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; and/or if procedure is "**other**" than surgical such as radiology CPT® codes then bill as:
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Real-time claims estimation/adjudication enhancement

Real-Time Claims Estimation/Adjudication application will soon have support for multiple diagnosis codes per line. The application now supports up to three supplementary diagnosis codes, in addition to the primary diagnosis code. Access to this free Web-based tool is available through *BlueAccess*, BCBST's secure area on its Web site, www.bcbst.com.

Endometrial ablation to require prior authorization

Effective Jan. 1, 2010, BlueCross BlueShield of Tennessee will require prior authorization for all Commercial lines of business for Endometrial Ablation, CPT® codes:

- 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)

To arrange prior authorization for these services, please contact our Utilization Management Department, **1-800-924-7141** Monday through Friday, 8 a.m. to 5:15 p.m. (ET) or *e-Health Services* online via *BlueAccess* on the company Web site www.bcbst.com. To access *e-Health* services, enter your ID number and password in the *BlueAccess* secure login box or for first-time users, click the "register now" tab.

Providers are encouraged to review the code descriptions to help ensure claims are filed appropriately.

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

BCBST offering online cultural competence training

As is true of the nation in general, Tennessee's demographics are becoming more culturally diverse.

BCBST is committed to helping providers improve their ability to treat patients from diverse backgrounds. In keeping with our commitment, BCBST has purchased Quality Interactions®, a program designed to help physicians, nurses and office staff better assist people from diverse backgrounds.

The training uses a case-based format supported by evidence-based medicine and peer-reviewed literature and is accredited for up to 2.5 hours of CME, CEU or CCM credits. There are a limited number of licenses available for these courses, so please register early to take advantage of the valuable learning experience.

The training is available on the Provider page of the company Web site, www.bcbst.com. Click on the "Quality Interactions® Cross Cultural Training" link under "Administration" and follow the PDF instructions for registration.

If you have any questions, please call the appropriate Provider Service line†.

Class action settlement affects BCBST commercial drug reimbursement

The U. S. District Court for the District of Massachusetts has granted final approval of the settlement regarding the mark-up factor used by two major publishers of drug pricing information used in calculating their Average Wholesale Price (AWP) rates.

This national ruling, effective Sept. 10, 2009, will affect some 400 brand name products. As a result of this decision, changes in the AWP rates will be reflected in the BCBST commercial drug reimbursement system on Oct. 1, 2009.

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

ADMINISTRATIVE

The CAHPS survey results are in

The Centers for Medicare & Medicaid Services (CMS) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to collect information about member experiences with Medicare Advantage (MA) health plans. There was a response rate of 74.68 percent,

The 2008 CAHPS survey of MA Prescription Drug (MA-PD) plans was conducted from February 2008 through June 2008. BlueAdvantage was 1 of 30 plans participating in the survey. This summary highlights the results of the survey for BlueAdvantage.

BlueAdvantage scored above the national average on all measures, to include:

- Customer Service
- Getting Needed Care
- Getting Information about Prescription Drugs
- Getting Needed Prescription Drugs

In addition, our plans showed a significant increase from the previous year in the area of *Ease of Getting Prescribed Medicines.*

Even though BlueAdvantage exceeded the national average on all measures, we believe that opportunities for improvement exist for the areas that remained the same between 2007 and 2008 to include:

- Health Plan Overall
- Getting Needed Prescription Drugs
- Getting Information from the Plan about Prescription

If you would like a more detailed summary, please call BlueAdvantage Provider Service at 1-800-841-7434.

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

ADMINISTRATIVE

Reminder: BlueAdvantage utilization management no longer reviewing select services

Effective June 1, 2009, select services no longer require utilization management review prior to payment for BlueAdvantage PFFS and PPO members when the HCPCS/CPT® code is filed with the accompanying diagnosis code(s) indicated in the grid below:

Mastectomy bras and prosthesis
(mastectomy bras) limited to six (6) per year)

When HCPCS/CPT® Code …	is filed with diagnosis code:
L8000; L8030 (L8000	174.0-74.9, 233.0, V45.71, 239.3, V10.3

Adenosine

When HCPCS/CPT® Code …	is filed with diagnosis code:
J0152	401.0, 401.1, 401.9 396-396.9, 410.50, 411.0, 411.1, 411.81, 411.89, 412, 413.0-414.06, 414.8, 414.9, 414.10-414.19, 424.0, 424.1, 425.1, 425.4, 426.2-426.54, 426.6-426.81, 426.9, 427.0, 427.2, 427.31, 427.32, 427.69, 427.89, 427.9, 428.0-428.9, 429.3, 440.21-440.24, 443.9, 780.2, 785.0, 785.1, 785.2, 786.50, 786.59, 794.30, 794.39, 794.31, 960.7, E942.0, E942.1, V45.01 V67.00, V67.09, V67.51, V67.59, V71.7, V72.81, V72.83, V81.0

Cardiac Rehabilitation

When HCPCS/CPT® Code …	is filed with diagnosis code:
93797-93799	410.00-410.92, V45.81, V43.3, V57.89, V57.9, V58.73

Synvisc

When HCPCS/CPT® Code …	is filed with diagnosis code:
J7322	715.16, 715.26, 715.36, 715.96, 715.90, 719.46, 719.49

BlueCare/TennCare*Select*

ADMINISTRATIVE

VSHP expands partnership with ValueOptions®*

Beginning Sept. 1, 2009, VSHP will expand its partnership with ValueOptions® of Tennessee, Inc., to include behavioral health care services statewide for TennCare*Select* members. These members include:

- Children whose eligibility category is SSI
- Children who are in the custody of the State
- Children who are in an institutional eligibility category, (which includes children in the Home and Community Based Services waiver for individuals with mental retardation)
- Enrollees whose residence are out-of-state
- Enrollees who have been identified as being 'potentially ineligible' – that is Uninsured and Uninsurable enrollees who have not responded to re-verification activities and whose family members have not used TennCare services for a set period of time.

Together, we are 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 statewide who offer behavioral health and consumer centered recovery services. TennCare*Select* will provide utilization management, case and disease management, customer service and claims processing services for both physical and behavioral health.

If you have questions or need more information about **contracting** or **credentialing** as a behavioral health provider, please call ValueOptions® of Tennessee at 1- 800-397-1630. For all other questions, please call the TennCare*Select* Provider Service line†.

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, V70.3-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 *VSHP Provider Administration Manual* located on the company Web sites, www.bcbst.com www.vshptn.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Volunteer State Health Plan (VSHP) adds new service to non-emergency transportation*

VSHP and Southeastrans are working together to provide members with access to non-emergency physical and behavioral health transportation using public transit systems.

When a member or health care provider calls Southeastrans to schedule transportation, the member will be offered bus passes if the pick-up and drop-off locations are within one-quarter mile of the bus stop and the member meets all the requirements for riding public transit.

Effective Aug. 1, 2009, Southeastrans will begin working with the Memphis Area Transit Authority (MATA) to provide a bus route that will cover many of the health care centers in the Memphis/Shelby County area. Bus passes may be available for BlueCare and TennCare*Select* members located in the West Grand Region needing transportation to and from covered physical and behavioral health care services.

When a member receives a Bus Pass packet from Southeastrans, included in the packet is Validation Form with instructions to give the form to the provider when he/she arrives for his/her appointment. Providers must complete the *Validation Form* and fax it to Southeastrans, Inc., at 1-423-296-1597.

Additionally, the provider must complete an *Exception Form* when a member's medical condition does not permit him/her to utilize the Bus Program. Both the Validation Form and the Exception Form are available in English and Spanish, and can be accessed in the BlueCare/TennCare*Select* section under Transportation on the Provider page of the company Web sites, www.bcbst.com and www.vshptn.com.

Implementation dates for this public transportation service across the remainder of the State will be:

Oct. 1, 2009
Hamilton County

Dec. 1, 2009
Knox County, Tri Cities, and Jackson

Providers and members and/or their representatives my 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

Medical record reviews for Medicaid and State Children's Health Insurance Program

The Bureau of TennCare has requested Volunteer State Health Plan remind providers that federal laws and regulations and provider agreements require providers to make medical records related to Medicaid and SCHIP payments available upon request to federal and state officials or their representatives. This includes on-site inspection or written requests for copies.

From time to time, federal or state officials or their representatives may request to review or receive copies of medical records related to claims that have been paid with federal funds. Mandatory compliance with these requests is required. Additional information about the **Payment Error Rate Measurement (PERM) Program** is available on the Provider page of our company Web sites, www.bcbst.com and www.vshptn.com.

Amendment to the Medical Assistance Act authorizes new home health services*

Under present law, the Medical Assistance Act requires the provision of medical assistance to eligible persons, including the provision of home health care services. Provision of home health care services under the Act are those services that are provided in the recipient's home and must follow the recipient into the community for the purposes of providing services during routine activities of daily living such as:

- outpatient medical appointments
- school and other educational functions
- employment and volunteer opportunities
- church and religious services.

Tennessee enacted Public Chapter 471 into law in 2009. This Act authorizes home health nurses and aides to accompany a recipient outside the home during the course of prior approved home health services, if all of the following criteria are met:

1. The home health nurse or aide must not transport the service recipient.
2. The home health agency will have discretion as to whether or not to accompany a recipient outside the home.
3. Additional visits or hours of care will not be approved for the purpose of accompanying a recipient outside the home.
4. No additional reimbursement will be paid to the home health agency in association with the decision of the agency to accompany a patient outside the home.

This Act specifies that its provisions are not intended to create an entitlement to services and that a home health agency will not be subject to legal action as a result of exercising its discretion pursuant to this amendment.

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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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BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

September 2009

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. 10, 2009

- Extracorporeal Photochemotherapy/Photopheresis
- Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress

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

ADMINISTRATIVE

Genzyme Corporation implements Cerezyme supply management plan

On Aug.3, 2009, Genzyme Corporation communicated that the projected inventory levels of Cerezyme (imiglucerase for injection) may not be sufficient to protect the most vulnerable patients through the month of August.

As a result of this situation, Genzyme implemented a Cerezyme supply management plan for all pharmacies, to include CVS Caremark Specialty Pharmacy, one of BlueCross BlueShield of Tennessee's specialty pharmacy vendors.

Per the supply management plan, CVS Caremark will only be able to ship to patients meeting the following criteria:

- Children age 18 years of age or younger;
- Patients with Type 2 or 3 Gaucher Disease; or
- Adult patients facing life-threatening clinical situations.

Additionally, they will:

- limit shipments to a one (1) dose supply;
- notify prescribers and patients of the revised management plan;
- direct prescribers and patients to information on the Cerezyme Emergency Access Program (CEAP) and product availability.

Note: Fabrazyme (agalsidase beta) supply will continue to be monitored, but is not included in this supply management plan at this time.

For more information on the Cerezyme Emergency Access Program, call Genzyme's Medical Information line, 1-800-745-4447, Option #2 or visit the product shortage Page on Genzyme's Web site at www.genzymesupplyupdate.typepad.com.

New feature being implemented to BCBST provider service line

Effective 4th quarter 2009, providers will be able to check claims status via the Provider Service line, 1-800-924-7141, 24-hours-a-day, 7-days-a-week. Member claims status will be available for all lines of business, including BlueCard® out-of-state member claims.

This new feature should help reduce the time you spend on the phone checking claims status by 50 percent. Many of the questions you have regarding claims status can be answered utilizing this automated function, to include, paid amount, patient liability, check number and check date.

In order to obtain information you will need your BCBST provider ID number, NPI number or tax ID number. Additional information you should have available at the time of the call is:

- member ID number, ***including the alpha characters (early September 2009);***
- member date of birth;
- date of service; and
- total charge.

BCBST to replace mailed explanations of benefits (EOBs) with monthly claims statements

Starting Oct.1, 2009, BCBST members currently receiving EOBs by mail will begin receiving a monthly Claims Statement reflecting claims paid to providers on their behalf.

Members can still see their detailed EOBs online at www.bcbst.com on the secure BlueAccess pages and print them from there if copies are needed. Members who do not have access to a computer or printer can call the Customer Service number listed on their BCBST ID card to request a copy.

There will be no change for members who opted for online EOB notices. These members will continue to receive e-mails when their EOB is posted on BlueAccess. Members can also access their Personal Health Statement which contains same information the monthly statement includes only more comprehensive and up to date.

Members who currently receive their information by mail can choose to receive EOBs electronically by logging on to BlueAccess and following the registration steps.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Clarification: Billing guidelines for bilateral procedures

In the August 2009 issue of BlueAlert, we reported per HIPAA guidelines, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported.

We included examples in the article, and noted sometimes 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, and/or if procedure is "other" than surgical such as radiology CPT® codes, then bill as:
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

The article failed to indicate the above guidelines are for facility claims only (CMS-1450/UB-04/ANSI-837I format).

We apologize for any inconvenience this may have caused.

Reminder: Electronic funds transfer (EFT)

A safe, secure and cost-effective way to receive your payments

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

Sign up today 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

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 – CH 2.4
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0001

The EFT Enrollment Form and Frequently Asked Questions (FAQs) 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. **Note:** when you begin to receive EFT payments, you will no longer receive a paper remittance advice as this information is made available online for viewing and printing.

We also support and provide the remittance information in the ANSI 835 format which for many providers facilitates automated posting of claims payment information.

BlueCare/TennCare*Select*

Clinical

American Academy of Pediatrics (AAP) recommends routine developmental screenings

The AAP recommends routine developmental/behavioral surveillance at every pediatric patient preventive care visit. Developmental and behavioral screening using standardized tools are recommended during preventive care exams for children aged 9 months, 18 months and 30 months, or if risks are identified through routine surveillance. Autism screening is recommended at the 18-month and 24-month visits.
Find additional information on developmental and behavioral surveillance and screening tools at <www.tnaap.org/DevBehScreening/surveillancescreening.htm>.

ADMINISTRATIVE

BlueCare transition of care unit needs your assistance

Beginning first quarter 2009, in an effort to assist our Transition of Care Unit with discharge planning for our BlueCare and TennCare*Select* members, VSHP began contacting facilities requesting discharge dates for inpatient admissions.

To help with this process, VSHP developed a "Discharge Fax" form for provider use in faxing the information to us. Facilities can call the VSHP Utilization Management Department to request a form or simply report any BlueCare or TennCare*Select* discharges at the time of the call. When calling or faxing, please use one of the numbers listed below:

BlueCare

Phone		1-888-423-0131
Fax	East	1-800-292-5311
Fax	West	1-800-919-9213

TennCare*Select*

Phone	1-800-711-4104
Fax	1-800-292-5311

Change in reimbursement for assistant-at-surgery provided by a physician*

Effective with dates of service Oct. 1, 2009, Volunteer State Health Plan (VSHP) will reimburse for eligible assistant-at-surgery services provided by a physician based on the lesser of total covered charges or16 percent of the maximum allowable fee schedule amount for all VSHP networks.

Assistant-at-surgery services provided by a physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon), 82 (Assistant Surgeon when qualified resident surgeon is not available) to the procedure code. This reimbursement is in accordance with the Centers for Medicare & Medicaid (CMS) guidelines.

The 80, 81, or 82 modifiers should **not** be used to report assistant-at-surgery services provided by a physician assistant, nurse

BlueCare/TennCare*Select*

ADMINISTRATIVE

Change in reimbursement for assistant-at-surgery provided by a physician*(cont'd)

practitioner or clinical nurse specialist. Assistant-at-surgery services provided by a physician assistant, nurse practitioner, or clinical nurse specialist should be reported by appending the Level II HCPCS modifier AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant-at-surgery). The maximum allowable for procedures reported with an AS modifier will be $0.00.

Change in reimbursement for procedures performed by two surgeons*

Effective with dates of service Oct. 1, 2009, Volunteer State Health Plan will reimburse eligible procedures performed by two surgeons based on the lesser of covered charges or 62.5 percent of the base maximum allowable fee schedule amount for the procedure for each surgeon (or a total of 125 percent of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the providers in accordance with standard coding and billing guidelines for all BCBST/VSHP networks.

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding **modifier 62** to the procedure code(s). Each surgeon should report the co-surgery once using the same procedure code(s).
This reimbursement is in accordance with the Centers of Medicare & Medicaid Services (CMS) reimbursement guidelines.

Annual eligibility re-determination process for TennCare enrollees

The Bureau of TennCare requested BlueCare and TennCare*Select* make the following important notification available to the provider community.

As you may be aware, a group of TennCare enrollees who had previously not been subject to TennCare's annual eligibility re-determination process are now going through that process. These enrollees are part of a group known as the Daniels Class.

A critical part of the eligibility re-determination process involves a requirement that the enrollee respond to a Request for Information (RFI). This information is provided on "peach pages" that are mailed to the enrollee. If these enrollees do not provide the requested information they will lose their TennCare coverage for failure to respond.

If you become aware of any patient who has lost his/her TennCare coverage and you believe it may be due to a failure to respond to the RFI you may direct them to **call the Family Assistance Service Center toll free at 1-866-311-4287. In the Nashville area they may call, 743-2000.**

It is not too late for these patients to complete the RFI and, if eligible, to regain their TennCare coverage. In some cases, coverage may even be reinstated retroactively to the date of termination.

Thank you for your assistance in helping to assure those who are eligible continue to receive TennCare coverage.

Reminder: Reporting home health non-covered shifts

Home health agencies are reminded to notify VSHP Case Management when home health/private duty shifts are not covered. A non-covered shift is defined as any scheduled home health/private duty visit or service that does not occur, including partially covered and future open shifts.

Effective Oct. 1, 2009, non-covered shifts can be reported by calling the new VSHP Home Health Compliance line, 1-800-215-3851, Monday through Friday from 8 a.m. to 6 p.m. After regular business hours, you can call the *NurseAdvise* line, 1-800-262-2873, 24-hours-a-day, 7-days-a-week. Effective with implementation of the new compliance line, VSHP will no longer accept faxed notification.

Note: Home health agencies should only submit claims for services actually rendered. Any liquidated damages, penalties or fines assessed against VSHP by TennCare related to non-covered shifts by the home health agency shall be passed on to the home health agency for payment.

New Volunteer State Health Plan edit requirements

The Contractor Risk Agreement between VSHP and the Bureau of TennCare requires BlueCare and TennCare*Select* to submit all data relevant to the adjudication and payment of claims according to standards and formats as defined by TennCare. In October 2009, VSHP will begin implementing a new set of edit requirements to improve the reporting capability of accurate claims data to the Bureau of TennCare.

These new edits will be listed in the BCBST EDI Front-End Edit Guides for 837 Professional and 837 Institutional claims available on the Provider page under eBusiness Technical Information of the company Web sites, www.bcbst.com and www.vshptn.com.

If you have any questions, please contact the eBusiness Service Center at (423) 535-5717 or via e-mail at ecomm_techsupport@bcbst.com. Technical support is available Monday through Friday, from 8 a.m. to 6:30 p.m. (ET).

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

ADMINISTRATIVE

Risk Adjustment Data Validation

Document medical records appropriately

Annually, the Centers for Medicare & Medicaid Services (CMS) randomly select Medicare Advantage (MA) Organizations for risk adjustment data validation (RADV) audits. 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.

At the recommendation of CMS, BlueCross BlueShield of Tennessee developed its own independent Data Validation process and during a recent audit found a reoccurring error related to diagnosis code 250.02, which indicates the diabetes is uncontrolled. The code for these occurrences should have been 250.00, as there was no documentation in the medical records supporting the "uncontrolled" status of the disease.

Tip: Document a cause and effect of the condition.

Examples:

250.40 - DM w/Renal Manifestations + CKD 585.9, Nephropathy 583.81, or Nephrosis 581.81 *(Instead of documenting "DM with Renal manifestations", which does not specify the manifestation, use "DM w/CKD" to be more concise.)*

250.50 - DM w/Ophthalmic Manifestations + Glaucoma 365.44, Macular Edema 362.07, Retinopathy 362.01-362.07, Cataract 366.41, or Retinal Edema 362.07

250.60 - DM w/Neurological Manifestations + Polyneuropathy 357.2, Gastroparesis 536.3, Peripheral Autonomic Neuropathy 337.1, Neurogenic Arthropathy 713.5

250.70 - DM w/Peripheral Circulatory Disorders + PVD 443.81

BlueCard®

ADMINISTRATIVE

Having trouble printing a legible copy of BlueCard remits?

If you recently tried to print a legible copy of a BlueCard remittance advice and were unsuccessful, please verify you are using Adobe Acrobat version 9.

In order to print a legible copy of the remit, you must upgrade to Adobe version 9. The remits on BlueAccess are in a PDF format and will automatically adjust to a smaller font and print to fit an 8 ½ by 11 sheet size. Once upgraded, you can print to legal size paper and expand the document to extend the margins of the page. Upgrading to version 9 is free and offered online by Adobe Acrobat.

If you have any questions, please contact the eBusiness Service Center at 423- 535-5717 or via e-mail at ecomm_techsupport@bcbst.com. Technical support is also available Monday through Friday, from 8 a.m. to 6:30 p.m. (EST).

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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).

Note: Some providers using phone numbers other than the Provider Service Line, 1-800-924-7141 will have the opportunity to take advantage of our Provider Self Service line when dialing the other numbers.

The caller will hear a message stating that some of the options have changed and can then choose the option that best suit his/her needs. The caller will be asked to enter specific identifying information via touchtone or voice activated response to provide necessary information pertaining to the specific line of business.

We are confident these changes will better serve your calling needs, and enable you to obtain information more efficiently.

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*These changes will be included in the appropriate 3Q 2009 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

October 2009

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 Nov. 14, 2009

- Meniscal Allograft Transplantation
- Cryosurgical Ablation for the Treatment of Renal Tumors
- Cryosurgical Ablation for the Treatment of Prostate Tumors
- Microarray-based Gene Expression Testing for Cancers of Unknown Primary

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

Modified Utilization Management Guideline updates/changes

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

Effective Nov. 20, 2009

The following as relates to Home Health:

- Skilled Nursing Visits - Invasive

The following as relates to Rehabilitative Care:

- Skilled Nursing Facility (SNF) Admission
- Skilled Nursing Facility/Inpatient Rehabilitation Fax Form

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

Improving treatment and care for chronic illnesses

We are pleased to announce that beginning in October members who suffer with certain less common chronic medical conditions such as hemophilia, Parkinson's, cystic fibrosis and others, will have access to a new program that will help them better manage their treatment. These members will be offered information regarding more effective treatment and self management techniques should help them maintain the quality of life that they desire. We will also work with providers to help educate their patients and stress the importance of adhering to their specified treatment programs. Members who choose to participate in the program will have access to:

- Nursing support via telephone 24-hours-a-day
- Monthly newsletters with preventive tips
- Web based information regarding their condition
- Various types of health resources

Providers who treat members choosing to participate in this program will be notified. We look forward to working with you to help improve the health of these members

Note: At this time, this program is only available for BCBST commercially insured members.

ADMINISTRATIVE

Federal government providing H1N1 influenza vaccine at no cost

This fall, to protect the public from the 2009 H1N1 pandemic influenza virus, the federal government is developing a program to provide states with the pandemic vaccine and supplies (needles, syringes, sharps containers, alcohol swabs) at no cost to the states. It is estimated that approximately 120 million doses will be available over the first month of shipping and that enough vaccine will be distributed to fully meet U.S. demand in less than 6 months. The Tennessee Department of Health (TDOH) will be responsible for directing the vaccine and supplies shipments in the State of Tennessee. We will continue to communicate new information on the program as it becomes available to us.

The TDOH is offering the opportunity for health care providers interested in having vaccine and supplies shipped to their facility. Pre-registered representatives will receive e-mail updates about the program and important information on how to store, handle and administer the vaccine properly.

Pre-registration is a two-step process:

1. Register for access to the Tennessee Web Immunization System (TWIS) at http://health.state.tn.us/twis/.

2. Select ***Online Registration Request*** and follow the prompts.

Once registered, or if you are already a registered TWIS user, you can log on and go to the online pre-registration form for the pandemic vaccine. Please note that an individual facility/practice should only register one time.
Once the program is finalized, points of contact will receive a federal pandemic vaccine provider agreement and instructions for ordering vaccine and supplies.

Because the program is still under development, the TDOH cannot guarantee that all pre-registered providers will receive vaccine directly shipped to them or the timing or size of shipments; however, vaccine is expected to begin shipping through this mechanism by mid October.

If you need any assistance with the registration process, please contact the TWIS Help Desk at 1-888-894-7435.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

BCBST to cover the administration of H1N1 flu vaccinations for its members

BCBST fully-insured members will receive full coverage for the H1N1 vaccination when it becomes available, including those in TennCare and Medicare Advantage plans. The Centers for Medicare & Medicaid Services (CMS) has created the code G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family) for this service. For members using an in-network provider, there will be no copay, deductible or coinsurance. We will pay network providers at the contracted rate to provide the immunizations to their patients. Members whose employers have a self-funded plan will need to check with their employer to determine coverage.

To further help fight the flu this year, BCBST has taken steps to ensure the antiviral prescription drugs Tamiflu® (oseltamir) and Relenza® (zanamivir) – commonly prescribed to treat the symptoms of flu – are more affordable. These changes apply only to members with BCBST prescription drug coverage; however, these savings may not apply to members with BlueAdvantage or BlueRx drug coverage. All members should contact their plan administrator to confirm drug coverage.

Additionally, VSHP has removed its prior authorization requirement for these drugs for BlueCare and TennCare*Select* children under age 5 years.

Reminder: Regular seasonal flu remains a threat

With all the attention on the H1N1 pandemic influenza virus, it is important providers remember to vaccinate against the regular seasonal flu. Seasonal influenza continues to be a major health threat year after year.

Providers are reminded not all BlueCross BlueShield of Tennessee health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate Provider Service line†.

The following regular seasonal influenza immunization guidelines apply:

Commercial

- ***Vaccine and administration*** Covered if member's health care plan has a Well care rider
- ***FluMist® nasal spray*** (recommended for healthy individuals ages 2-49) Entire cost may not be covered and member may be responsible for any charges that exceed the standard reimbursement amount

If your commercial patients elect to have the *FluMist®* nasal spray, a *FluMist®* financial acknowledgement form is available online for provider use at http://www.bcbst.com/providers/forms/FluMist.pdf.

Note: ***If you utilize the waiver form, you are still required to file a claim with BlueCross BlueShield of Tennessee for the services.***

BlueCare or TennCare*Select*

- ***Vaccine and administration***
  - Covered

  Note: Providers who normally receive influenza vaccine through the Vaccine for Children (VFC) program may use their purchased supply and submit claims using a Modifier 32 to receive fee for service reimbursement **only** when the VFC supply is depleted or delayed.
- ***FluMist® nasal spray*** (recommended for healthy individuals ages 2-49)
  - Covered

Note: *FluMist®* is available under the Vaccines for Children (VFC) Program for children ages 5 through 18 years.

Does the Tennessee Department of Health have your current contact information?

The Tennessee Department of Health (TDOH) is requesting assistance in ensuring all providers report their current Professional License information.

To update the state's licensing database, visit the state's Web site at www.tennesseeanytime.org/hlrs/begin.jsp and click on the link "Begin here to update your Professional License information and/or renew your Professional License".

BCBST billing guideline exceptions for serious reportable adverse events ("never events")*

In conjunction with the Dec. 1, 2009, implementation of the Centers for Medicare & Medicaid Services (CMS) guidelines for serious reportable adverse events ("never events") addressed in August *BlueAlert*, the following BCBST billing guideline exceptions apply:

HCPCS codes will be required for **all** outpatient service lines related to the three (3) never events established in conjunction with appropriate surgical error modifiers; PA, PB, or PC.

The appropriate E code‡ should be attached to all claims to explain surgical error diagnosis as follows:

- **E876.5** - Performance of wrong operation (procedure) on correct patient. (Revised description 10/1/2009)
- **E876.6** – Performance of operation (procedure) on patient not scheduled for surgery.
- **E876.7** – Performance of correct operation (procedure) on wrong side/body part.

‡An E code cannot be filed as the principal/primary diagnosis on a claim per National Standard Coding Guidelines.

Note: In addition to the standard BCBST billing guideline exceptions indicated above, we will follow CMS guidelines for the billing and reimbursement of all inpatient and outpatient "never events" filed on a CMS-1450/ANSI-837I claim form for participating facilities.

Medical emergency diagnosis code listings updated

Effective Nov. 1, 2009, providers will be able to view the updated CoverTN, BlueCare and TennCare*Select* medical emergency diagnosis code listings online. To view these updated lists and other important information, visit the company Web site, www.bcbst.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder – New feature being implemented to BCBST provider service line

Providers are reminded in the near future they will be able to check claims status for all BCBST lines of business via the Provider Service line, 1-800-924-7141, 24-hours-a-day, 7-days-a-week.

In order for you to obtain this information, please have the following information available at the time of your call:

- provider ID number, NPI number or tax ID number;
- member ID number, **including the alpha prefix** and date of birth;
- date of service; and
- total charge.

Current claims status information continues to be available on BlueAccess, on our company Web site, www.bcbst.com.

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 (VSHP) 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;
- coronary artery disease;
- obesity;
- bipolar disease;
- major depression; and
- schizophrenia.

Members enrolled in a disease management program are assigned a VSHP disease manager (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

Diabetes - gaps in care program

Volunteer State Health Plan (VSHP) has launched a new initiative based on HbA1c gaps in care. This program focuses on HbA1c testing, diabetes monitoring, and gaps in care measures. It was designed to provide relevant and timely member-specific clinical information to providers helping them improve diabetes care for their BlueCare and TennCare*Select* members receiving treatment in the past 12-months.

Some providers may receive an on-site visit from our clinical team or a mailing including an educational packet that includes member detail that you might find useful in treating your BlueCare and TennCare*Select* patients who suffer from diabetes. Our goal is to work with providers to increase HbA1C testing rate, reduce diabetes gaps in care, and improve diabetes care.

ADMINISTRATIVE

Change to hospice prior authorization requirements*

Effective Nov. 1, 2009, all hospice services for BlueCare and TennCare*Select* members will require prior authorization and must be billed in accordance with VSHP billing guidelines. Previously, these services required notification only.

Benefits are provided for hospice care when the member's practitioner establishes a plan of treatment and an approved provider of hospice care provides the services. Hospice services must be provided by an organization certified pursuant to Medicare Hospice requirements.

To arrange prior authorization for hospice services, fax our Utilization Management Department 24-hours-a-day, 7-days-a-week at:

Eastern Region	1-800-292-5311
Western Region	1-800-919-9213

Change in reimbursement for multiple procedure claims filed with modifier 59*

Effective Nov. 1, 2009, to be consistent with the Centers for Medicare & Medicaid Services (CMS), BlueCare and TennCare*Select* are changing the reimbursement amount for some multiple procedure claims when filed with Modifier 59.

The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries). Although modifier 59 is used to indicate a distinct procedural service, it should only be used as a modifier of last resort.

The multiple procedure reduction is based on the multiple procedure indicators published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/ Transmittals (these documents are located on the CMS Web site at www.cms.gov/) and will apply to codes with a multiple procedure indicator of "2" or "3".

BlueCare and TennCare*Select* will reimburse 100 hundred percent of the fee schedule amount for the highest valued procedure and 50 percent of the fee schedule amount for the additional eligible procedures. This reimbursement is consistent with CMS reimbursement methodology for modifier 59.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Arranging non-emergency transportation

Non-emergency transportation to TennCare covered services is provided for BlueCare and TennCare*Select* members regardless of whether the member is ambulatory, in a wheelchair, or on a stretcher.

VSHP members and/or their representatives may arrange non-emergency transportation services prior to needing transport by calling Southeastrans, Inc. at one of the phone numbers listed below:

BlueCare East	1-866-473-7563
BlueCare West	1-866-473-7564
TennCareSelect	1-866-473-7565

Providing home health/private duty nursing services for multiple enrollees in same home

VSHP is aware of some confusion among providers regarding the provision of home health and private duty services for members where there is more than one member needing services in the same household. Based on TennCare rule 1200-13-13-.01(52) and 1200-13-13-.01(88), "*A single nurse may provide services to multiple enrollees in the same home and during the same hours, as long as he/she can provide these services safely and appropriately to each enrollee*."

Our case managers will be contacting agencies having these kinds of situations to discuss care provision options as VSHP has special reimbursement arrangements for a single nurse/aide providing services to multiple members in the same home. Please feel free to contact the member's case manager(s) for additional information.

Changes to readmission guidelines

Effective Nov. 1, 2009, the readmission rule, "Specific to CMS-1450 Claim Form Billing and Reimbursement Guidelines," for BlueCare and TennCare*Select* is changing from fourteen (14) days to thirty (30) days.

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

ADMINISTRATIVE

Risk Adjustment data submission/validation

Document medical records appropriately

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 legibly **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 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 of signature	Acceptable
Hand-written or initials, including credentials	Authenticated by provider Mary C. Smith, MD, or MCS
Electronic, including credentials	Requires authentication by the responsible provider (for example, but not limited to "Approved by", "Signed by", "Electronically signed by")

Unacceptable physician signatures and credentials:

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

A signature log may be utilized in the event a physician's signature in a medical record is determined to be illegible. The signature log captures the physician name and credentials as well as variations in the physician's signature. Once the signature log is obtained, it is compared to the original signature in question.

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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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BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

November 2009

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. 12, 2009

- Golimumab
- Intravenous Immune Globulins
- Degarelix
- Dexamethasone Intravitreal Implant
- Tadalafil
- Everolimus
- Certolizumab Pegol
- Bevacizumab
- Sorafenib
- Mitoxantrone (Systemic)
- In Vivo Analysis of Colorectal Polyps
- Positron Emission Tomography (PET) for Oncologic Applications
- Shoulder Resurfacing
- Transurethral Microwave Thermotherapy
- Transcatheter Hepatic Arterial Chemoembolization

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

New drugs added to commercial specialty pharmacy listing

Effective Oct. 1, 2009, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by a (PA).

Provider-administered via medical benefit:
Degarelix
Feraheme
Ilaris
RiaSTAP

Self-administered via pharmacy benefit:
Adcirca (PA)
Sabril (PA)
Tyvasco (PA)

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

Changes to commercial preferred drug listing

The Pharmacy and Therapeutics Committee attempts to minimize annual changes to the BlueCross BlueShield of Tennessee Commercial Preferred Drug List (PDL), but changes are necessary due to availability of generics, pricing changes and changes to market availability.

Effective Oct. 1, 2009:

Drugs moving from Tier 3 to Tier 2:
Bysolic
Coreg CR
Savella
Trilipix
Venlafaxine ER

Clinical practice guidelines adopted

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

Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2008). <http://www.goldcopd.org/index.asp?l1=1&l2=0>

Practice parameter: Evidence-based Guidelines for Migraine Headache (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology. <http://www.neurology.org/cgi/reprint/55/6/754.pdf>

1998: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. <http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf>

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.

BlueAlert is now available on BlueAccess!

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, TennCare and Medicare Advantage members. As part of the QIP, BCBST conducts member education and other activities to improve rates on clinical initiatives.

Despite 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® 2009 results show more emphasis is needed to increase rates for the following measures:

Product	HEDIS Measure		
	Retinal Eye Exam	Mammo gram	Pap Test
BlueCare	44.74%	47.60%	66.67%
TennCare*Select*	36.50%	21.25%	45.99%
Commercial	37.80%	68.06%	73.64%
Medicare Advantage	59.19%	71.22%	N/A

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.

VSHP providers can help improve preventive screening rates for their BlueCare and TennCare*Select* members by participating in VSHP-sponsored community health events featuring onsite screening clinics. Providers who provide screenings at these events are eligible for reimbursement at their contracted rates. Providers can also host an outreach event for their BlueCare and TennCareSelect patients at their practice location. Providers may contact Sheila Keith at (423) 535-7603 for more information.

The Preventive Services section of 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) 535-6705.

ADMINISTRATIVE

Red flags rule

The Federal Trade Commission (FTC) issued a final rule (Red Flags Rule) on Nov. 9, 2007, which requires financial institutions and "creditors" to develop and implement written identity theft prevention programs, as part of the Fair and Accurate Credit Transactions Act of 2003. The FTC has interpreted physicians to be "creditors" and, therefore, subject to the compliance obligations of the Red Flags Rule.

The American Medical Association (AMA) has attempted to get physician practices exempt from this Rule, but so far have not been successful. In accordance with the FTC ruling, provider practices must have "reasonable policies and procedures in place" by Nov. 1, 2009.

To learn more how your practice can comply with the Red Flags Rule, visit the AMA Web site, www.ama-assn.org or call 1-800-262-3211 and ask for AMA Practice Management Center.

H1N1 billing and reimbursement guidelines

The following billing and reimbursement guidelines are offered to assist you when filing claims for the administration of the H1N1 influenza vaccine:

When filing an H1N1 claim for…	use HCPCS codes:
Commercial* (CoverTN, CoverKids, AccessTN)	G9141 and G9142 or 90470 and 90663 (**File** serum code)
BlueCare, or TennCare*Select,*	G9141 and G9142 or 90470 and 90663 (**File** serum code)
Medicare Advantage	G9141 only (Do **not** file serum code)

The H1N1 vaccine is being supplied to providers free of charge. Regardless of the age of the member, BlueCare and TennCare*Select* will reimburse $10.25 for the administration of the vaccine. All other lines of business will follow the Centers for Medicare & Medicaid Services (CMS) guidelines reimbursing G9141 the same as 90470 according to provider contracted rates.

Typically, TennCare does not provide pharmacies an administration fee for vaccines; however, this flu season, pharmacies will be reimbursed the $10.25 administration fee via SXC Health Solutions for the H1N1 vaccine administered to TennCare members.

*Not all BlueCross BlueShield of Tennessee self-funded plans cover immunizations. We encourage you to check with the member's specific health care plan to verify benefits.

Federal mental health parity dates approaching

The Mental Health Parity and Addiction Equity Act of 2008 amends the Employment Retirement Income Security Act (ERISA) and the Public Health Services Act prohibiting employers' health plans from imposing any caps or limitations on mental health treatment or substance use disorder benefits that are not applied to medical and surgical benefits. It also requires that member out-of-pocket expenses (copays, coinsurance, deductible) for mental health and substance abuse be no more restrictive than member cost share for medical care.

For more information about mental health parity, please visit the Provider page on BlueCross BlueShield of Tennessee's Web site, www.bcbst.com. Once there, choose:

- Commercial Behavioral Health
  - Linking to Magellan
    - Provider Focus
      - Summer 2009

Reminder: All Blue 2009 Q & As

If you submitted questions during the All Blue 2009 online registration process, you can view the questions and answers on our Web site at www.bcbst.com/providers/materials/.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Change in reimbursement for multiple procedure claims filed with modifier 59*

Effective Feb. 1, 2010, to be consistent with CMS, BlueCross BlueShield of Tennessee will be changing the reimbursement amount for some multiple procedure claims when filed with modifier 59 for the commercial lines of business.

The physician may need to indicate a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries). Although modifier 59 is used to indicate a distinct procedural service, it should only be used as a modifier of last resort.

The multiple procedure reduction is based on the multiple procedure indicators published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/ Transmittals (these documents are located on the Centers for Medicare & Medicaid (CMS) Web site at www.cms.gov/) and will apply to codes with a multiple procedure indicator of "2" or "3".

BCBST will reimburse 100 percent of the fee schedule amount for the highest valued procedure and 50 percent of the fee schedule amount for the additional eligible procedures. This reimbursement is consistent with CMS reimbursement.

Provider online services enhanced

Over the next few months BCBST will be enhancing our provider online services located on the company Web site, www.bcbst.com. Providers, through our Service Center feature on BlueAccess can create and submit authorizations for home health services. Home health services included are: medical social services, skilled nursing visits, and home physical, occupational and speech therapies.

Providers can perform online predeterminations for durable medical equipment including electrical bone growth stimulation and oral appliances for management of mild to moderate obstructive sleep apneas. This includes specialty pharmacy drugs, Botulinum Toxin and Synvasc.

Effective Jan. 1, 2010, outpatient Endometrial Ablation will require prior authorization. With the enhanced BlueAccess, providers can submit these prior authorizations via the Service Center.

Reminder: Recoupment of inappropriate payment

BCBST will not make payment to an Acute Care Facility for any CPT®/HCPCS codes where the UB-Editor indicates it is not appropriate to reimburse for these codes in an Acute Care Hospital Outpatient setting. In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder – Don't forget to submit your disclosure form

Federal regulations require 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 online at www.bcbst.com/providers/Disclosure.pdf.

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

Volunteer State Health Plan (VSHP) new edit requirements

Beginning Dec. 1, 2009, VSHP will begin implementing a new set of electronic claim edit requirements to improve the reporting capability of accurate claims data to the Bureau of TennCare. The Contractor Risk Agreement between VSHP and the Bureau of TennCare requires BlueCare and TennCare*Select* to submit all data relevant to the adjudication and payment of claims according to standards and formats as defined by TennCare. These edits include the validation of code sets filed, such as:

- ICD-9-CM procedure codes
- ICD-9-CM diagnosis codes
- CPT®/HCPCS codes
- Revenue codes
- Type of Bill codes
- Place of Service codes
- Admission Source codes
- Occurrence codes
- Value codes
- Modifier codes
- Patient Status codes

Also included are edits for:

- Balancing of claim information
- Appropriate filing of date parameters
- Validity of Zip codes
- Validity of State codes

These new edits will be listed on the eBusiness Technical Information page under Supplemental BlueCare/TennCare*Select* Edits on the company Web site, www.bcbst.com. Claims non-compliant with these edits will be returned to the provider.

If you have any questions, please call the eBusiness Service Center at 423 535-5717 or e-mail Ecomm_techsupport@bcbst.com. Technical support is available Monday through Friday, from 8 a.m. to 6:30 p.m. (ET).

Correction: *FluMist* nasal spray

In October issue of *BlueAlert* we incorrectly reported *FluMist* is available under the Vaccines for Children (VFC) Program for children ages 5 through 18 years. The correct ages are 2 through 18 years.

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

ADMINISTRATIVE

BlueAdvantage member information available through Shared Health®

The secure online health records of BlueAdvantage members are available through Shared Health. Providers can access their BlueAdvantage patients' Clinical Health Record (CHR) and manage their BlueAdvantage patients' care through Shared Health.

Shared Health allows doctors who are registered on Shared Health to write prescriptions from their own computers and send them directly to any BlueAdvantage patient's pharmacy through the ePrescribe feature.

Shared Health ePrescribe® gives providers critical information about prescriptions for BlueAdvantage patients:

- The medicines that BlueAdvantage reimburses
- The medicines that need BlueAdvantage's prior authorization or quantity limits;
- BlueAdvantage patients' medication claims history; and
- Drug interactions that could potentially harm a patient.

Benefits of using Shared Health:

- Allows more time for patient care and less time for administrative paperwork.
- Protects valuable medical information in the case of a catastrophic event such as Hurricane Katrina.
- Improves preventative care by giving a more holistic view of your patients.
- Helps emergency departments quickly access relevant patient information when time is crucial.

If you have additional questions, or would like to become a registered clinician please contact Shared Health at 1-888-283-6691.

How do providers influence risk adjustment data?

Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburse Medicare Advantage (MA) plans, such as BCBST, for the health status and demographic characteristics of their enrollees.

CMS looks to providers to code identified conditions accurately using ICD-9-CM guidelines with supporting documentation of those codes in their medical record.

Providers influence risk adjustment data by:

- Submitting medical records timely upon request
- Documenting clearly, completely and legibly in the medical record
- Documenting coexisting conditions and treatment at least annually
- Using standard abbreviations
- Identifying patient and date of service on each page of the record (**CMS requirement**)
- Authenticating the record with a legible signature and credentials (**CMS requirement**)
- Coding to the highest level of specificity using ICD-9-CM coding guidelines and document in the medical record accordingly.

BlueCard®

ADMINISTRATIVE

Verifying eligibility of limited benefit products

Verifying Blue patients' benefits and eligibility is now more important than ever since new products and benefit types entered the market. In addition to patients having traditional Blue PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e. $1 million or more), you may now see patients whose annual benefits are limited to $50,000 or less.

Currently BlueCross BlueShield of Tennessee offers limited benefit plans to its members, so you may see patients having limited benefits who are covered by another Blue Plan.

BlueCross BlueShield of Tennessee's, CoverTN product is a limited benefit plan. It has an ID card with a red stripe at the bottom and "Limited Benefits" in red at the top.

For more information about Limited Benefit Products, please visit the *News* section on the Provider page on our company Web site, www.bcbst.com.

Reminder: Coordination of benefits and patient liability

Coordination of benefits (COB) refers to how the Blue System ensures members receive full benefits and helps prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains which entity has primary and secondary responsibility for payment.

For more information on COB claims and patient liability, visit the "News" section on the Provider page on our company Web site, www.bcbst.com.

†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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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

BlueCard
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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).

*These changes will be included in the appropriate 4Q 2009 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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December 2009

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. 9, 2010
- Total Facet Arthroplasty

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

Correction:

In the November issue of *BlueAlert* we incorrectly reflected a Dec. 12, 2009, effective date for:
- Bevacizumab
- Transurethral Microwave Thermotherapy

The correct effective date is Dec. 18, 2009.

Changes to commercial preferred drug listing

The Pharmacy and Therapeutics Committee attempts to minimize annual changes to the BlueCross BlueShield of Tennessee commercial Preferred Drug List (PDL), but changes are necessary due to availability of generics, pricing changes and changes to market availability.

Effective Jan. 1, 2010 the following changes are being made:

Drugs moving from Tier 3 to Tier 2:
Astepro
Boniva
Bystolic
Coreg CR
Savella
Trilipix
Venlafaxine ER
Ventolin HFA

Drugs moving from Tier 2 to Tier 3:
Atacand (Preferred ARB'S: Avapro, Benicar, Micardis)
Atacand HCT (Preferred ARB/Combo's: Avalide, Benicar HCT, Micardis HCT)
Copaxone
Proventil HFA (other preferred brand available: ProAir HFA, Ventolin HFA)
Rebif

Drugs moving from Tier 2 to Tier 3 due to generic equivalent availability:
Alphagan P (brimonidine)
Miacalcin (calcitonin-salmon)
Prevacid (lansoprazole; the 15mg will be OTC)
Valtrex (valacyclovir)

Generic and branded generic drugs being added to Tier 1:
brimonidine (Alphagan P)
budesonide inhalation (Pulmicort inhalation)
lansoprazole (Prevacid)
miglitol (Glyset-no longer on the market)
repaglinide (Prandin)
valacyclovir (Valtrex)

Drugs being added to prior authorization list:

Enbrel	Nuvigil
Cimzia	Provigil
Humira	Simponi
Kineret	

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 (VSHP) 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, coronary artery disease, obesity, bipolar disease, major depression and schizophrenia.

Members enrolled in a disease management program are assigned a Volunteer State Health Plan Disease Manager 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

Clarification: Provider online services enhanced

In the November issue of *BlueAlert*, BCBST announced over the next few months it was enhancing its eHealth provider online services allowing providers to perform online predetermination requests for a number of procedures, durable medical equipment, and pharmacy drugs.

At this time, these enhanced services are not available for BlueCare or TennCare*Select* members. We apologize for any inconvenience this may have caused.

Remember BlueAlert is now on BlueAccess!

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Vaccinate against flu

The Centers for Medicare & Medicaid Services (CMS) has developed an 8.5" x 11" bilingual poster to help communicate, especially to seniors and vulnerable populations, that Medicare and Medicaid cover the seasonal and H1N1 flu vaccines. The poster is available for download at <http://www.tnpharm.org/FluPoster_2009_Final_508.pdf>.

CMS asks that it be posted in places where Medicare patients will see it, helping them understand the need for their seasonal flu shot and letting them know they can get the H1N1 vaccine once high-risk groups are vaccinated.

CMS encourages Medicare practitioners to refer patients to www.flu.gov if they need more information about the seasonal and H1N1 flu vaccines. Information for practitioners, mass immunizers and others who want to bill Medicare for the flu vaccines can be obtained at www.cms.hhs.gov/adultimmunizations.

BlueCross BlueShield of Tennessee fully-insured members will receive full coverage for the seasonal flu and H1N1 vaccination, including those in TennCare and Medicare Advantage plans. However, providers are reminded not all BCBST health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate BCBST Provider Service line†. Detailed billing and reimbursement guidelines can be referenced in the October 2009 issue of *BlueAlert*.

Recovery audit contractor program

As previously disclosed by the Centers for Medicare & Medicaid Services (CMS), the Recovery Audit Contractor (RAC) program has begun. Tennessee is included in Region "C" with Connolly Consulting, Inc. serving as the Recovery Audit Contractor and Viant Payment Systems, Inc. serving as the subcontractor. The mission of the RAC program is to "…*reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.*" BCBST will begin accepting RAC initiated secondary adjustment claims through the Coordination of Benefits Contractor (COBA) crossover process starting in December 2009.

Claims will not be crossed over to BCBST before the RAC has issued a demand letter and a Remittance Advice has been sent showing the claim adjustment with Remark Code N432 "Adjustment Based on Recovery Audit".

More information about the Recovery Audit Contractor (RAC) program may be found on the CMS Web site at www.cms.hhs.gov/RAC/ , through MLN articles, and through the following CMS press release: "CMS ENHANCES PROGRAM INTEGRITY EFFORTS TO FIGHT FRAUD, WASTE AND ABUSE IN MEDICARE" from Monday, October 06, 2008, located online at <http://www.cms.hhs.gov/apps/media/press_releases.asp>.

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

Reminder: Reimbursement guidelines for substitute high-tech imaging procedures

Effective May 22, 2007, BlueCross BlueShield of Tennessee began reimbursing for substitute high-tech imaging procedures performed in place of procedures previously authorized by MedSolutions when the CPT® code for the substitute procedure fell into an established "family of codes"; and the procedure was of **less** intensity than the originally authorized procedure. Example: Procedure code 70460, *CT Head or Brain **with** Contrast*, was authorized, but procedure code 70450, *CT Head or Brain **without** Contrast*, was actually performed.

If a procedure is substituted for a **higher** intensity procedure at the point-of-service, it is still necessary to call MedSolutions and update the authorization to ensure reimbursement. Example: Procedure code 70450, *CT of the Brain **without** Contrast*, was authorized by MedSolutions, but at the point-of-service, procedure code 70460, *CT Head or Brain **with** Contrast*, was performed. Any questions regarding this favorable change, please contact your Provider Network Manager.

BCBST transitioning to new mailing addresses*

BlueCross BlueShield of Tennessee is transitioning from P O Box numbers to four-digit zip code extensions and suite numbers for improved enhancement to our current processes.

As we transition, we will begin phasing out the P O Box numbers to allow time for you to make system or other necessary changes. We would like you to begin using the new suite numbers and four digit zip code extensions effective immediately; however, if the U.S. Post Office receives correspondence using the old P O Box numbers during this transition, your mail will be routed appropriately to BCBST for a limited time. **Once the PO Box expires, it is important to know that the mail will not be forwarded to us if "Return Service Requested" is on the envelope.**

Eliminating the PO Box numbers will help us receive your correspondence more efficiently, thus allowing a faster response to you. Listed below are two specific addresses for use with all lines of business:

Claims:
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Medical records:
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0037
Chattanooga, TN 37402-0037

Other address changes can be found in the 4th quarter update to BCBST and VSHP provider administration manuals. If you receive correspondence from BlueCross BlueShield of Tennessee requesting information, please use the suite number indicated on the correspondence to return the additional documentation.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Hospice billing guidelines

As communicated in November 2008 *BlueAlert*, the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) does not allow both inpatient and outpatient services to be billed on the same Institutional claim form. Claims filed with **both** inpatient and outpatient codes will be rejected.

Hospice providers may bill with either Type of Bill (081x or 082x) as long as the inpatient and outpatient services are on separate claims. The *Statement From/Thru Dates* must also correspond with the total days billed on the inpatient care.

You may review these billing guidelines in the *VSHP Provider Administration Manual* located on the Provider page of our company Web sites, www.vshptn.com and www.bcbst.com or on the quarterly Blue*Source* Provider Information CD. If you have any questions, please call the appropriate BlueCare or TennCare*Select* Provider Service line†.

Change to prior authorization requirements for CPT® 19300

Effective Jan.1, 2010, Mastectomy for Gynecomastia, CPT® code 19300, will no longer require prior authorization for BlueCare or TennCare*Select* members.

These claims, however, will pend in our system for nurse review. Submitting clinical documentation supporting medical appropriateness along with the claim will help expedite review.

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

ADMINISTRATIVE

Reminder: 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.

Reminder: Multiple products under BlueAdvantage PPO

BCBST offers two Medicare Advantage Preferred Provider Organization (PPO) products: BlueAdvantage Sapphire and BlueAdvantage Diamond. Effective Jan. 1, 2010, we will be offering members a third PPO option, ***BlueAdvantage Ruby***.

Recently, there has been some confusion by providers whether they accept members covered by one of these products. Please keep in mind these product names simply identify the member's benefit package within the BlueAdvantage PPO plan. If you are a contracted BlueAdvantage PPO provider, you have agreed to treat members covered under BlueAdvantage PPO whether their benefit package is BlueAdvantage **Sapphire**, BlueAdvantage **Diamond**, or our newest addition, BlueAdvantage **Ruby**.

BlueCard®

ADMINISTRATIVE

Claims run-out period for La Cruz Azul de Puerto Rico

Effective Jan. 1, 2010, claims for services rendered prior to July 1, 2009, for La Cruz Azul members will be returned. The licensing rights of the Blue Cross brand in Puerto Rico has been transferred to Triple-S Management Corporation.

The La Cruz Azul member ID cards have alpha prefixes ZTA, ZTB, ZTC, and ZTD and should no longer be accepted.

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

CoverTN

ADMINISTRATIVE

Reminder: HealthyTNBabies is maternity coverage for CoverTN members

If a pregnant CoverTN member meets eligibility requirements, she is allowed maternity coverage through *HealthyTNBabies*, the State of Tennessee's maternity coverage for CoverTN members. During the pregnancy, the member will maintain coverage under both plans – CoverTN for non-pregnancy services and HealthyTNBabies for all pregnancy-related services.

It is important providers do not delete the CoverTN coverage information on their patients while the member is covered under HealthyTNBabies. Once the baby is delivered, the HealthyTNBabies coverage will cease.

VisionBlue

ADMINISTRATIVE

Filing routine VisionBlue claims appropriately

Effective Jan. 1, 2010, routine VisionBlue claims should be submitted to EyeMed VisionCare. All other routine vision claims should continue to be filed with BlueCross BlueShield of Tennessee.

Please check the back of the member's ID card when determining whether claims should be submitted to BCBST or EyeMed VisionCare. Any VisionBlue claims filed to BCBST in error will be returned to the provider with Reject Code 650090, "Claim must be filed with EyeMed".

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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 moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

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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Season's Greetings

BlueCross BlueShield of Tennessee offices will be closed Dec. 24 & 25, 2009 and Jan. 1, 2010 in observance of the Holiday Season

*These changes will be included in the appropriate 1Q 2010 provider administration manual update. Until then, please use this communication to update your provider administration manuals.