BlueAlert
provider news flash

BlueCross BlueShield of Tennessee
plans for better health. plans for a better life.

Please Route to all Providers & Office Staff

January 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

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

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New drugs added to commercial specialty pharmacy listing

Effective Jan. 1, 2010, 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 benefits:
Arzerra
Berinert (PA)
Dysport (PA)
Folotyn
Stelara (PA)
Zevalin

Self-administered via pharmacy benefits:
Votrient

Reminder: Case management and disease management programs available

Case management services are available to members with complex or chronic conditions, a major trauma or complicated care such as transplantation and high-risk maternity care.

Our services involve extensive interaction to connect with our members, their health care providers and all other parties involved in the member's care. Members enrolled in a case management program are assigned a BlueCross BlueShield of Tennessee Case Manager (registered nurse) to address and coordinate their needs.

Our Disease Management program, Healthy Focus, offers members not only chronic condition support but also decision support and 24/7/365 Nurseline availability. 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 works with the member to address the issues. Via this process, members are provided with information and guidance and 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 1-800-225-8698.

ADMINISTRATIVE

ICD-10 and ICD-10-PCS are on the horizon

On Aug. 21, 2008, the US Department of Health and Human Services (HHS) proposed new code sets to be used for reporting diagnoses and procedures on health care transactions. Effective Oct.1, 2013, ICD-9-CM code sets would be replaced with the ICD-10 code sets. Under the proposed rule, adoption of the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* for diagnosis coding, and the *International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)* for inpatient hospital procedure coding would concurrently take place. The new codes would replace the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Volumes 1 and 2*, and the *International Classification of Diseases, Ninth Revision, Clinical Modification (CM) Volume 3* for diagnosis and procedure codes, respectively.

Developed almost 30 years ago, ICD-9-CM is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9-CM contains only 17,000 codes and is expected to start running out of available codes this year. By contrast, the ICD-10-CM code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures. The additional codes will help enable the implementation of electronic health records because they will provide more detail in the electronic transactions. This granularity will also help to improve efficiencies by helping to identify specific health conditions.

BCBST is actively developing implementation plans for all lines of business and is troubleshooting possible complications and issues associated with such a major change to the medical community.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: "Never events"

Effective Dec. 1, 2009, BCBST implemented guidelines for Serious Reportable Adverse Events ("Never Events"). In conjunction with the Centers for Medicare & Medicaid Services (CMS) guidelines see the billing exceptions reported in the October 2009 *BlueAlert*. BCBST will follow all other CMS guidelines for billing and reimbursement of Inpatient and Outpatient "Never Events" filed on any claim form in any clinical setting for all participating providers.

Claim Status now available

You can now obtain claim status on all lines of business including BlueCard, 24-hours-a-day, 7-days-a-week. When calling the Provider Service line, 1-800-924-7141, you will need to provide the following information:

- Provider ID, NPI Number or Tax ID
- Member ID number (including all ALPHA characters)
- Member date of birth
- Date of service (beginning with the "from" date)
- Total charge

You will be given the following claims information:

- Paid amount
- Check date
- Patient liability
- Check number
- Remittance number

Screening colonoscopy provides richer benefits compared to diagnostic colonoscopy for most commercial groups*

Effective Jan. 1, 2010, BCBST will expand configuration and code mapping for screening colonoscopy resulting in colonoscopy procedures **intended** to be screenings to be **paid** as screenings.

With the emphasis on prevention and screening, many employer groups have reduced or waived the member cost-sharing amount for screening colonoscopies. However, a common member complaint in these groups is that when presenting for a screening colonoscopy they expected to owe a copayment or nothing, and they received deductible/coinsurance benefits for a diagnostic colonoscopy.

Currently only HCPCS code G0121 is configured to pay as a screening colonoscopy. The expanded configuration will include G0105, plus a number of diagnostic colonoscopy codes when filed with either one (1) or two (2) screening diagnosis codes. When the following codes are filed, screening colonoscopy benefits will be provided:

HCPCS Code	Description
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
ICD-9 Code	**Description**
V76.50	Special screening for malignant neoplasm Intestine, unspecified
V76.51	Special screening for malignant neoplasm Colon
CPT® Code	**Description**
When filed with V76.50 or V76.51:	
45378	Colonoscopy
45380	Colonoscopy with biopsy
45381	Colonoscopy with directed submucosal injection
45383	Colonoscopy with ablation of tumor, polyp or other lesion
45384	Colonoscopy with removal of tumor, polyp or other lesion by hot biopsy forceps or bipolar cautery
45385	Colonoscopy with removal of tumor, polyp or other lesion by snare technique

BlueCare/TennCare*Select*

ADMINISTRATIVE

TennCare*Select* Program for Persons with Intellectual Disabilities*

The Bureau of TennCare has established a new TennCare*Select* program for certain persons with Intellectual Disabilities called SelectCommunity. The program will be open primarily to persons enrolled in one of the State's Section 1915(c) Home and Community Based Services Waiver programs for persons with mental retardation as well as persons residing in a private Intermediate Care Facility for persons with Mental Retardation (ICF/MR). All SelectCommunity members will be assigned a Nurse Care Manager (NCM) who will serve as the member's and provider's primary point of contact for physical and behavioral health needs.

An Electronic Visit Verification (EVV) system will be used to monitor the initiation and daily provision of home health/private duty services for SelectCommunity members who need such services, in accordance with the member's individualized plan of care, and to facilitate immediate action to resolve any service gaps.

Effective April 1, 2010, the State will begin a process to transition persons with Intellectual Disabilities who meet the established enrollment criteria to SelectCommunity. This process is expected to take sixty days for each group of persons transitioned. Eligible members will be given the opportunity to transition to SelectCommunity or remain with their existing MCO.

All participating TennCare*Select* providers are eligible to provide services to SelectCommunity members. In addition, a special SelectCommunity Primary Care Network, similar to the Best Practice Network, is being developed. If you are a PCP, and would like to participate in the SelectCommunity Primary Care Network, or if you are not in the TennCare*Select* network, but would like to be part of this holistic approach to health care for persons with Intellectual Disabilities, please call the Provider Service line, 1-800-924-7141, and say "Network Contracting" when prompted.

Remember, you can access BlueAlert on BlueAccess

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Watch the mail for federally mandated training materials

In accordance with the *Deficit Reduction Act*, the Centers for Medicare & Medicaid Services (CMS) revised the Code of Federal Regulations (C.F.R.) to require all federally funded health care programs to provide training materials to all contracted providers and entities. Specifically, the training materials consist of information concerning the *False Claims Act Amendment of 2009* and Fraud, Waste and Abuse.

As the administrators of federal health care programs BlueAdvantage®, BlueCare, and TennCare*Select*, BlueCross BlueShield of Tennessee and Volunteer State Health Plan developed the applicable training materials to send to all contracted providers within both programs. Please keep an eye out for these important materials to arrive in the mail. We respectfully request that providers share the material with each employee, complete the attestation form provided, and return it to us for placement in the provider's file.

The training materials will also be available on the Provider page of the company Web site, www.bcbst.com under the link *Deficit Reduction Act Training Material*.

VSHP implementing new HH and PD monitoring processes*

VSHP is implementing new processes to monitor home health and private duty services using electronic visit verification (EVV) for the TennCare program. This program will be phased in with the first agency going live in mid-January. These new processes are intended to improve home health compliance, while enhancing the quality of care for our members. VSHP has entered an agreement with Sandata Technologies, Inc., a leading nationwide provider of information technology solutions to the home health care and social services communities, to monitor electronic visit verification.

VSHP and its contracted home health care providers will benefit from improved oversight and quality monitoring. Training will be provided over the next several months to all home health care providers free of charge. Each agency will be contacted and provided information on training dates, times and locations. If you have questions about these new processes, please contact your local Network Manager.

Changes to prior authorization list*

Beginning Feb. 1, 2010, the TennCare*Select* and BlueCare prior authorization lists will be the same. Both plans have the same prior authorization requirements with the only exception being that TennCare*Select* does not require prior authorization for high tech imaging services when rendered by in-network providers. The prior authorization listing can be found in the *VSHP Provider Administration Manual* located on our Web sites, www.bcbst.com and www.vshptn.com.

NICU to require prior authorization*

Effective Feb. 1, 2010, all Neonatal Intensive Care Unit (NICU) admissions and concurrent reviews will require prior authorization. **The concurrent review authorization requirement applies to per diem facilities only**. Note: At this time, NICU admissions cannot be submitted electronically via *BlueAccess*.

To request NICU prior authorizations, call the appropriate BlueCare or TennCare*Select* provider service line†.

Long-term care community choices act of 2008 update*

In August, 2009, Governor Bredesen signed the *Long-Term Care Community Choices Act of 2008*. Included in the act were provisions for Home and Community Based Services (HCBS) which provide a variety of services for individuals unable to take care of themselves due to chronic illness, advanced age or cognitive impairment without the assistance of others. Long-term care may be provided at home, in the community or in a nursing home.

On March 10, 2010, Volunteer State Health Plan will begin coordinating HCBS for TennCare*Select* members in the Middle Grand Region. Implementation dates for East and West Grand Regions are scheduled for second quarter of 2010.

You can access Long-Term Care Transformation *Frequently Asked Questions* from the Provider page on the company Web sites, www.bcbst.com or www.vshptn.com, or, on the Bureau of TennCare's Web site, www.tennessee.gov/tenncare/long-faq.html.

BlueCard®

ADMINISTRATIVE

Reminder: Verifying Blue Plan member ID cards

With the New Year here, many of your patients may receive new member ID cards. To help ensure prompt and accurate claims processing, please make sure you have a copy of the member's current ID card.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file.
- Make copies of the front and back of the member's ID card and pass this key information to your billing staff.
- Blue Plan member ID cards include a three-digit alpha prefix in the first three positions. This alpha prefix identifies the member's Blue Plan and is critical for eligibility/benefits verification and claims processing. The alpha prefix may be followed by up to fourteen additional characters, any combination of letters and numbers.
- When filing claims, always enter the identification number exactly as it appears on the member's ID card - do not add, omit or alter any of the characters.

BlueCard®

ADMINISTRATIVE (cont'd)

WalMart associates receiving new member ID cards

New ID cards, effective Jan. 1, 2010, will be issued before the first of the year to Walmart associates. Some ID cards will include a new alpha prefix as part of the member's ID number. To ensure that claims are processed correctly:

Verify the ID card at every visit and make sure your have the correct number on file. File claims to BlueCross BlueShield of Tennessee using the ID number as it appears on the card, to include the alpha prefix. Do not add, omit or alter any characters from the member ID number.

Notes:
[1]Continue to contact BlueCross BlueShield of Tennessee for assistance.
[2]Check eligibility and benefits - send an electronic eligibility inquiry through BlueAccess, the secure area of our Web site, www.bcbst.com, or call 1-800-676-BLUE (2583) and provide the three-letter alpha prefix.

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

Transition to new BlueCard remittance advice

BCBST will transition out-of-state remittance advices for claims received on or after Jan. 11, 2010, to the commercial line of business remittance advice format to streamline claims operations and migrate all provider payments to a common format. This transition will occur in several phrases beginning with inpatient facility claims received on or after Jan. 11, 2010. Outpatient and professional claims will transition later in 2010.

FEP (Federal Employees Program)

FEP wellness initiative available

As part of the Federal Employees Program (FEP) Member Engagement Strategy of providing a higher level of member health management engagement, a new wellness initiative will become available to FEP members beginning Jan. 1, 2010.

Certificates offering incentives will be given to adults who complete a Blue Health Assessment and to children who complete a Body Mass Index (BMI) Assessment and have a BMI in the 85th percentile or higher. Members will be instructed to present the certificate of completion to their provider in order to take advantage of the appropriate incentive.

Incentives for member participation include:

- Copayment waived for adult member's subsequent annual physical examination or an individual preventive counseling visit; and
- Copayment waived for children ages five (5) through seventeen (17) years for up to four (4) nutritional counseling visits.

Provider instructions for handling the waived copayment will be noted on the certificates. Please ensure that your entire office staff is aware of these programs and the process, especially those that normally collect member copayment amounts and arrange appointments. If you have a patient who is an FEP Plan member, you may want to ask if he/she has a certificate that waives the copayment amount.

CoverTN

ADMINISTRATIVE

Reminder: Endometrial ablation requires prior authorization

Providers are reminded effective Jan. 1, 2010, BlueCross BlueShield of Tennessee will require prior authorization for **all** Commercial lines of business to include CoverTN for Endometrial Ablation (CPT® codes 58353, 58356, and 58563).

To arrange prior authorization, please contact our Utilization Management Department, **1-800-924-7141** Monday through Friday, 8 a.m. to 5:15 p.m. (ET) or visit *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 and follow the prompts.

AccessTN

ADMINISTRATIVE

AccessTN now allowing enrollment of children

Effective immediately, AccessTN will begin accepting uninsurable children with chronic and acute medical conditions. As Tennessee's high risk health insurance plan, AccessTN has provided comprehensive coverage since 2007 for adults who have been denied insurance coverage due to pre-existing health conditions.

Until recently, CoverKids had provided coverage to children in similar situations, but suspended new enrollment in November 2009 due to budget limitations. Premiums for children will be based on the lowest premium level charged to AccessTN enrollees and will range from $284 to $410 per month. Premium assistance is an option for some families earning less than $75,000.

For more information about any of the Cover Tennessee programs, visit www.covertn.org or call 1-866-COVERTN.

†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).

*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.

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CPT® is a registered trademark of the American Medical Association

BlueAlert
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February 2010

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(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

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

Effective Feb. 14, 2010

- Transcather Closure Devices for Cardiac Defects

Effective Feb. 19, 2010

- Percussion/Oscillating Devices for the Treatment of Respiratory Conditions

Effective March 11, 2010

- Pemetrexed
- Lenalidomide
- Sunitinib Malate
- Zoledronic Acid
- Octreotide (Systemic)
- Bosentan for the Treatment of Pulmonary Hypertension
- Esterase Inhibitor
- Canakinumab
- Human Papillomavirus (HPV) Vaccine
- Tinzaparin Sodium
- Ustekinumab
- Ingestible pH and Pressure Capsule

Effective March 12, 2010

- Epoprostenol Sodium for the Treatment of Pulmonary Hypertension
- Treprostinil for the Treatment of Pulmonary Hypertension

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:

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

2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults.
<http://content.onlinejacc.org/cgi/content/full/j.jacc.2008.11.013>

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.

Behavioral health clinical practice guidelines adopted

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

Magellan Health Services Clinical Practice Guideline for Assessing and Managing the Suicidal Patient
<https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_prac_guidelines/suicide.pdf>

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

Shared Health® Smart Tools
Healthy Outcomes - -Smart Business

What are Condition Tracker and Clinical Insight?

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

Specifically, ***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; and ***Clinical 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.

How do these tools benefit clinicians?

- A simplified condition management and wellness care process
- Better tracking of patients with chronic conditions, generate actionable lists
- Ability to quickly see other patient care opportunities
- More accurate performance metrics
- Tools to offset spiraling costs and declining reimbursements that affect a practice's income.

These tools are designed to provide a way for clinicians to operate their practice more efficiently while providing the best outcomes for their patients. If you haven't been introduced to Shared Health, now's the time! Visit us online at http://www.sharedhealth.com/home/index.jsp.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

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ADMINISTRATIVE

Tough economy creates spike in fraud activity: Five tips for avoiding losses

While most of the nation suffered through the weakest economy in years, people who attempted to fraudulently access the health care system may have enjoyed a banner year in 2009.

Most leading health care investigative professionals note that in times of economic strife fraud attempts increase from two to three percent. BlueCross BlueShield of Tennessee records showed a rise many times that rate, as allegations of possible fraud increased 58 percent.

Because Tennessee Providers are targets of these increasing number of fraud attempts, Enterprise Integrity Services (EIS), the investigative arm of BlueCross BlueShield of Tennessee reminds you of some simple steps to take for mitigating your risk:

- Ask for a picture ID to confirm insurance card information.
- Protect your prescription forms, which are often stolen and used in pharmacy fraud schemes.
- Check patient histories to help prevent prescription drug fraud.
- Verify that billing codes are accurate.
- Implement best practices to ensure all information is accurately communicated to your billing staff and to any third-party firms.

If you suspect possible fraud or would like to report a concern, contact the BlueCross BlueShield of Tennessee EIS team toll-free at 1-888-343-4221 or locally at 423-535-7900.

Reminder: Significant changes to HCPCS codes in 2010

Effective Jan. 1, 2010, the following HCPCS coding changes are of particular note:

A4456, Adhesive Remover, Wipes, any type each replaced A4365, Adhesive Remover, Wipes, any type per 50. Providers should bill according to the new description of "per each" and verify units billed.

Additionally, several "L" codes, (L0210, L1800, L1815, L1825, L1901, L3651, L3652, L3700, L3701, L3909, and L3911) have been discontinued and have been replaced with a new code, **A4466, Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each**. These "L" codes were previously used for support devices made of elastic or similar stretchable material.

Providers should note that supplemental information; i.e., manufacturer, brand name and/or product number will be required with submission of the new "A" code.

Reminder: Screening colonoscopy coding expanded

As of Jan. 1, 2010, BlueCross BlueShield of Tennessee expanded the configuration and code mapping for screening colonoscopy for its commercial lines of business. The intent of this change is to more accurately identify screening colonoscopies and apply appropriate benefits.

The new expanded configuration includes G0105, plus a number of diagnostic colonoscopy codes when filed with either one or two cancer screening diagnosis codes. A *Description of Codes that Point to Screening Colonoscopy Benefits* flyer is available online at http://www.bcbst.com/providers/news/

Reminder: Be aware of member rights and responsibilities

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

Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and Volunteer State Health Plan provider administration manuals, which are available on *BlueSource*, BCBST's quarterly provider information CD, and on both our Web sites, www.bcbst.com and www.vshptn.com.

BlueCare/TennCare*Select*

ADMINISTRATION

Changes to newborn billing guidelines

Effective March 1, 2010, providers may only bill for newborn babies using the mother's identification number for **30 days** after the birth of the baby. If the baby has been issued a temporary or permanent identification number of its own from TennCare, the baby's identification number must be used for claim submission.

Note: Facilities may request a temporary identification number for newborn babies from the Department of Human Resources.

Changes to billing guidelines for claims spanning multiple-year dates

Based on the Centers for Medicare & Medicaid Services (CMS) guidelines, effective March 1, 2010, Professional and Outpatient Institutional claims spanning multiple-year dates of service (expenses incurred in different calendar years) must be billed on separate claims. On or after this date, all Professional and Outpatient Institutional claims will be returned to the provider.

Note: *These guidelines do not apply to **Inpatient** Institutional claims.*

Are you reading BlueAlert on BlueAccess?

BlueCare/TennCare*Select*

ADMINISTRATION

Volunteer State Health Plan, Inc. (VSHP) to use BlueCross BlueShield of Tennessee's Preferred Specialty Pharmacy Vendors

On Dec. 1, 2009, VSHP began using BlueCross BlueShield of Tennessee's Preferred Specialty Pharmacy Vendors. This service is for any specialty pharmacy injectable drug given in the provider's office.

The Specialty Pharmacy Program uses preferred vendors that have expertise in these types of high-cost medications and offer these drugs at discounted rates reducing the overall costs associated with the TennCare program. The vendors will send charges directly to VSHP, thus freeing the physician of inventorying these expensive drugs; however, the physician may still bill the appropriate administration charges for these drugs.

These vendors can also request prior authorization on your behalf. Specialty pharmacy medications are available in a 30-day supply for VSHP members through:

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

CuraScript, Inc.
Phone 1-888-773-7376
Fax 1-888-773-7386

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

Update: Electronic visit verification system

In the January 2010 issue of *BlueAlert*, we announced we were implementing new processes for monitoring home health and private duty nursing services using the *Electronic Visit Verification* system for the TennCare Program. Please be advised implementation of this new process has been delayed until further notice. We apologize for any inconvenience this may have caused.

Patients presenting as self-pay may have BlueCare coverage

Patients presenting as self-pay may actually be eligible for BlueCare coverage. You can verify TennCare eligibility on the State of Tennessee's Web site, www.Tennesseeanytime.org, even if patients do not tell you they have BlueCare.

If *Tennessee Anytime* indicates the individual is **NOT** eligible, print a copy of that screen to keep in the patient's record. Also, we strongly encourage you to have the patient sign the *Acknowledgement of Financial Responsibility for the Cost of Services* form advising the patient he/she may be responsible for the cost of specific service(s) and any related services. A sample copy of this form can be found on the company Web sites, www.vshptn.com and www.bcbst.com, and is also included in the BlueCross BlueShield of Tennessee and Volunteer State Health Plan provider administration manuals on *BlueSource*, BCBST's quarterly provider information CD.

Referring members to in-network specialists

Much information regarding a member's experience with a provider is obtained as a result of reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This survey is conducted annually as a part of the National Committee for Quality Assurance (NCQA) accreditation.

After reviewing survey responses, we would like to encourage you to help ensure your patients are able to schedule appointments with applicable specialists in a timely manner and to easily access the care and treatment they need.

If you have difficulty locating an in-network specialist, please call us at 1-800-468-9736 or utilize the "Provider Directory" feature on our Web sites, www.vshptn.com and www.bcbst.com.

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

CLINICAL

Clinical practice guidelines adopted

As you know from your practice, diabetes is one of the most common conditions treated in the Medicare population. BlueCross BlueShield of Tennessee has adopted the *American Diabetes Association (ADA) Position Statements for Standards of Medical Care in Diabetes -2009* as a recommended diabetes best practice reference. These guidelines may be accessed via www.bcbst.com.

Following the guidelines will help improve outcomes for your BlueAdvantage members. Specifically, we believe improvement is possible for BlueAdvantage diabetic members by utilizing the following recommended screenings. These screenings are covered services for BlueAdvantage PFFS and PPO members:

- Dilated Retinal Eye Exam
- LDL-C Screening
- Medical attention for Nephropathy (Microalbuminuria Testing)
- HbA1c Testing and Control

We also offer telephonic Care Management from registered nurses for members who need assistance managing their diabetes or other chronic illnesses. To refer a member to our program or for more information, contact our Care Management department at 1-800-611-3489.

Reminder: Skilled nursing facility contracts support billing for outpatient therapy

Providers contracted under the Skilled Nursing Facility Attachment of the Medicare Advantage Agreement are eligible to file claims for outpatient therapy services. Separate contracting is **not** required for reimbursement.

If you received the Outpatient Rehabilitation Attachment for Medicare Advantage PPO **in addition** to the Skilled Nursing Facility Attachment, **please disregard the rehabilitation Attachment.**

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

ADMINISTRATIVE

Changes to specialty pharmacy authorization requirements*

Effective Jan. 18, 2010, all BlueAdvantage PPO products began requiring prior authorization for a number of specialty pharmacy drugs. Previously, prior authorization was only required for specialty pharmacy drugs costing over $200. A listing of these drugs can be found at <http://www.bcbst.com/providers/bcbst-medicare/pdfs/BlueAdvantage_Specialty_Pharmacy.pdf>.

To satisfy notification requirements of this change, the specialty pharmacy listing was made available to providers Dec. 18, 2009, via the company Web site at www.bcbst.com/providers/pharmacy.shtml.

If you have questions regarding this information, please call the BlueAdvantage Provider Service line†.

Note: The listing may not be all inclusive. To determine if a specialty pharmacy drug requires authorization, please call the Utilization Management department at 1-800-924-7141 or fax your request to 1-888-535-5243.

CAHPS survey results for Medicare Advantage

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 over the previous six months. 76.7 percent of our members surveyed, responded.

The 2009 CAHPS survey of MA Prescription Drug (MA-PD) plans was conducted from February 2009 through June 2009. BlueAdvantage was one of forty-four Private Fee-For-Service MA plans that participated 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 Care Quickly
- Getting Needed Care
- Getting Needed Prescription Drugs

In addition, our plan showed a significant increase from the previous year in the areas of *Getting Appointments*, *Overall Rating of Health Plan* and *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 2008 and 2009 to include:

- Care Received Overall
- Rating of Personal Doctor
- Doctors Who Communicate Well Composite
- Influenza Vaccination

Again, we want to emphasize that information received from this survey reflects not only members' feelings about our overall plan but also about the services received from you, their physician. In the near future, you can view the CAHPS data in its entirety from the Provider page on our Web site www.bcbst.com. .

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

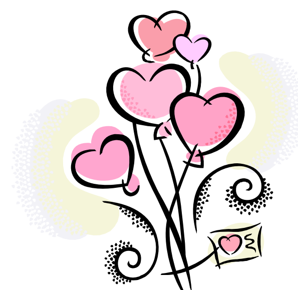
Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

Commercial Lines; CoverTN; CoverKids; AccessTN **1-800-924-7141**
Operations –
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)
Medical Management –
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-800-782-2433**
(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).



Happy Valentine's Day

*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.

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Please Route to all Providers & Office Staff

March 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

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

Effective April 8, 2010

- Intrastromal Corneal Ring Segments (ICRS) for Vision Correction
- Ultrasound Accelerated Fracture Healing Device
- Urethral Bulking Agents for Stress Urinary Incontinence
- Ingestible Video Capsule Imaging of the Gastrointestinal Tract
- Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty

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

ADMINISTRATIVE

2010 HEDIS® medical record review

In March 2010, BlueCross BlueShield of TN and Volunteer State Health Plan will begin their annual Healthcare Effectiveness Data and Information Set (HEDIS®) project to meet National Committee for Quality Assurance (NCQA) accreditation and the Bureau of TennCare reporting requirements for BlueCare, TennCare*Select* and Commercial members.

Measures that require additional information from medical record documentation to report accurate results include:

- Childhood immunizations;
- Prenatal and postpartum care;
- Cervical cancer screening;
- Controlling high blood pressure;
- Comprehensive diabetes management;
- Cholesterol management for patients with cardiovascular conditions;
- Adult BMI assessment; and
- Weight assessment and counseling for nutrition and physical activity for children/adolescents.

A representative from BlueCross BlueShield of TN will be calling your office in the near future to request documentation or schedule an onsite review of medical records for data abstraction. To meet strict reporting timeframes for this project, all information must be retrieved before May 15, 2010.

Note: The Privacy element of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows exchange of information by insurers and providers in the course of normal business when related to a member's treatment, payment or health care operations (TPO).

Reminder: Submitting CMS-1500 corrected bills appropriately

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

- Submit a **new** claim form with correct data.
- Attach correspondence **behind** the claim form indicating what information was originally submitted and what was changed on the new claim form. (Example: "Procedure code in Block 24D on first line item was submitted as 99201; corrected to 99202 on new claim").
- Write (using pen with **black** ink), stamp or type "CORRECTED BILL" in Block 19 (all lines of business) **OR** "CC" in Block 22 (information in this block only retrieved for BlueCare and TennCare*Select*).

Some Important Tips to Remember:

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

BCBST hard drives stolen; member information at risk

In October 2009, 57 hard drives belonging to BCBST were stolen from a leased facility in Chattanooga. The hard drives contained approximately 1.6 million video and audio data files from provider and member calls that related to eligibility and coordination of care.

Upon immediate investigation, BCBST determined that these files contained personal data and PHI of more than 500,000 members. BCBST has undertaken an exhaustive process to identify, notify and protect members at-risk from this crime. That process is ongoing, as is the investigation of the theft by local and federal law enforcement.

BCBST believes there is minimal risk to members' data being accessed due to the specialized nature of the hardware stolen and the difficulties associated with accessing the stored data. To date, there is no evidence any member's data has been accessed and used as a result of the theft. If you or your staff receive inquiries from your patients about this theft, please direct them to www.bcbst.com for the most up-to-date information.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATION

Use of member ID numbers helps reduce risk

Like you, BCBST values your patients' privacy. As a security consideration, we do not solicit Social Security numbers (SS#) for processing a claim unless required to do so by state or federal programs or regulations. Our preferred method is to ask only for member ID numbers when conducting business with our members or on their behalf. When calling BCBST, please be sure to have them ready at the time of your call.

New prior authorization requirements for certain medications

BlueCross BlueShield of TN helps you ensure the clinical efficacy and safety of drug therapy for its members by requiring clinical edits for certain medications.

Beginning Jan. 1, 2010, we began requiring prior authorization for the following prescribed drugs:

- Rapaflo (silodosin)
- All testosterone products (orals, topicals, and self-injectable) for patients 30 years of age and younger
- All second generation antipsychotics for patients 17 years of age and younger
- Nuvigil (armodafinil)
- Provigil (modafinil)

Requests for prior authorization‡ for the above listed drugs can be made by calling BlueCross BlueShield of TN's pharmacy benefits manager, CVS Caremark at 1-877-916-2271or fax request to 1-888-836-0730.

‡ If authorization is not obtained by April 1, 2010, the member may be charged substantially for the cost as these drugs may not be covered by the member's health care plan after April 1, 2010.

Reminder: 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, Medicare Advantage, BlueCare, or TennCare*Select*	G9141 and G9142 or 90470 and 90663 (**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.

CoverTN

ADMINISTRATIVE

CoverKids resumes enrollment

Effective March 1, 2010, CoverKids, a program under Governor Bredesen's Cover Tennessee initiative addressing the health care needs of Tennessee's uninsured, will reopen enrollment to new members. Enrollment was suspended late last year when membership reached the maximum that could be supported by the current budget. As part of the State Children's Health Insurance Program (SCHIP), CoverKids picks up where TennCare eligibility ends and provides comprehensive medical and dental coverage to families who cannot otherwise afford or access private health insurance.

For more information about CoverKids, or any of the Cover Tennessee programs, visit www.CoverTN.gov or call toll-free 1-866-COVERTN.

BlueCare/TennCare*Select*

CLINICAL

Reminder: Behavioral health consultation line available

Volunteer State Health Plan (VSHP) can assist you in obtaining referrals for your BlueCare and TennCare*Select* patients having mental health and substance abuse treatment needs. Our 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.

VSHP established a toll-free primary care provider consultation line staffed by 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.

BlueCare/TennCare*Select*

ADMINISTRATION

Reminder: Changes to medical emergency code list

The 2010 VSHP Medical Emergency Code List has been updated to reflect the following changes. This listing can be viewed in its entirety on the company Web sites, www.vshptn.com and www.bcbst.com.

Effective Oct. 1, 2009, the following diagnosis (DX) code was added to the medical emergency code list:

DX Code	Description
488.1	Influenza due to identified novel H1N1 influenza virus

Effective Nov. 1, 2009, the following diagnosis (DX) codes were removed from the medical emergency code list:

DX Code	Description
300.00	Anxiety State NOS
305.00	Abuse, Alcohol unspecified
307.81	Headache, Tension
311	Disorder, Depressive NOS
599.70	Hematuria, unspecified
780.60	Symptoms, Fever unspecified

Reminder: Reporting non-covered home health/private duty nursing shifts timely

Home health agencies are responsible for notifying Volunteer State Health Plan (VSHP) once they are aware a shift will not be staffed as ordered.

VSHP requires advance notice in order to allow time for us to contact the member and make other arrangements for the care. Receiving calls after the shift is missed does not meet our intent of evaluating the need for alternative care. Members receive home health services when the care has been ordered by a physician and authorized by VSHP. Failure to provide the services as ordered puts the member's safety and health needs at risk.

The VSHP Home Health Compliance Hotline, 1-800-215-3851, is available 24-hours-a-day, 7-days a week for most home health services, and on weekends, holidays, and after-business hours for Private Duty Nursing (T1000) only.

A shift is considered missed when the staff:
1. is unable to provide the shift as scheduled.
2. leaves two or more hours prior to the end of the scheduled shift.
3. arrives two or more hours after the scheduled shift is to begin.

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.

Quantity limits implemented for blood glucose test strips*

Effective Feb. 15, 2010, in an effort to reduce costs and help prevent billing errors, the Bureau of TennCare implemented quantity limits for preferred and non-preferred blood glucose test strips.

Prescriptions exceeding the limitations described below require prior authorization:

If Member is…	test strips are:
under age 6 years	limited to 306 strips every 30 days
6 years and over	limited to 204 strips every 30 days

To arrange prior authorizations, call the TennCare Pharmacy Benefits Manager, SXC Health Solutions at 1-866-434-5524 or fax, 1-866-434-5523.

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.

BCBST Specialty Pharmacy Program expands for VSHP

The February issue of *BlueAlert* announced effective Dec. 1, 2009, VSHP began using BCBST's Preferred Specialty Pharmacy vendors to provide Provider-Administered specialty drugs to physicians treating BlueCare and TennCare*Select* members. Provider-Administered specialty medications are high-cost injectable biologicals (IV and IM).

Since that announcement, BCBST has expanded its Specialty Pharmacy Program to include Walgreens Specialty Pharmacy in its network of Specialty Pharmacy vendors. These vendors ship medications directly to the physician's office and send charges directly to VSHP. The specialty pharmacy can also request prior authorization on behalf of the prescriber.

Specialty pharmacy medications are available in a 30-day supply for VSHP members through:

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

CuraScript, Inc.
Phone 1-888-773-7376
Fax 1-888-773-7386

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

Walgreens Specialty Pharmacy
Phone 1-888-347-3416
Fax 1-877-231-8302

BlueCare/TennCare*Select*

ADMINISTRATION

Reminder: Change in reimbursement for procedures performed by two surgeons

Effective with dates of service Oct. 1, 2009, Volunteer State Health Plan began reimbursing 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.

Reminder: Verify existence of TennCare eligibility

Some patients presenting with commercial or Medicare coverage may also have TennCare coverage. TennCare Standard Operating Procedure (TSOP) 14 states in part "providers may not seek payment from a TennCare enrollee if the provider failed to ascertain the **existence** of TennCare eligibility or pending eligibility prior to providing non-emergency services".

Based on this rule, TennCare Solutions Unit (TSU) recommends providers conduct an eligibility search on **all** patients to identify any existence of TennCare coverage prior to rendering services. TennCare eligibility can be verified using the Bureau of TennCare's online services at http://www.tennesseeanytime.org/tncr/ or by calling 1-800-852-2683.

Prior to rendering services, providers are also encouraged to have patients presenting as self-pay sign the *Financial Responsibility for the Cost of Services* form. These forms are available for provider use in the *Forms* section on the Provider page of the company Web site, www.bcbst.com.

It is important that providers using their own form ensure it contains the specific question, "*Do you have or have you applied for TennCare coverage?*"

Reminder: 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*."

VSHP has special reimbursement arrangements for a single nurse/aide providing services to multiple members in the same home. Agencies having these kinds of situations can contact the member's case manager(s) for additional information.

BlueCard®

ADMINISTRATIVE

2010 BlueCard Program Survey

Help us make your future interactions with us a smoother, simpler experience

Again this year, you will have the opportunity to tell us how we are doing.

Some time during the year, 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 be inviting you to participate in a phone or online survey. Remember, your feedback is important to us, so 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 improvement, please consider:

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

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

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

Commercial Lines; CoverTN; CoverKids; AccessTN 1-800-924-7141

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(Monday – Friday, 8 a.m. to 5 p.m. ET).

*These changes will be included in the appropriate 2Q 2010 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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Please Route to all Providers & Office Staff

April 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

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

Effective May 8, 2010

- Meniscal Allografts Transplantation and Collagen Meniscus Implants
- Saturation Biopsy for Diagnosis and Staging of Prostate Cancer

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

Medical policy for magnetic resonance imaging (MRI) of the breast revised

The medical policy on *MRI of the Breast* has been reviewed and revised to be more consistent with MedSolutions guidelines.

A draft of this policy can be accessed under *Draft Medical Policies* on the Provider page on the company Web site at http://www.bcbst.com/providers/mpm.shtml

ADMINISTRATIVE

Real-time claims estimation/adjudication now available for Federal Employee Program (FEP)

The Real-Time Claims Adjudication application now supports claim submissions for your FEP patients. If you have not used this 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 review the *Real-Time Claims Estimation/Adjudication* tutorial in the e-Health section. To find out more about this application, contact our eBusiness Support area at 423-535-5717, the eBusiness Marketing Team at 423-535-3057, or e-mail us at eComm_Marketing@bcbst,com.

Reminder: Filing surgical equipment claims appropriately

Providers are reminded that charges for any device or medical equipment used during a surgical procedure is considered all-inclusive with the surgery reimbursement and is not separately reimbursed; i.e., pneumatic compression devices.

Changes to credentialing requirements for Optometrists

Effective March 4, 2010, BCBST changed its credentialing requirements for Optometrists. These providers are no longer required to have a Drug Enforcement Administration (DEA) certificate or have an affiliation with a practitioner having a DEA certificate in order to be credentialed with BCBST. However, if the Optometrist holds a DEA certificate, the certificate will be verified by BCBST Credentialing department. This change was made because we determined that most optometrists refer members to an ophthalmologist when a narcotic medication is indicated for treatment of the member's illness.

Provider appeals now has single point address for all lines of business

BlueCross BlueShield of Tennessee continues to improve its processes to help expedite services to you.

In the December *BlueAlert,* we notified you of a new address containing a suite number and zip code extension for "Claims and Medical Records". Now, the "Provider Appeals" area also has a new suite number, which applies to all lines of business.

Like the new suite number and zip code extension for Medical Records and Claims, the new address for Provider Appeals allows us to receive your correspondence faster and provide you with a quicker response. The new address for Provider Appeals is:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0039
Chattanooga, TN 37402-0039

Remember, if you receive correspondence from BCBST requesting information, please use the **suite number** indicated on the correspondence when returning the requested documentation.

If you have any questions regarding the new addresses, please call the BCBST Provider Service line[†].

BlueCare/TennCare*Select*

ADMINISTRATION

Helping ensure continuity of care for new members

In order to ensure members transitioning to Volunteer State Health Plan (VSHP) from other managed care organizations continue receiving covered, Medically Necessary services, providers are asked when calling for prior authorization of services to inform VSHP if the member is currently receiving services. This will help maintain continuity of care for members and accuracy of payment for providers.

BlueCare/TennCare*Select*

ADMINISTRATION

Reminder: Submitting Abortion, Sterilization, or Hysterectomy (ASH) consent forms appropriately

VSHP covers abortion, sterilization and hysterectomy procedures pursuant to applicable federal and state laws. Each procedure requires the pertinent ASH form be correctly completed and submitted along with the claim.

As a rule, these forms should **not** be corrected. If a mistake occurs or circumstances change do **not** make corrections on the form…a **new** form should immediately be generated.

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

ADMINISTRATIVE

Dedicated unit available for SNF admissions

The Senior Care Division recently created a dedicated nursing unit within Case Management to handle all skilled nursing facility admissions. The nurses are reporting turn around times of 24-48 hours for Medical Necessity reviews . As such, providers who submit a patient's discharge plan (usually initiated at the time of admission) within a reasonable amount of time prior to those services being needed, should not experience delays in obtaining approval for placement needs.

In an effort to be proactive, the nurses of the SNF unit are identifying inpatient admissions by diagnosis that are likely to need a SNF bed after discharge and contacting the hospital to begin working on the placement. It is recommended that facilities call in any cases that may be currently holding for discharge or transfer as these will be worked as priority above others.

Providers can contact the SNF unit by phone at 1-800-611-3489 or by fax at 1-800-727-0841.

Reminder: BlueAdvantage Plus is product within the PPO plan

Feedback from our BlueAdvantage Plus members indicates a number of providers are not aware that BlueAdvantage Plus is a product offered within the BlueAdvantage PPO plan. BlueAdvantage Plus joins the other products, Sapphire, Diamond and Ruby, as another BlueAdvantage product offered our employer groups.

If your practice participates in the BlueAdvantage PPO network, you are eligible to render services to BlueAdvantage Plus members.

For questions on any of the BlueAdvantage PPO products, call the BlueAdvantage Provider Service line†.

BlueCard®

ADMINISTRATIVE

BlueCard Eligibility Line enhanced

Effective April 1, 2010, providers will experience an improved BlueCard Eligibility line, 1-800-676-BLUE (2583) when calling to verify eligibility or obtain prior authorization for out-of-area Blue members.

When calling for prior authorization only, providers can select the "prior authorization" option, choose the type of service, and the call will be routed to the appropriate area of the member's Blue plan.

Specific types of service options are:

- Medical/Surgical
- Behavioral Health
- Diagnostic Imaging/Radiology
- Durable Medical Equipment

When calling for eligibility only, or if you need both eligibility and prior authorization, the call will be handled as it is today. Select the "eligibility and prior authorization" option to receive the member eligibility information. Once you have the eligibility information, the call will be transferred to the appropriate prior authorization area to complete the call.

If you have any questions regarding the BlueCard Eligibility Line, please call BlueCard at 1-800-705-0391.

New BlueCard coordination of benefits fax number available

For your convenience, BlueCard added a new fax number for provider use in sending updated Coordination of Benefits (COB) information for their BlueCard patients.

As a reminder, a COB questionnaire is available on our Web site at <http://www.bcbst.com/providers/forms/COB-Questionaire.pdf>. Providers can print, complete and submit the updated information via the new fax line or by mail.

Fax to:
423-535-1959, Attn: Correspondence
Or,
Mail to:
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle Suite 0034
Chattanooga, TN. 37402-0034

If you have questions or need further assistance, please call the BlueCard Provider Service line†.

• • • • • • • • • • • • • • • • • • • •

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provider news flash

BlueCross BlueShield of Tennessee — plans for better health. plans for a better life.

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May 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

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CLINICAL

Medical policy update/changes

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Effective June 12, 2010

- Fludarabine (Fludara®)
- Ofatumumab (Arzerra™)
- Romidepsin (Istodax®)
- Antihemophilic Factor (Factor VIII)
- Ecallantide (Kalbitor®)
- Pazopanib (Votrient®)
- Pralatrexate (Folotyn®)
- Gene Expression Profiling Assays as a Technique to Determine Prognosis for Managing Breast Cancer Treatment
- Genetic Testing for Inherited Susceptibility to Colon Cancer, Including Microsatellite Instability Testing

Effective June 16, 2010

- Bevacizumab (Avastin®)

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

New drugs added to commercial specialty pharmacy listing

Effective April 1, 2010, the following drugs were added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by a (PA).

Provider-administered via medical benefit:
Actemra (PA)
Arzerra
Kalbitor (PA)

Self-administered via pharmacy benefit:
Ampyra (PA)
Oforta

Clinical practice guidelines adopted

BlueCross BlueShield of Tennessee has 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>

Update to the AHA/ASA 2008 Recommendations for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack
<http://stroke.ahajournals.org/cgi/content/full/39/5/1647>

AHA/ASA 2006 Guideline: Guidelines for 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.

NCCN® resource tool updated

The National Comprehensive Cancer Network (NCCN®) has published updates to the *NCCN Resource Tool: Risk Evaluation Mitigation Strategies (REMS)* to reflect the recent FDA requirement to have a REMS program for Erythropoiesis-Stimulating Agents (ESAs). REMS are currently being mandated to assess adverse risks associated with specific oncologic drugs, biologics, and supportive care therapies.

The NCCN Resource Tool provides oncology practitioners with a list of medications used for patients with cancer (i.e., for active treatment or supportive care) with one or more REMS components.

For the ESA REMS, health care providers who dispense and/or prescribe ESAs for patients with cancer and hospitals that dispense ESAs for patients with cancer must enroll in the ESA APPRISE Oncology Program. Enrollment for the ESA APPRISE Oncology Program began **March 24, 2010**. For more information on ESA APPRISE Oncology Program training, please visit www.esa-apprise.com.

These strategies are intended to ensure that the benefits of particular drugs continue to outweigh the risks they pose for patients.

ADMINISTRATIVE

State of Tennessee pharmacy benefits changing

Beginning July 1, 2010, the State of Tennessee's benefit plans will change to a single pharmacy benefits manager with CVS Caremark®. This means a new formulary with new limits and new criteria.

Complete information about the benefit change will be available online prior to the start date. Watch for more information next month!

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

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Non-Discrimination policy

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by BlueCross BlueShield of Tennessee, Inc., including its licensed affiliate, Volunteer State Health Plan, Inc.

Furthermore, no person shall be subjected to any form of retaliation to include threats, coercion, intimidation, or discrimination as a result of filing a complaint, testifying, assisting or participating in an investigation, proceeding, or hearing.

Reminder: Include your provider identification information on written correspondence

When BCBST receives an inquiry requesting member information, we are required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to verify the identity of the requester before providing any patient health identifiable information (PHI).

Including your NPI, Tax ID or PIN number on the correspondence will help expedite the verification process and allow us when requested to send the information to a location other than the address reflected in our provider data system.

Reminder: New prior authorization requirements for certain medications

BlueCross BlueShield of Tennessee helps you ensure the clinical efficacy and safety of drug therapy for its members by requiring clinical edits for certain medications.

Effective Jan. 1, 2010, we began requiring prior authorization for our **Commercial** members for the following prescribed drugs:

- Rapaflo (silodosin)
- All testosterone products (orals, topicals, and self-injectable) for patients 30 years of age and younger
- All second generation antipsychotics for patients 17 years of age and younger
- Nuvigil (armodafinil)
- Provigil (modafinil)

Requests for prior authorization[‡] for the above listed drugs can be made by calling BlueCross BlueShield of TN's pharmacy benefits manager, CVS Caremark at 1-877-916-2271 or fax request to 1-888-836-0730.

[‡] If authorization is not obtained by April 1, 2010, the member may be charged substantially for the cost as these drugs may not be covered by the member's health care plan after April 1, 2010.

Reminder: Protecting patient health identifiable information

Providers are reminded that patient health identifiable information (PHI) is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. As such, it is the provider and their staff's responsibility to ensure that patient information is not compromised.

For example, when providing a patient with a copy of an explanation of benefits (EOB) reflecting patient financial responsibility and other personal health information, please remember to secure all other patients' information. On many occasions, more than one patient's PHI is shown on the same document, so **always** mark through or blackout any other patient's information before providing the document. This will help protect the security and privacy of all your patients.

Reminder: Appropriate billing for enteral feeding supply kits

HCPCS codes B4034-B4036 for enteral feeding supply kits are specific to the route of administration and include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients for one day. These codes must be billed by a Durable Medical Equipment (DME) provider or medical supplier using the appropriate span dates and one (1) unit for each day of service on a single line item.

These supply codes describe a daily supply fee rather than a specifically defined "kit" and individual items may differ from patient to patient and from day to day. Items such as Y connectors, adapters, gastric pressure relief valves, and extension tubing, utilized with low-profile G-tubes, are part of the supply kit and should not be separately billed with codes for feeding tube or B9998.

For additional information, please refer to the *BlueCross BlueShield of Tennessee Provider Administration Manual* and the following publication from the DME MAC Jurisdiction C contractor at <http://www.cignagovernmentservices.com/jc/pubs/news/2009/1109/cope10980.html>.

Need CME, CEU, or CCM credits?

BlueCross BlueShield of Tennessee is offering Quality Interactions®, a program designed to help physicians, nurses, and office staff enhance interactions with people from diverse backgrounds. The training uses a case-based format supported by evidence-based medicine, and peer-reviewed literature. It is accredited for up to 2.5 hours of CME, CEU, or CCM credits.

BCBST purchased the licenses for these courses, so there is **no cost** to our providers. There are a limited number of licenses available for theses courses, so please register quickly to take advantage of this valuable learning opportunity.

To register, visit www.bcbst.com, select "I'm a Provider" and then click on "Quality Interactions® Cross Cultural Training" under "Administration" or simply click on the following link: <http://www.qualityinteractions.org/clients/bcbstenn.html>

This is a great way to get valuable professional credits, for no cost, and gain useful knowledge to work with the culturally diverse population of Tennessee. If you have questions, please call the BCBST Provider Service line[†].

BlueCare/TennCare*Select*

CLINICAL

CareSmart® pediatric asthma program initiative

Volunteer State Health Plan (VSHP) launched a new pediatric asthma initiative based on emergency department utilization, hospital admissions, and use of appropriate medications for children with asthma.

This initiative was designed to provide relevant and timely member-specific clinical information to providers and intended to assist them in improving the health outcomes of their BlueCare and TennCare*Select* patients. These members were identified as receiving treatment in the past 12 months and diagnosed with asthma. VSHP is requesting assistance from providers in identifying and enrolling BlueCare and TennCare*Select* members in the CareSmart® Asthma Program.

Some providers may receive an on-site visit from our asthma team. At that time the team will present the provider with chronological data on asthma-related inpatient admissions, asthma related emergency department visits, and HEDIS measures for the appropriate use of controller medication for people with persistent asthma. Providers may find this member-specific detail useful in treating their BlueCare and TennCare*Select* patients who suffer from asthma. Our goals are to work with members and providers to increase the use of appropriate medications for their patients, reduce asthma emergency department (ED) visits, reduce asthma in patient/hospital admissions, increase enrollment in the Asthma Disease Management Program, and promote member compliance in an asthma action plan. These goals are focused on improving member health status.

To refer members to our CareSmart® Asthma Program, please call 1-888-416-3025

Tennessee pediatric immunization schedule updated

The Tennessee Department of Health has new rules for immunization requirements affecting all children who attend child care, pre-school, school and college. Most of the new requirements take effect July 1, 2010. Children presenting for their immunization visit offers a great opportunity to complete other age-appropriate TENNderCare screenings.

The state's immunization schedule follows the current schedule published by the Centers for Disease Control and Prevention (CDC) and is endorsed by the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP).

Additional information about the state's updated vaccine schedule is available on the company Web sites, www.vshptn.com or www.bcbst.com, and also on the Tennessee Web Immunization System (TWIS) Web site.

ADMINISTRATIVE

BlueCare non-risk contract ends

Effective June 30, 2010, all claims processing activity will cease for the BlueCare "Non-Risk" contract between the State of Tennessee and Volunteer State Health Plan, Inc. (VSHP), affecting claims filed for dates of service July 1, 2002 through Dec. 31, 2008. This contract ended Dec. 31, 2008, and affects BlueCare members for the previously mentioned dates of service.

After June 30, 2010, please remit any recoupment checks, correspondence, adjustment requests, or questions to the Bureau of TennCare. If you have any questions regarding this information, please contact your Provider Network Manager, or call the BlueCare Provider Service line†

***Note**: This information does **not** apply to the BlueCare East, BlueCare West or TennCareSelect contracts.*

Reminder: When providers may or may not seek payment from TennCare members

Federal and Tennessee law prohibit providers participating in the TennCare program from billing or attempting to collect payment from TennCare enrollees for TennCare-authorized and/or covered services other than applicable co-payments and special fees permitted by TennCare Rules and regulations 1200-13-12-.08, 1200-13-13-.08 (Medicaid) or 1200-13-14-.08 (Standard), found at http://state.tn.us/tenncare/forms/pro08001.pdf. As directed by the Bureau of TennCare Office of Contract Compliance and Performance, Volunteer State Health Plan, Inc. (VSHP), as a TennCare Managed Care Contractor, shall ensure that the participating provider ceases all actions to bill a BlueCare and/or TennCare*Select* member by issuing a "Cease to Bill Notice" to the provider. In addition, the provider must confirm, in writing, to VSHP that he/she has stopped or agrees to stop billing the TennCare Enrollee.

The rules for when providers may or may not seek payment from TennCare members are outlined in the Member Policy section of the *VSHP Provider Administration Manual* located on the company Websites, www.vshptn.com and www.bcbst.com.

PCPs can access membership listings online

Recently, VSHP offered its Primary Care Providers (PCPs) the opportunity to access their membership listing electronically via *BlueAccess*, the secure area on our company Web sites, www.vshptn.com and www.bcbst.com.

Effective June 15, 2010, based on positive provider feedback, our PCP providers will no longer receive their membership listings via mail. Rather, they will be able to view the listings electronically via *BlueAccess*. If you have not registered for *BlueAccess*, simply visit us online, click on "Register" in the *BlueAccess* login box and follow registration instructions. If you need assistance, please contact our eBusiness Service Center by e-mail at Ecomm_TechSupport@bcbst.com, or call 423-535-5717.

BlueCare/TennCare*Select*

ADMINISTRATION

New behavioral health referral line*

Effective May 3, 2010, VSHP will implement its new Behavioral Health Referral line, 1-800-367-3403, for use by primary care providers (PCP) and their staff. The line will be staffed by individuals who can assist PCPs with accessing services for their BlueCare and TennCare*Select* patients' mental health needs. Our behavioral health staff can locate providers and resources in the area and arrange appropriate services for patients with mental health needs.

The Referral line is available Monday through Friday, 8 a.m. to 5 p.m. (ET). Messages left after hours and on weekends will be returned the following business day. Should there be urgent/emergent needs after hours, please contact the local Crisis Response Team, ER or Crisis Stabilization Unit for immediate attention.

We look forward to working with you and hope you will find this service to be a valuable asset to your practice and the care of your patients.

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

ADMINISTRATIVE

Reminder: Changes to inpatient rehabilitation facility billing guidelines

Effective April 18, 2010, BlueAdvantage claims filed with Revenue Code 0024 require a 5-digit Health Insurance Prospective Payment System (HIPPS) code.

If the claim does not have the HIPPS code along with Revenue Code 0024, the claim will be rejected. To avoid claim delays, providers are encouraged to update their claims filing system prior to filing these claims.

A current HIPPS code listing can be found online at <http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp>.

If you have questions regarding this billing guideline, please call the BlueAdvantage Provider Service line†.

MedSolutions, Inc. to provide prior authorization reviews for elective outpatient imaging services*

Effective for dates of service beginning June 1, 2010, and after, MedSolutions Inc., will provide prior authorization reviews of outpatient advanced imaging services for BlueCross BlueShield of Tennessee BlueAdvantage PPO members.

For all outpatient, elective, CT, CTA, MRI, MRA, MRS, PET Scans and Nuclear Cardiology imaging services performed on or after June 1, 2010, referring providers will be required to obtain prior authorization directly from MedSolutions Inc. **Note**: *These services will not require authorization if they are performed when a patient is receiving treatment in an emergency room or in an inpatient setting.*

Prior authorization requests for advanced imaging services can be submitted via MedSolutions' Web site, www.MedSolutionsOnline.com, available 24/7, or call toll-free 1-888-693-9211.

Reminder: Illegible, missing, and invalid physician signatures

Medicare regulations require that the individual practitioner who ordered or provided services be clearly identified and validated through a signature in the medical record documentation. The method used should be written or an electronic signature (stamp signatures are not acceptable) to sign an order or medical record documentation for medical review purposes.

Claim denials will occur if required and there is no signature present in the documentation. This applies to all providers, including those in private practices.

Federal Employees Program (FEP)

ADMINISTRATIVE

Reminder: Changes to prior authorization requirements for Intensity Modulated Radiation Therapy (IMRT)

Effective Jan. 1, 2010, the Federal Employees Program (FEP) began requiring prior authorization for Intensity Modulated Radiation Therapy (IMRT) for its members. CPT® codes affected by this change are 77301 and 77418.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

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

Commercial Lines; CoverTN; CoverKids; AccessTN **1-800-924-7141**
Operations –
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)
Medical Management –
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-800-782-2433**
SelectCommunity **1-800-292-8196**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – 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 2010 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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CPT® is a registered trademark of the American Medical Association

BlueAlert
provider news flash

BlueCross BlueShield of Tennessee
plans for better health. plans for a better life.

Please Route to all Providers & Office Staff

June 2010

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 10, 2010

- Dasatinib (Sprycel®)
- Nilotinib (Tasigna®)
- Tocilizumab (Actemra®)
- Lapatinib (Tykerb®)
- Epiretinal Radiation Therapy for Age-Related Macular Degeneration (ARMD)
- Percutaneous Discectomy
- Electrical Bone Growth Stimulation

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

Clinician's quick reference guide to personal health records

A Personal Health Record (PHR) guide is accessible from the Provider page on the company website, www.bcbst.com. The PHR is an electronic tool for use by patients to help manage their care and support through more effective communication with their physicians and other health care professionals. This guide also answers some of the questions you may have about this technology and the role it plays in improving the quality of health care for your patients.

The benefits of a PHR are convenience, availability of educational resources, and access to lifesaving information. For additional information on the PHR guide, a list of FAQs is also available on the same hyperlink connecting to the guide.

BCBST enters arrangement with ProgenyHealth

BCBST recently entered an arrangement with ProgenyHealth, a company specializing in neonatal care management services throughout the first year of life. Under the agreement, ProgenyHealth's neonatologists, pediatricians and neonatal nurse care managers will work closely with families, attending physicians and nurses to promote healthy outcomes for our members having premature and medically complex newborns.

For hospitals, ProgenyHealth will serve as a liaison for BCBST providing inpatient review services and assisting with the discharge planning process to help ensure a smooth transition to the home setting.

ProgenyHealth will provide experienced case managers who will work closely with families providing education and support so they can become active participants in the health care decision making processes regarding their infants. ProgenyHealth case managers will also:

- work to support the newborn's medical home upon discharge;
- encourage close continuity of care with the infant's primary care provider by assisting families with appointments, transportation, obtaining medications; and
- provide assistance with any other issues regarding the infant.

Changes to commercial pharmacy formulary

Effective July 1, 2010, the BCBST commercial pharmacy formulary will change to only include one (1) preferred human growth hormone (hGH) product, Norditropin® (somatropin [rDNA origin]. Although some hGH products vary in indications, the major difference in Norditropin® and other hGH products is the device used to administer the drug (i.e. Norditropin NordiFlex®).

Norditropin® requires prior approval. Existing authorizations will remain valid until the end of the original requested date. Your office will be contacted about transferring patients to the preferred product.

ADMINISTRATIVE

Reminder: Enhanced support for Web services

Provider's are reminded that BlueCross BlueShield of Tennessee supports eHealth Services® on Blue*Access,* BCBST's secure area on its website, allowing providers a more enhanced Web experience. The BCBST Provider Outreach Department (POD), in conjunction with eBusiness Solutions uses the latest technology offering in-depth instruction on navigating the site.

Claims, Eligibility or Benefits Questions?
Please call the Provider Service line† and ask the customer service representative for the "POD". You will be connected with a knowledgeable staff member who will assist you.

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

All Blue 2010 Provider Workshops

The annual state-wide All Blue Provider Workshops have been scheduled. These educational workshops are designed to assist provider office staff starting with a general session to share current information and followed by **Professional** and **Facility** breakout sessions.

At the workshops, provider staff can visit our Resource Centers and take advantage of one-on-one discussions with dedicated BlueCross BlueShield of Tennessee professionals.

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

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Spring 2010 provider data facility audit

Beginning May 14, 2010, through June 4, 2010, the BlueCross and BlueShield Association (BCBSA) contracted with Thoroughbred Research to conduct provider data audits on group/clinic and facility providers.

The audit is performed on a semi-annual basis to validate provider information (e.g., name, address, phone number, specialty) that is currently published on the National Blue Doctor & Hospital Finder website and the Federal Employee Program (FEP) Online Provider Directory website.

Correct coding for hemophilus influenza b vaccine (Hib)

Providers are reminded products matching CPT® codes 90645 (HbOC conjugate – HibTITER®) and 90646 (PRP-D conjugate – ProHibit®) are no longer available.

Only two (2) Hib conjugate vaccines are currently available:

As noted in Table 1 from the Centers for Disease Control's (CDC) *Chapter 2: Haemophilus influenzae Type b Invasive Disease, Manual for the Surveillance of Vaccine-Preventable Diseases (4th Edition, 2008*). This information can be found online at <http://www.cdc.gov/vaccines/pubs/surv-manual/chpt02-hib.htm>.

Vaccine	Trade Name
PRP-T conjugate	ActHIB®
PRP-OMP conjugate	PedvaxHIB

Note: The above listed vaccines should be billed with the most specific code (90647 or 90648) whose description matches the product administered.

Shared Health® customizable features for the way you operate.

With the Shared Health Clinical Health Record (CHR), you get actionable, clinically relevant information at the point of care.

You will gain the ability to prepare a wide variety of reports and other evaluation documents, giving you a complete, long-term view of how your practice operates.

Features in Clinical Xchange include:

- **Problem List:** Maintains an up-to-date view of a patient's conditions based on data from multiple sources.
- **Care Opportunities**: Delivers clinical decision support rules relevant to specialty, high clinical priority conditions, and preventive care.
- **ePrescribing:** With Shared Health ePrescribe, you get a convenient way to prescribe formulary compliant medications, access drug interaction and allergy alerts, and reduce the chance for errors.
- **Comprehensive medication lists:** Perform medication reconciliation at relevant encounters and sort medications by date, source, types, etc.
- **Enhanced inter-practice communication:** Access secure messaging and exchange meaningful clinical information among members of a patient's health care team.
- **Clinical Insight:** Generate list of patients by specific conditions to use for quality improvement.
- **Child Wellness:** Perform comprehensive WellChild care with guideline- and Medicaid-compliant exam templates from ages 0-21 years.

To learn more or to speak with a Shared Health representative, call 1-888-283-6691 or visit www.sharedhealth.com.

Reminder: Benefit plans vary- always verify benefits

Because BlueCross BlueShield of Tennessee benefit plans vary, providers are encouraged to verify member benefits prior to rendering services. A number of benefit plans cover specific services and/or medications while others may not.

Member health care benefits may be verified by calling the Provider Service lines†, the Customer Service number on the member ID card or accessing e-Health Services® via BlueAccess, the secure area on the company websites, www.bcbst.com or www.vshptn.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Volunteer State Health Plan, Inc. (VSHP) introduces P4 Pathways oncology program

Effective June 30, 2010, VSHP will partner with P4 Healthcare to implement the P4 Pathway oncology program, which utilizes clinical pathways based on evidence-based guidelines as management tools for standardizing the way physicians and other health care providers treat certain diseases, specifically various cancers such as lung, breast, colon , and ovarian cancer. The program will also provide supportive care in the areas of neutropenia, anemia, nausea, and vomiting.

Participation in the program is voluntary, however, providers agreeing to participate in the program, and demonstrating compliance with the pathways will receive enhanced reimbursement for specific injectible drug codes included in the P4 Pathway program for oncology treatment and supportive care agents.

By partnering with VSHP in this program we can enhance your patient outcomes by minimizing side effects and toxicities, and help reduce any potential errors. For more information, please contact your local Provider Network Manager.

BlueCross BlueShield of Tennessee anticipates implementing the P4 program for its Commercial providers by mid September 2010.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Reminder: Prior authorization required for observation stays

As of May 15, 2010, VSHP began requiring prior authorization for observation stays. Authorization requests may be submitted via telephone or electronically through *BlueAccess*, VSHP's secure page on its website, www.vshptn.com.

Although providers are encouraged to utilize *BlueAccess* when requesting prior authorizations, requests may be submitted via the appropriate BlueCare or TennCare*Select* Provider Service line[†].

Reminder: New/revised edits listed online

Providers are reminded to review the new or revised edits listed on the eBusiness Technical page under "*Supplemental BlueCare/TennCareSelect Edits*" on the company website, www.bcbst.com. Claims received that are 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, Monday through Friday, 8 a.m. to 6:30 p.m. (ET), or e-mail to ecomm_techsupport@bcbst.com.

Reminder: Abortion, Sterilization, Hysterectomy (ASH) services

VSHP covers abortions, sterilizations and hysterectomies pursuant to applicable federal and state laws and regulations.

Abortions and services associated with the abortion procedure are covered when the abortion in Medically Necessary as the mother suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would place the mother in danger of death unless an abortion is performed, or the pregnancy is the result of an act of incest or rape.

Elective abortions are **not** covered under BlueCare or TennCare*Select*.

Sterilization procedures require the patient to be at least 21 years old at the time consent is obtained. The individual to be sterilized has to be mentally competent, and is not institutionalized. There must be 30 days between the date of the member's signature and the date of sterilization procedure.

Hysterectomy is a covered service if it is Medically Necessary. The member or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing. Hysterectomies will **not** be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing, or if there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing.

Please refer to the *VSHP Provider Administration Manual* located on Blue*Source*, BlueCross BlueShield of Tennessee's quarterly provider information CD or on the company websites, www.vshptn.com and www.bcbst.com for complete rules and regulations regarding ASH requirements.

Filing claims appropriately for mental health services provided in settings other than your office*

A number of BlueCare and TennCare*Select* providers rendering mental health services in nursing care facilities and other alternate settings are incorrectly billing for those services with office-based CPT® codes.

Providers are reminded there are a series of CPT® codes that correspond with in-office coding and are designed specifically for use when services are delivered in an alternate setting.

Effective July 1, 2010, providers of mental health services will be required to bill CPT® codes 90816-90819 and/or 90821-90822 in conjunction with Place of Service Codes 31, 32, and 33.

Additionally, for dates of service on or after July 1, 2010, mental health services provided in these alternative settings will require prior authorization. Authorization may be obtained on the ValueOptions' ProviderConnect online provider services website, www.valueoptions.com/providers/Providers.htm or by calling:

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

Should you have any questions regarding these changes, please contact your ValueOptions Regional Provider Representative.

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

ADMINISTRATIVE

Changes to prior authorization requirements for therapy services*

Effective Aug. 1, 2010, BlueAdvantage PPO will require prior authorization for all therapy services performed in a home or outpatient setting. An advanced determination is recommended for these services for BlueAdvantage PFFS members.

Initial BlueAdvantage PPO therapy requests will be accepted telephonically by calling the Provider Service line, 1-800-924-7141 or via BlueAccess, BlueCross BlueShield of Tennessee's secure area on its website, www.bcbst.com. All concurrent review requests should be faxed to BlueAdvantage utilization management at 1-888-535-5243.

Additionally, home health claims with fourteen (14) or more therapy visits will no longer require submission of medical records prior to payment, however, they will be subject to focused, retrospective post claims review similar to Original Medicare.

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

ADMINISTRATIVE

Reminder: When is it appropriate to take vision copay versus specialist copay?

In an effort to clarify when it is appropriate to take the vision copayment versus the specialist copayment for BlueAdvantage members, providers should follow the below guideline:

When filing HCPCS Code(s)…	the provider should
92002-92004 or 92012-92015	Take the vision copay amount

Reminder: MedSolutions initiative delayed

In May BlueAlert, we reported effective for dates of service June 1, 2010, and after, MedSolutions, Inc. would be providing prior authorization reviews of outpatient advanced imaging services for BlueAdvantage PPO members.

Please be advised this initiative is being delayed until the Centers for Medicare & Medicaid (CMS) approves the member notification. Once approval is received, providers will be notified of the new effective date and processes for gaining authorizations.

BlueCard®

ADMINISTRATIVE

New BlueCard accounts select Network S

As of Jan. 1, 2010, eight new BlueCard National Account groups chose BlueCross BlueShield of Tennessee's BlueNetwork S for their members to receive services in Tennessee.

These ID cards are easily identifiable by the suitcase logo reflecting "PPO" inside and "Network S" printed beside the suitcase. Some Blues Plans choose to list their policy type or contract name on member ID cards; however, this information is only for use by the other Plan. There are only three (3) types of contracts represented by the information on a Blues Plan ID. These are:

1. Empty suitcase represents a traditional policy which is supported by BlueNetwork P;
2. Suitcase with PPO inside indicates a true PPO contract, which is supported by BlueNetwork P; and
3. Suitcase with PPO inside with "Network S" printed beside the suitcase, which is supported by BlueNetwork S.

For additional information, please call 1-800-705-0391.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

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

Commercial Lines; CoverTN; CoverKids; AccessTN 1-800-924-7141
Operations –
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)
Medical Management –
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare 1-800-468-9736
TennCare*Select* 1-800-276-1978
CHOICES 1-800-782-2433
SelectCommunity 1-800-292-8196
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – 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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CPT® is a registered trademark of the American Medical Association

BlueAlert
provider news flash

BlueCross BlueShield of Tennessee
plans for better health. plans for a better life.

Please Route to all Providers & Office Staff

July 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

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

Effective Aug. 14, 2010

- Trastuzumab (Herceptin®)
- Collagenase Clostridium Histolyticum (Xiaflex™) for Dupuytren's
- Filgrastim (Neupogen®) Pegfilgrastim (Neulasta®)
- Sargramostim (Leukine®)
- Molecular Anatomic Pathology Testing
- Whole Body Dual X-Ray Absorptiometry (DEXA) to Determine Body Composition
- Cranial Orthosis for the Treatment of Plagiocephaly
- Hyperbaric Oxygen Pressurization Therapy (HBO2)

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

Modified utilization management guideline updates/changes

BCBST's website has been updated to reflect upcoming modifications to select Utilization Management guidelines. These modified 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. 25, 2010

The following as relates to Ambulatory Care:

- Sling Procedures, Male
- Uvulopalatopharyngoplasty (UPPP)

The following as relates to Home Care:

- Hyperemesis Gravidarum

The following as relates to Inpatient and Surgical Care:

- Liver Transplant

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

Behavioral health clinical practice guidelines adopted

BCBST has adopted the following guidelines as recommended best practice:

Updated Helping Patients Who Drink Too Much-A Clinician's Guide (NIAAA)
<http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>

Clinical Practice Guideline for Assessing and Managing the Suicidal Patient and Tipsheet

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

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

American Psychiatric Association's (APA) Guidelines for Major Depressive Disorder
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx>

Practice Guideline for the Treatment of Patients with Eating Disorders Third Edition
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_12.aspx>

Why SharedHealth® is different — and needed in today's health care system.

SharedHealth is designed to answer the needs of an entire health care community. By connecting diverse health care professionals and providing the secure exchange of medical information and clinical decision support tools, SharedHealth helps improve the quality of care while increasing efficiency. We've addressed some of the most vexing problems facing clinicians today — incomplete patient medical information, redundant paperwork, workflow interruptions, and time-consuming record retrieval.

In addition, SharedHealth's solutions can help you meet all three stages of "meaningful use" criteria that may qualify you for incentive payments under the American Recovery and Reinvestment Act of 2009 (ARRA).

At the center of SharedHealth's solutions is the SharedHealth Clinical Xchange platform, which features a community-based, patient-centric record — a SharedHealth Clinical Health Record (CHR) for each patient— that allows you to access comprehensive data from that patient's entire health care team. Clinical Xchange also includes a number of tools that enable proactive patient and population management, including electronic prescribing and more.

Clinical Xchange is designed to complement your practice's workflow, not disrupt it. Our interoperable applications will work in any computing environment, so you don't need to make a major investment in new equipment. Using SharedHealth is the best long-term choice you can make to increase the quality of patient care in all settings.

To learn more or to speak with a SharedHealth representative, call 1-888-283-6691 or visit www.sharedhealth.com today.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

Adherence to drug therapy program begins July 11, 2010

Adherence to Drug Therapy is a new drug therapy monitoring program being launched on July 11 by BlueCross BlueShield of Tennessee's Pharmacy Management in cooperation with CVS Caremark, our pharmacy benefit manager. This program emphasizes medication management, helping ensure a member's appropriate adherence to his or her prescribed medication therapy. The program includes nine top disease states that affect many of our members:

Behavioral health	Heart failure
BPH	Osteoporosis
Diabetes	Parkinson's disease
High cholesterol	High blood pressure
Respiratory	

Program-specific triggers include:

1. Identifying patients who are new to a specific therapy and sending educational material and encouragement. Educational material is specific to the disease state and its common drugs.
2. Sending refill reminders to members. Although many pharmacies send reminders, our program will also target members taking a maintenance medication.
3. Monitoring for discontinuation after the first fill. If a member fails to refill a new medication for one of these disease states, and/or
4. Notifying the prescribing physician (usually by fax) if the member appears to discontinue a maintenance medication. There may be various reasons why a member stops taking medication, which happens frequently. To better serve the patient, the physician needs to be aware of the discontinuation. Stopping drug therapy can have significant health consequences. Patients are surveyed to determine reasons for not taking their medications and will assist in customizing our outreach to members.

Outcomes from this program will be reported to the groups.

If you have questions, please call the BlueCross BlueShield of Tennessee Provider Service line†.

New materials for Childhood Obesity toolkit coming soon

Prior to the 2010-2011 school year, new materials to combat childhood obesity and diabetes will be mailed to pediatricians and family practice physicians.

The new toolkit will be available in both English and Spanish and contains tip sheets, wall posters, physician reference materials, tracking sheets and brochures with educational information.

We are advocates for healthy choices as a part of every day life. Our hope is to support you in preventing future cases of diabetes by instilling healthy behaviors in America's youth today. The BlueCross and BlueShield Association was fortunate to share this vision with the following organizations, which were consulted in the development of the toolkit*:*

- The American Academy of Pediatrics (AAP)
- The American Diabetes Association (ADA)

The *Childhood Obesity and Diabetes* toolkit will be available on our company website, www.bcbst.com in coming months.

For more information on childhood obesity, please visit: http://www.cdc.gov/obesity/childhood.

ADMINISTRATIVE

Reminder: BCBST automates 2BC secondary claims processing

BCBST automates processing of secondary claims for members having two (2) BlueCross BlueShield of Tennessee health care benefit plans. For these members the remittance advice will reflect remark code ***Z2B,*** "this claim is being processed under your secondary coverage".

On an electronic remit, the remark code "MA18" will appear in either data element MOA03 or MIA05 to indicate the claim is being forwarded to the secondary plan.

If the member has coverage with **another** Blue plan (i.e. BlueCross BlueShield of Alabama) or Federal Employees Plan (FEP), the claim will be crossed-over manually. These codes will **not** appear when the secondary coverage is FEP or another Blue plan.

If Z2B or MA18 appears on the remit, it is not necessary for you to submit the secondary claim. In most cases, the secondary payment will be made the following week.

For more information, please call the eBusiness Service Center at 423-535-5717, 8 a.m. to 6:30 p.m. (ET).

Reminder: Always include reason you are refunding monies to BCBST

BCBST receives a high volume of refund checks daily; so it is always important for providers to include the reason they are refunding any monies to us. Two ways to help ensure the refund is applied appropriately and timely are:

1. Return a copy of the refund request letter along with the refunded amount; or
2. Complete and attach a copy of the BCBST overpayment information form located on the company website at <http://www.bcbst.com/providers/forms/OverpaymentInformationForm_gcb.pdf>.

Reminder: Wal-Mart associates receive new member ID cards

Effective Jan. 1, 2010, we reported that Wal-Mart associates had changed their Home Plan and were being issued new ID cards reflecting alpha prefix "**WMW**" as part of the member ID number.

Effective July 1, 2010, BCBST will no longer accept claims filed with the **old** alpha prefixes "**WLA**", **WMR**" or "**MRT**"

To ensure claims are processed correctly, verify the ID card at every visit and make sure your have the correct number on file.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Billing hospice services appropriately

Hospice services must be billed in accordance with BlueCross BlueShield of Tennessee billing guidelines to include but not limited to:

- Hospice claims must be billed on a CMS-1450/ANSI-837I.
- To facilitate claims administration, a separate line item must be billed for each date of service.
- Hospice Providers may bill with either Type of Bill (081X or 082X) in Form Locator 4 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.
- Hospice claims should be billed with the Hospice provider number and/or NPI referenced in the Network Attachment.
- For Continuous Home Care, RC 0652, one unit will equal 15 minutes. Continuous Home Care will not be reimbursed when less than 8 hours (32 units) and will be capped at 24 hours (96 units) per calendar day.
- Reimbursement allowable rate per unit will be rounded up to the second decimal amount (e.g. $8.7110 would reimburse at $8.72).

In all cases reimbursement for Hospice services is based on:

- Per diems allowed on a per day basis, not per visit;
- The lesser of total covered charges or maximum allowable Hospice Fee Schedule

Note: *Charges submitted for non-Covered Services are not eligible for meeting the per diem amount.*

BlueCare/TennCare*Select*

ADMINISTRATIVE

Bureau of TennCare implements new "plain language" initiative

The Bureau of TennCare has implemented a new initiative called "Plain Language." This is part of a national program encouraging health care providers to promote health literacy among their patients by ensuring they understand written and oral health information.

The *National Adult Literacy Survey* found that 66 percent of adults age 60 years and over have inadequate or marginal literacy skills. Many informed consent forms and medication package inserts are written at high school level or higher, while the average patient reading level is closer to 6th grade. In one study, out of 659 hospital patients, those with poor health literacy skills were five (5) times more likely to misinterpret their prescriptions than those who had adequate literacy skills. Most patients will not tell you they do not understand. Using plain language allows your patients to understand their treatment plan, know how to take their prescriptions properly, and better follow your instructions. For additional information on Health Literacy, please refer to the Department of Health and Human Services website at <http://www.hrsa.gov/publichealth/healthliteracy/>.

Patient Protection and Affordable Care Act (PPACA) hospice amendment for children

Effective immediately, children who elect to receive hospice care may also elect to continue to receive curative treatment for their terminal illness.

Section 2302 of the Patient Protection and Affordable Care Act (PPACA) amends Section 1905 (o) (1) of Title XIX of the Social Security Act and states that a "voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payment for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made".

The provision applies only to children, including children who elected hospice care prior to the date of enactment; i.e., if the child entered hospice care in February 2010 but now wishes to receive concurrent treatment, the previous election to receive hospice services cannot be construed as a waiver of the right to receive curative services. **Note**: The rules continue to prohibit concurrent treatment for adults in Medicaid.

Reminder: BlueCare non-risk contract ends

On June 30, 2010, all claim processing activity ended for the BlueCare "non-risk" contract between the State of Tennessee and VSHP. After June 30, 2010, providers are reminded to remit any checks and/or requests for payment to the **Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243.**

Note: This does not apply to the current BlueCare or TennCare*Select* Networks. If you have any questions, please contact your Provider Network Manager.

Reminder: Civil penalties imposed for presenting false or fraudulent claims

Under the Deficit Reduction Act (DRA) of 2005, there are civil penalties for presenting false or fraudulent claims for payment or approval by the government. Providers receiving any federal funds are required to have policies and procedures in place addressing the DRA, False Claims Act, and what employees should do if they suspect fraud, waste, or abuse. The policies and procedures should include verbiage to address whistle blower's protection. You should also have training available for all of your staff to include this information.

As directed by the Bureau of TennCare, Provider Network Managers will be asking to view your policies and procedures, as well as training provided to your staff regarding the Deficit Reduction Act and False Claims Act. You may access BCBST training materials on the Provider page on our website, www.bcbst.com for use in training your staff, or your Network Manager can provide you with a copy. Please ensure your policies and procedures and training are easily accessible.

BlueCare/TennCare*Select*

ADMINISTRATIVE

CHOICES coming to East and West grand regions

Beginning Aug. 1, 2010, Volunteer State Health Plan (VSHP) is implementing CHOICES, the Bureau of TennCare's long-term care program, in the East and West Grand Regions. All East and West Tennessee residents participating in the State's existing Statewide Home and Community-Based Service (HCBS) Waiver for the Elderly and Disabled will be automatically transitioned into the CHOICES Program. TennCare's goal is to integrate the CHOICES benefits with the member's medical and behavioral health services which are administered by managed care organizations. Per TennCare, "Providing continuity of care for these individuals during the transition is our primary concern. We want to ensure that services currently delivered under the Statewide Waiver continue to be provided, without interruption, in CHOICES".

Individuals aged 65 and over and adults with physical disabilities, who qualify for Medicaid, require the level of care provided in a nursing facility, and who need long-term care, including nursing facility services, or HCBS such as personal care, homemaker services, or home delivered meals, are eligible to participate in CHOICES.

CHOICES will utilize an Electronic Visit Verification (EVV) System for tracking some of the HCBS services provided. The EVV monitors delivery of services and allows immediate action to occur so that members receive timely assistance. To learn more about the CHOICES program, visit the company websites, www.vshptn.com and www.bcbst.com, on the Provider page for Frequently Asked Questions regarding CHOICES, or on the Bureau of TennCare's website at www.tennessee.gov/tenncare/long-faq.html.

A list of services provided under the CHOICES program can be found on the State of Tennessee's website at <http://state.tn.us/comaging/waiver.html#SERVICES>.

BlueCard®

ADMINISTRATIVE

Reprocessing claims for UAW retirees

Effective April 1, 2010, some General Motors, Ford Motor Company and Chrysler Corporation (Auto) UAW retiree claims began being reprocessed due to retroactive membership updates.

Impacted are processing of claims for GM, Ford and Chrysler UAW retirees, surviving spouses and dependents who are part of the UAW Retiree Medical Benefit Trust (URMBT) group.

Retroactive retirements occur when the membership records are not updated until after the member's true retirement date. This process covers hospital, medical, surgical and hearing claims administered by Blue Cross Blue Shield of Michigan on behalf of UAW retirees of GM, Ford and Chrysler, including original claim submissions, adjusted claims, BlueCard and non-BlueCard claims.

If you have any questions or need additional information, please contact your Provider Network Manager.

Tips for submitting out-of-area Blue Plan member claims

To help ensure prompt and accurate processing, please make sure you have a copy of the patient's current member ID card for use in submitting claims.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will help ensure you have the most up-to-date information in your patient files.
- Make copies of the front and back of the member's ID card and pass this key information to your billing staff.
- Blue Plan member ID cards include a three-digit alpha prefix in the first three positions of the member ID number. This alpha prefix identifies the member's Blue Plan and is critical for eligibility/benefits verification and for claims processing. The alpha prefix may be followed by ***up to fourteen (14) additional characters of any combination of letters and numbers.***
- When filing the claim, always enter the identification number exactly as it appears on the member's card, including the alpha prefix. ***Do not add, omit or alter any characters***.

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

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

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

Commercial Lines; CoverTN; CoverKids; AccessTN **1-800-924-7141**

Operations –
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)

Medical Management –
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CHOICES	**1-800-782-2433**
SelectCommunity	**1-800-292-8196**

(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard

Benefits & Eligibility	**1-800-676-2583**
All other inquiries	**1-800-705-0391**

(Monday – Friday, 8 a.m. to 5:15 p.m. ET)

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

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BlueCross BlueShield of Tennessee offices will be closed Monday, July 5, 2010, in observance of the Fourth of July Holiday

BlueAlert
provider news flash

BlueCross BlueShield of Tennessee
plans for better health. plans for a better life.

Please Route to all Providers & Office Staff

August 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/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. 12, 2010

- Velaglucerase Alfa (Vpriv™)
- Occipital Nerve Stimulation
- Tandem High Dose Chemotherapy with Hematopoietic Stem Cell Support

Effective Sept. 15, 2010

- Bortezomib (Velcade®)
- Botulinum Toxin (Botox®, Dysport® or Myobloc®)
- Rituximab (Rituxan®)

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

Clinical practice guidelines adopted

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

National Institutes of Health (NIH) Guidelines for the Diagnosis and Management of Asthma and Managing Asthma During Pregnancy: Recommendations for Pharmacologic Treatment
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)
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>

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>

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

American Diabetes Association (ADA) Position Statements for Standards of Medical Care in Diabetes - 2010
<http://care.diabetesjournals.org/content/33/Supplement_1/S11>

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>

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>

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

ACOG: Guidelines for Perinatal Care, Sixth Edition and the ICSI: Guidelines for Routine Prenatal Care -2009
The ACOG Guidelines for Perinatal Care, Sixth Edition is available for purchase at:
<http://www.acog.org/bookstore/Guidelines_for_Perinatal_Care,_Fifth_Edition_P262.cfm>

ICSI Guidelines for Routine Prenatal Care - 2009:
<http://www.icsi.org/prenatal_care_4/prenatal_care__routine__full_version__2.html>

ACC/AHA Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction
2007 Focused Update of the ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction:
<http://circ.ahajournals.org/cgi/content/full/117/2/296>

ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction:
<http://circ.ahajournals.org/cgi/content/full/110/5/588>

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 website at http://www.bcbst.com/providers/hcpr/. Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

New drugs added to commercial specialty pharmacy listing

Effective July 1, 2010, the following drugs have been added to our commercial Specialty Pharmacy Drug list. Those requiring a prior authorization are identified by a (PA).

Provider administered via medical benefit:
Glassia
Istodax
Prolia
Provenge
Xiaflex
Vpriv

Self-administered via pharmacy benefit:
Cayston
Hizentra (PA)

Reminder: Need CME, CEU, or CCM credits?

BCBST is offering Quality Interactions®, a program designed to help physicians, nurses, and office staff enhance interactions with people from diverse backgrounds. The training uses a case-based format supported by evidence-based medicine, and peer-reviewed literature. It is accredited for up to 2.5 hours of CME, CEU, or CCM credits. BCBST has purchased the licenses for these courses, so there is **no cost** to our providers. There are a limited number of licenses available for theses courses, so please register quickly to take advantage of this valuable learning opportunity.

To register, go to the Provider page on the company website, www.bcbst.com. Look under the "Administration" section, and click on the "Quality Interactions® Cross Cultural Training" link. There you will find instructions for registering for the class. This is a great way to get valuable professional credits, for no cost, and gain useful knowledge to work with the culturally diverse population of Tennessee.

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

ADMINISTRATIVE

Reminder: Filing appropriate "place of service" on durable medical equipment (DME) claims

Providers are reminded to report the appropriate place of service (POS) code on claims when distributing durable medical equipment, prosthetics/orthotics, and/or supplies from the physician's office (POS 11) for home (POS 12) use. The place of service should identify where the equipment will be **used**, not where it is **dispensed**.

Please refer to the DME billing and reimbursement guidelines found in the BCBST or VSHP provider administration manuals located on the company websites, www.bcbst.com and www.vshptn.com and also on Blue*Source*, our quarterly provider information CD.

Reminder: External bone growth stimulators authorized for rental use only

As a reminder, BCBST follows the Centers for Medicare & Medicaid Services (CMS) guidelines when authorizing External Bone Growth Stimulators as a rental item as these items are not used for a lifetime.

Authorization spans for durable medical equipment (DME) are based on the expected length of time a member will need the equipment. Rental equipment is generally needed for a finite period and, based on the member's continuing medical need, will be reimbursed on a monthly basis up to the maximum allowable amount or purchase price.

For additional information on authorizing DME services, please refer to the billing and reimbursement sections of the provider administration manuals located on the Provider page on the company websites, www.bcbst.com and www.vshptn.com or on Blue*Source*, BCBST's quarterly information CD.

Shared Health® ePrescribe®

The ease and clarity you need when writing prescriptions.

The increased accuracy of ePrescribe enables you to reduce pharmacy callbacks and the back-and-forth time you and your staff spend clarifying prescription information. ePrescribe also includes a "prescribe on behalf of" feature, allowing nurses and other authorized personnel to write electronic prescriptions.

When a prescription is written, the ePrescribe system automatically checks drug interactions and patient allergy information to prevent adverse reactions. In addition, ePrescribe checks formulary information so you can select the appropriate medications at the lowest possible cost to the patient. You also get a more comprehensive view of a patient's prescription history. Our participation in The Surescripts® Information Network gives you access to prescription information for your patients enabling you to:

- Reduce medication errors
- Simplify medication reconciliation and management
- Increase formulary compliance and generic use

ePrescribe is one component of the Shared Health® Clinical Xchange® platform. Shared Health's solutions can help you meet all three stages of "meaningful use" criteria that may qualify you for incentive payments under the American Recovery and Reinvestment Act of 2009 (ARRA).

Integrating ePrescribe into your practice gives you easy access to:

- Medication claims history
- Formulary information
- Simplified prescription entry
- Drug interaction alerts
- Easier, safer filling

To learn more or to speak with a Shared Health representative, call 1-888-283-6691 or visit www.sharedhealth.com today.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Prior authorization for private duty services is based on medical necessity

According to TennCare Rules, prior authorization for in-home services must be medically necessary. In-home services include home health nurse, home health aide, and private duty nursing services (over eight (8) hours of nursing per day). The prior authorization process can be expedited when all required information is submitted.

The following information must be provided when seeking prior authorization for home health nurse, home health aide, and private duty nursing services:

- Name of physician prescribing the service(s);
- Specific information regarding the patient's medical condition and any associated disability that creates the need for the requested service(s); and
- Specific information regarding the service(s) the nurse or aide is expected to perform, including the frequency with which each service must be performed (e.g., tube feed patient 7 a.m., 12 p.m. and 5p.m. daily; bathe patient once per day or three (3) times a week; administer medications three (3) times per day; catheterize patient as needed from 8 a.m. to 5 p.m., Monday through Friday; change dressing on wound three (3) times per week). Such information should also include the total period of time the services are anticipated by the treating physician to be medically necessary; i.e. total number of weeks or months.

Home health services will not be approved to provide child care services, prepare meals, perform housework, or generally supervise patients. Any hours allotted to these tasks are not considered medically necessary and will not be authorized.

All requests for home health nurse, home health aide and private duty nursing services are reviewed by VSHP Medical Directors for medical necessity. Prior to authorizing the services, VSHP staff contacts the prescribing physician and the member/caregiver for additional information that will enable the Medical Director to authorize appropriate level of care. VSHP Case Managers and Social Workers may make home assessment visits to assist the Medical Director in determining the specific needs of the members.

Changes to ER billing guidelines

Effective for dates of service Sept. 1, 2010, and after, VSHP will no longer utilize the secondary diagnosis code for Emergency Room claims to determine if the facility claim will be paid as a medical emergency. Emergency level benefits will be determined by the principal diagnosis code in Form Locator 67, or patient's reason for visit code in Form Locator 70 of the CMS-1450 claim form.

Additionally, forty-seven (47) emergency room codes will be removed. A complete listing can be found on the Provider page on the company website, www.vshptn.com.

CHOICES®

ADMINISTRATIVE

Billing for services rendered to CHOICES members

When billing for services rendered to CHOICES members, providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 (professional), CMS-1450 (institutional) health insurance claim forms and/or the appropriate electronic filing format.

Reimbursement rates and codes for CHOICES are based on methodology established by the Bureau of TennCare and are updated in accordance with their direction and discretion. Only those HCPCS (CPT® and HCPCS Level II) codes on the fee schedule will be considered for reimbursement when filed in conjunction with the corresponding Revenue Code(s) and modifiers, otherwise, charges will be denied for billing guidelines.
Note: Services billed outside of the Agreement are subject to recovery. All services require prior authorization.

CHOICES billing and reimbursement guidelines can be found in the *Volunteer State Health Plan, Inc. (VSHP) Provider Administration Manual* located on the company websites, www.bcbst.com and www.vshptn.com, and on Blue*Source*, BCBST's quarterly provider information CD.

Additional Bureau of TennCare Long-term Care billing guidelines can be found online at the following:

http://www.tn.gov/tenncare/forms/ltcmanual.pdf
http://www.tn.gov/tenncare/forms/ltcmanualappa.pdf
http://www.tn.gov/tenncare/forms/ltcmanualhcbs.pdf>

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

ADMINISTRATIVE

BlueAdvantage PPO to begin denying unauthorized services as noncompliant*

Effective Sept. 1, 2010, services requiring prior authorization rendered to a BlueAdvantage PPO member without obtaining prior approval will be considered noncompliant and will deny as provider liability.

When prior authorization is required, the provider must obtain authorization prior to the scheduled services. Non-compliance will apply to initial as well as concurrent review for ongoing services beyond dates previously approved. Please note, BCBST providers cannot bill members for covered services that are denied due to non-compliance. Detailed information concerning this change will be included in the 3rd quarter update to the BCBST Provider Administration Manual.

Reminder: Diabetic retinopathy considered a manifestation

To remain consistent with the American Medical Association guidelines, BCBST considers diabetic retinopathy to be a manifestation rather than a primary diagnosis. In accordance with ICD-9-CM 2009, manifestation codes may never be used alone or as a primary diagnosis.

To help avoid claims processing delays, submit these claims to BCBST reflecting the applicable diabetes diagnosis code as primary.

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

ADMINISTRATIVE

Changes to timely filing requirements for private fee-for-service (PFFS)

The Centers of Medicare & Medicaid Services (CMS) is updating its edit criteria related to the timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. In accordance with the Patient Protection and Affordable Care Act (PPACA), claims with dates of service on or after **Jan. 1, 2010,** received later than one (1) calendar year beyond the date of service will be denied by Medicare and BlueCross BlueShield of Tennessee's BlueAdvantage PFFS plan. Please ensure your billing staff is aware of this important change.

This change does not affect BlueAdvantage Preferred Provider Organization (PPO) as those guidelines currently indicate claims must be submitted within three hundred sixty-five (365) days from the date of service.

For more detailed information on these timely filing requirements, visit the CMS website at http://www.cms.gov/MLNproducts.

Reminder: MedSolutions, Inc. to provide prior authorizations for elective outpatient advanced imaging services

Effective for dates of service Aug. 1, 2010, and after, MedSolutions, Inc., will provide prior authorization reviews of outpatient advanced imaging services for BlueCross BlueShield of Tennessee BlueAdvantage PPO members.

For all outpatient, elective, CT, CTA, MRI, MRA, MRS, PET Scans and Nuclear Cardiology imaging services performed on or after Aug. 1, 2010, referring providers will be required to obtain prior authorization directly from MedSolutions, Inc. **Note**: *These services will not require authorization if they are performed when a patient is receiving treatment in an emergency room or in an inpatient setting.*

Prior authorization requests for advanced imaging services can be submitted via MedSolutions' website. www.MedSolutionsOnline.com available 24/7, or call toll-free 1-800-575-4594.

BlueCard®

ADMINISTRATIVE

Reminder: Limited benefit plans offered

Providers are reminded that verifying Blue patients' benefits and eligibility is more important than ever as new products and benefit types enter the market. In addition to patients having traditional Blue PPO or other coverage, typically with high lifetime coverage limits (i.e., $1million or more), you may see patients with limited benefits (i.e.,$50,000 or less) who are covered by another Blue Plan.

Members who have Blue limited benefits coverage carry ID cards that have either of two product names - **InReach** or **MyBasic** and reflect the following distinctive elements:

- a tagline in a **green stripe** at the bottom of the card (some ID cards may not have a product name, but will include a statement in the green stripe that reads "**A health care plan providing limited benefits**"; and
- a **black cross and/or shield** to help differentiate it from other BlueCross BlueShield identification cards.

For questions and answers about limited benefit products, please visit the Provider page on our company website, www.bcbst.com and look under the "News" section

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2010 BlueCard® program seeking your feedback

Your feedback is important to help us make improvements in our processes and make your interactions with BlueCross BlueShield of Tennessee a smooth and simple experience.

Again this year, you will have an opportunity to tell us how we are doing via phone and/or online satisfaction survey.

From ***July 15 to Sept. 30, 2010***, you may receive a call on behalf of BlueCross BlueShield of Tennessee seeking input on your experience with servicing out-of-area members. Our research vendor may invite you to participate in online surveys and collect your e-mail address. If your office is contacted, we encourage you to participate in these surveys. We take your feedback seriously and incorporate into enhancements of our services to you.

If you need information about the BlueCard Program or have suggestions for improvements, there are three ways to contact us:

- Talk to your provider relations representative
- Visit us online at www.bcbst.com
- Contact your customer service representative 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

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

Commercial Lines **1-800-924-7141**
(includes CoverTN; CoverKids & AccessTN)

Operation Hours
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)

Medical Management Hours
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-866-502-0056**
SelectCommunity **1-800-292-8196**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – 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 2010 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueCross BlueShield of Tennessee, Inc., is an Independent Licensee of the BlueCross BlueShield Association. ®Registered marks of the BlueCross BlueShield Association of Independent BlueCross BlueShield Plans
CPT® is a registered trademark of the American Medical Association

BlueAlert
provider news flash

BlueCross BlueShield of Tennessee
plans for better health. plans for a better life.

Please Route to all Providers & Office Staff

September 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/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. 9, 2010

- Sipuleucel-T (Provenge®)
- Capecitabine (Xeloda®)
- Bendamustine (Treanda®)
- Everoloimus (Zortress®)
- Ablation Treatments for Barrett's Esophagus
- Multi-gene Expression Assay for Predicting Recurrence in Colon Cancer

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

ADMINISTRATIVE

Guidelines for use of locum tenens*

A "locum tenens" is a temporary practitioner who fills in for a practitioner on a short-term basis. A practitioner who is to be a permanent member of a practice or who performs services for over sixty (60) days does not meet the definitions of a "locum tenens" and must initiate contracting and credentialing with BCBST. Any practitioner that has been denied credentials by BCBST and has not successfully appealed that denial can not serve as a locum tenens and treat BCBST members as an in-network provider or bill under an in-network provider's number.

The BCBST locum tenens policy can be found in its entirety in both the BCBST and VSHP provider administration manuals located on the company websites, www.bcbst.com and www.vshptn.com.

Reminder: Protecting patient health identifiable information

Providers are reminded that patient health identifiable information (PHI) is protected under the Health Insurance Portability and Accountability (HIPAA) Act of 1996. As such, it is the provider and their staff's responsibility to ensure that patient information is not compromised.

For example, when providing a patient with a copy of an explanation of benefits (EOB) that shows a patient's copay, any documentation of payment history or patient financial responsibility, please ensure the document is being sent to the appropriate address and remember to secure other patient's information, if applicable. More than one patient's PHI is reflected on a number of documents, so **always** mark through or blackout other patients' information in order to protect the security and privacy of all your patients.

Shared Health® customizable features for the way you operate

With the Shared Health Clinical Health Record (CHR), you get actionable, clinically relevant information at the point of care. And soon, you'll gain the ability to prepare a wide variety of reports and other evaluation documents, giving you a complete, long-term view of how your practice operates. New features in Clinical Xchange include:

- **Problem List and Care Opportunities**
  Problem List provides an at-a-glance view of a patient's conditions based on data from a number of sources. ***Care Opportunities*** delivers treatment and preventive care checklists based on patient data analysis.
- **Add-a-patient** lets you add patients via the "Add-a-patient" function.
- **Improved ePrescribing** makes filling prescriptions much easier for you and your patients. ePrescribe also features formulary information and allows authorized staff members to prescribe on a physician's behalf.
- **Comprehensive medication lists** allow you to sort medications by various column headings and see how a medication was prescribed (ePrescribed, claimed, or portal entered).
- **Enhanced intra-practice communication** allows authorized clinicians within a practice view the patient list of another registered user. In addition, registered Shared Health users can securely exchange messages.
- **Customized patient information** allows you to group patients into priority categories and create a "favorite search" for the patient information you access most often.
- **Streamlined information resources** Clinical Xchange enables you to quickly prepare documents such as WellChild forms and immunization schedules.
- **Better immunization recordkeeping** Clinical Xchange lets you add immunizations to a patient's CHR.
- **Improved claims data** allows you to see claim numbers assigned by payers, making it easy to look up records for adjustments, and sort claims data by procedure and diagnosis codes.

To learn more or to speak with a Shared Health representative, call 1-888-283-6691 or visit www.sharedhealth.com today.

Notice: Code bundling edits

Effective Oct. 1, 2010, BCBST will only publish the code edit and source.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Clarification: 2BC secondary claims

BCBST recently notified providers in the July issue of *BlueAlert* of our automated process for handling secondary claims when members have two BCBST health care benefit plans. In the article, we failed to indicate that, at this time, this process does NOT apply to BlueCare/TennCare*Select*.

Blue Cross and Blue Shield Association expands Blue Distinction program

The Blue Cross and Blue Shield Association (BCBSA) recently announced the expansion of its Blue Distinction designation program to include Blue Distinction Centers for Spine Surgery℠ and Blue Distinction Centers for Knee and Hip Replacement℠. Blue Distinction designations are awarded to facilities that have demonstrated a commitment to quality care by meeting objective, evidence-based thresholds for clinical quality and safety developed with input from expert clinicians and leading professional organizations.

The Blue Distinction designation is awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery and transplants. The program is part of The Blues efforts to collaborate with physicians and medical facilities to improve the overall quality and safety of specialty care.

For a complete listing of Blue Distinction Centers for Spine Surgery and Blue Distinction Centers for Knee and Hip Replacement, or for more information on all designated Blue Distinction Centers, please go to www.bcbs.com/bluedistinction/ or call 1-800-810-BLUE.

Correct coding of bevacizumab (Avastin®) for intravitreal injection

Commercially distributed bevacizumab is supplied from the manufacturer in 400 mg and 100 mg vials with a concentration of 25 mg / mL. It is typically repackaged into single dose syringes with a concentration of 1.25 mg / 0.05 mL for intravitreal injection and must be prepared under sterile conditions by a compounding pharmacy prior to ocular use.

Any legend drug altered from its manufactured form for use by a specific patient is considered a compound. Since compounded medications do not have an NDC number, specific HCPCS Level II codes may not be used. Eligible compound drugs must be billed with the most appropriate HCPCS Level II unclassified/ not otherwise classified code.

Billing guidelines for compound drugs can be reviewed in the billing and reimbursement section of both the BCBST and VSHP provider administration manuals found online at www.bcbst.com

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New look for the member provider directory

There is a new look to the members' online Provider Directory located in the Member Section on the company website, bcbst.com. These changes were made to simplify the process for our members when searching for a provider within one of our provider networks. The Provider Directory located in the Provider Section on our website, www.bcbst.com has not changed and is the same directory that you have become familiar.

Reminder: Consumer Directed Health Care Plan (CDHC)

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

Real Time Claims Adjudication (RTCA) provides many Tennessee practitioners the ability to determine member financial responsibility either prior to services or while the member is on-site. RTCA is used to gain an estimate of member financial responsibility.

We encourage providers to work with their patients in determining if the member financial responsibility can be paid after the claim has been submitted and adjudicated by BCBST.

BlueCare/TennCare*Select*

ADMINISTRATION

Neonatal care management program to be implemented*

Pending State of Tennessee approval, VSHP will partner with Alere® Women's and Children's Health Division to provide comprehensive neonatal care management services for premature and medically complex newborns admitted in NICUs and special care nurseries.

Slated to begin this Fall, Alere®'s neonatologists and experienced nurse care managers will coordinate services and assist parents and neonatal staff in meeting pre- and post-discharge needs of these newborns.

If you have any questions regarding this neonatal care management program, please call the appropriate Provider Service line†, or contact your Provider Network Manager.

BlueCare/TennCare*Select*

ADMINISTRATION (cont'd)

Reminder: Access and availability guidelines

Contractually, VSHP shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

For Primary Care Provider or Physician Extender:

- **Distance/Time between the practitioner and member in <u>urban</u> area**: 20 miles or 30 minutes;
- **Distance/Time between the practitioner and member in <u>rural</u> area**: 30 miles or 30 minutes;
- **Member Load**: 2,500 or less for physician; 1,250 or less for physician extender;
- **Appointment/Wait Times**: Usual and customary practice not to exceed 3 weeks from date of Member's request for regular appointments and 48 hours for urgent care; and
- **Office Wait Times**: Wait times should not exceed 45 minutes.

Note: Appointments for BlueCare and TennCare*Select* members must reflect local practice, and be on the same basis as all other patients served by the practitioner.

Health Care Reform: National Correct Coding Initiative edits

Under Health Care Reform, Medicaid health care plans are mandated to begin using the National Correct Coding Initiative edits (NCCI). The Centers for Medicare & Medicaid (CMS) will determine the methodology, and have until Sept. 1 to notify states of the specific requirements. This legislation will go into effect on Oct. 1, 2010.

We will provide updates via our website, www.vshptn.com as we receive them. Please check the website frequently for updates.

Update: BlueCare "Non-risk" contract

Providers were recently notified that on June 30, 2010, all claims processing activity ended for the BlueCare "non-risk" contract between the State of Tennessee and VSHP affecting claims filed for dates of service July 1, 2002, through December 31, 2008. Additionally, providers were advised to remit any checks and/or requests for payment to the Bureau of TennCare.

Most recently, all claims processing activity for this non-risk contract has reverted back to VSHP. Please remit any recoupment checks, correspondence, or adjustment requests to VSHP.

Note: This does not apply to the TennCare*Select* network. Please continue to send TennCare*Select* claims to TennCare*Select*. If you have questions, please contact your Provider Network Manager or call the BlueCare Provider Service line†.

CoverKids

ADMINISTRATION

Missed appointments for CoverKids Members

There has been some confusion as to whether or not members with coverage under the CoverKids Program can be billed by providers when they miss their scheduled appointment. Federal regulations require that providers **not** bill CoverKids members when they fail to appear for their scheduled appointments.

In order to minimize these occurrences, we will work to educate CoverKids members and parents on the importance of keeping scheduled appointments and providing advance notice when they will be unable to keep an appointment. We appreciate your cooperation in this matter and your support of the CoverKids Program.

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

ADMINISTRATIVE

Reminder: Risk Adjustment-Coding to the highest specificity

For risk adjustment purposes, the Centers for Medicare & Medicaid Services (CMS) utilizes ICD-9-CM diagnosis codes to support Hierarchical Condition Category (HCCs).

ICD-9-CM codes have three, four, or five digits. Diagnoses should be reported to the highest level of code available for that category. Reporting the highest level of specificity on a claim not only accurately reflects the patient's condition, but may also additionally support the complexity level of your medical decision making in evaluation and management services.

Example 1:
Diabetes (250.62): The fourth digit designates manifestations or complications of diabetes such as neurological conditions, eye disorders, or diabetic ulcers. The fifth digit subclassification specifies type and controlled or uncontrolled. In this example, the fourth digit "6" specifies neurological complications, such as neuropathy or gastroparesis; and the fifth digit "2" is used for patients type II or unspecified type, uncontrolled, even if the patient requires insulin.

Example 2:
Acute myocardial infarction (410.72): The fourth digit in this example "7", is a subendocardial infarction and the fifth digit "2", is a subsequent episode. All initial care for a new MI should have the fifth digit of "1".

Documentation and coding resources:
Official Coding Guidelines on CDC website
www.cdc.gov/nchs/icd9.htm

American Health Information Management Association (AHIMA) www.ahima.org

American Academy of Professional Coders (AAPC) www.aapc.com

American Hospital Association (AHA)
www.aha.org

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

ADMINISTRATIVE

Risk Adjustment: Medical record documentation requirements

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.

Acceptable physician signatures and credentials:

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

Unacceptable physician signatures and credentials

- Typed name (unless authenticated by the provider);
- Non-physician or non-physician extender (unless co-signed by acceptable physician); or
- Provider of services' signature (unless name is linked to provider credentials or name on physician stationery).

Clarification: MedSolutions to provide prior authorization reviews for elective outpatient advanced imaging services

BCBST recently notified providers in a June 24, 2010, letter and reminded them via August *BlueAlert* that effective for dates of service Aug. 1, 2010, and after, MedSolutions, Inc., would be providing prior authorization reviews of elective outpatient advanced imaging services for BlueAdvantage **PPO** members. Providers are reminded this authorization requirement is **only** for BlueAdvantage **PPO** members and does **not** apply to BlueAdvantage Private Fee-for-Service (PFFS) members.

Neither BCBST nor MedSolutions, Inc. will provide prior authorization reviews of elective outpatient advanced imaging services for BlueAdvantage PFFS members. However, upon request, an Advance Determination can be done, but is **not required**.

Prior authorization requests for BlueAdvantage **PPO** members can be submitted via MedSolutions' website. www.MedSolutionsOnline.com, available 24/7, or call toll-free 1-888-693-3211.

BlueCard®

ADMINISTRATIVE

Access to out-of-area Blue members' medical policy and prior authorization requirements soon available online*

Effective Oct. 1, 2010, you will easily be able to look up medical policy applicable to your out-of-area Blue patients, along with general prior authorization requirements, and contact information for initiating prior authorization.

To access medical policy and prior authorization requirements:

- Go to www.bcbst.com
- Log onto BlueAccess
- Click the BlueCard/FEP link
- Click on Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization
- Enter the patient's three-letter alpha prefix

You will be routed to the Home plan's medical policy and/or prior authorization requirements. Once medical policy and/or prior authorization requirements are viewed, you will be reconnected to the local plan's website.

We are always interested in your feedback and would be pleased to answer any questions you might have. Please contact us at 1-800-705-0391.

†Provider Service lines

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

Commercial Lines **1-800-924-7141**
(includes CoverTN; CoverKids & AccessTN)
Operation Hours
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)
Medical Management Hours
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-866-502-0056**
SelectCommunity **1-800-292-8196**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – 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 2010 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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Please Route to all Providers & Office Staff

October 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/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. 13, 2010
- Denosumab
- Imatinib Mesylate
- Microprocessor-Controlled Prostheses for the Lower Limb
- Myoelectric Prosthetic Components for the Upper Limb
- Varicose Vein Treatments for the Lower Extremities

Effective Nov. 17, 2010
- Hyaluronan Derivatives
- Infant Home Apnea Monitoring

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

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website 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. 17, 2010

The following as relates to Ambulatory Care:
- Wheelchairs, Manual
- Wheelchairs, Powered

The following as relates to Inpatient and Surgical Care:
- Apnea, Apparent Life-Threatening Event
- Bone Excision
- Prostatectomy, Transurethral Resection (TURP)
- Urethroplasty, Complex Reconstruction

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

ADMINISTRATIVE

Prepare now for HIPAA 5010 requirements

The Health Insurance Portability and Accountability Act (HIPAA) requires the adoption of specific standards for electronic health care transactions e.g., claims, eligibility inquiries, claims status requests and responses. The current version is 4010A1, but federal regulation mandates that it be replaced with the new 5010 version by Jan. 1, 2012. At that time, all electronic transactions you, or your vendors send to BlueCross BlueShield of Tennessee and other payers must use HIPAA 5010 version.

This deadline may appear to be distant, but significant work must be accomplished to prepare for this mandatory conversion. At a high level, you must meet three objectives:

1. Identify the differences between 4010A1 and 5010, and determine what applications, systems and operating protocols will need to change. (This should be **complete or underway now**.)
2. Implement changes to systems and protocols, and test the changes (This should be completed by the **end of 2010**.)
3. Schedule and complete tests with external partners and transition with them to the 5010 transactions by the compliance date. (You are encouraged to start this as early as **Jan. 1, 2011**.)

BlueCross BlueShield of Tennessee's preparations for the implementation of 5010 are underway.

- BCBST is currently performing 5010 readiness strategies and conducting internal testing
- BCBST plans to begin external 5010 testing in May 2011

If you have questions about 5010, please contact the eBusiness Service Center at 423-535-5717 or e-mail at ecomm_technicalsupport@bcbst.com.

Reminder: Review superbills regularly for changes in medication codes and availability

Providers are reminded **only** off-the-shelf, pre-packaged medications manufactured by a pharmaceutical company should be coded utilizing specific HCPCS Level II codes.

Many currently valid codes have no commercially available product matching their code description. Some administered medications are commercially available agents more appropriately coded with a different specific HCPCS code and some are compounded (re-packaged, altered, or mixed from bulk powders). Providers should refer to the appropriate Centers for Medicare & Medicaid (CMS) NDC-HCPCS Crosswalk(s) found at <http://www.cms.gov/McrPartBDrugAvgSalesPrice/> for further coding guidance.

"Compounds" should only be billed with the most appropriate *unclassified/not otherwise classified* code. Additional billing guidelines for compound drugs can be found in both the BCBST and VSHP provider administration manuals located on the Provider page on the company website, www.bcbst.com and on *BlueSource*, BCBST's quarterly provider information CD.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

BCBST gains CORE Phase II certification

BlueCross BlueShield of Tennessee was recently recognized by the Council for Affordable Quality Health Care (CAQH) for efforts to simplify information exchange for providers and increase the standard of care for millions of Tennesseans. The certification, called CORE Phase II, reflects BCBST is streamlining the exchange of administrative data resulting in improved access to coverage and financial information by providers.

A recent study by IBM indicates this initiative can result in improved administrative efficiencies and cost savings because of reductions in claims denials, and an increase in patient eligibility verification while decreasing the costs for phone calls to obtain this information. By adopting the CORE requirements, the health care system could save over $3 billion in three years.

While a number of health care plans have satisfied the requirements for Phase I of the CORE project, BCBST is a very select company having achieved Phase II certification. The Phase II rules address requirements for electronic connectivity and digital certificates, patient identification, real-time claims status, and reporting of year-to-date deductibles.

Additional information about this certification can be found on the company website at http://bluecore.bcbst.com/.

If you have questions concerning this initiative you can contact our eBusiness Service Center at (423) 535-5717 or via email: ecomm_techsupport@bcbst.com, Monday through Friday, 8 a.m. to 6:30 p.m.

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 website, 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
Walgreens Specialty Pharmacy
Phone: 1-888-347-3416
Fax: 1-877-231-8302

Changes to commercial drug formulary

Effective Oct. 15, 2010, BlueCross BlueShield of Tennessee's Pharmacy and Therapeutics Committee will implement the following changes to its commercial drug formulary:

- **Solodyn® (minocycline) and Doryx® (doxycycline)** will be removed from formulary
- **Femara®, Arimidex®, and Aromasin®** will be available only for treatment of breast cancer in post menopausal females (coded at age 45 and older)
- **Suboxone® and Subutex®** (non-covered by most BCBST Plans) will require prior authorization for continued treatment

Letters were mailed in mid-September to prescribers identified having BCBST patients being treated with any of the above mentioned medications alerting them to these formulary changes.

Reminder:Accessing physician quality and cost reporting program

The Physician Quality and Cost Information, including 2010 program updates, will soon be available for physician[1] review. 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, click on "Register Now!" in the *BlueAccess* login box and then follow the registration instructions 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.

For more information or *BlueAccess*, call eBusiness Solutions at 423-535-5717, Monday through Friday, 8 a.m. to 6:30 p.m. (ET) or e-mail, Ecomm_TechSupport@bcbst.com

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

Note: At this time, this tool is not available for BlueCare, TennCare*Select*, FEP or Cover Tennessee plans.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Provider satisfaction survey going electronic

BlueCross BlueShield of Tennessee and Volunteer State Health Plan have measured provider satisfaction for many years. We encourage feedback as it helps us to understand what we are doing well, and identify areas for improvement. Our current process requires we send paper-based surveys to randomly selected network providers. These are mailed monthly, completed directly by physicians, or the knowledgeable experts within the physician practice (i.e., office manager), and mailed to BCBST.

This can be a time-consuming and costly process. Therefore, we are continually looking for ways for improved administration and collection of Provider Satisfaction information.

During the months of October and November, we will be running a pilot to explore the effectiveness and efficiency of offering a web-based survey tool. During these months we will be placing our Provider Satisfaction Survey tool on the company website, www.bcbst.com.

Beginning Oct. 11, 2010, you can access the Provider Satisfaction survey tool by following the below steps:

- Go to www.bcbst.com
- Enter your username and password in the *BlueAccess* login box**
- Click on the Survey Tool link

**First time users can click on "Register Now!" and then follow the simple registration instructions.

We invite you to participate in this online pilot by accessing the survey and submitting your Provider Satisfaction results to us.

Reminder: ProgenyHealth to provide utilization and case management services for infants admitted to NICU or special care nurseries

Effective Nov. 1, 2010, clinical updates for approved Diagnosis Related Group (DRG) inpatient hospitalizations will be requested based on Medical Necessity rather than every seven (7) days.

Prior authorization or DRG approval will be determined by ProgenyHealth on behalf of BCBST. However, the **initial** call or request should still be directed to BCBST Utilization Management at 1-800-924-7141 to determine the fully-insured member's eligibility for the ProgenyHealth program. After verifying the member's eligibility and benefits, the call will be transferred to ProgenyHealth.

If the request is initiated by fax, Web or Voicecert, the information will be forwarded to ProgenyHealth after BCBST verifies the member's eligibility and benefits. ProgenyHealth will use Milliman and BCBST Modified Utilization Guidelines to determine authorizations.

If you have any questions, please call ProgenyHealth, 1-888-832-2006, Monday through Friday, 8:30 a.m. to 5 p.m. (ET). A ProgenyHealth Utilization Management nurse is available for urgent UM requests outside of normal business hours. Case Managers are also available 24/7.

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

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 Volunteer State Health Plan Disease Manager who supports and coaches members in adopting and maintaining healthy habits. When theses 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

You are invited to a virtual costume party Webinar

Please join VSHP, the SelectCommunity Clinical Advisory Panel and ValueOptions Oct. 29, 2010, from 10:30 a.m (9:30 a.m. CST) until noon (11 a.m. CST) to discuss medical and behavioral profiles and best practices in meeting SelectCommunity member needs.

E-mail invitations containing a registration link to participate in the Webinar will be distributed approximately two weeks in advance of the event.

If you do not receive an invitation via e-mail and wish to participate, or you have questions about this event, please contact Laurel Pala at 423-535-8380 or e-mail laurel.pala@valueoptions.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE

VSHP contracts with CareCentrix for DME and medical supply services

Beginning Nov.1, 2010, VSHP contracted with CareCentrix to authorize DME and Medical Supply services and arrange for delivery of the services through their network of credentialed and contracted DME and Medical Supply providers. All requests for services should be sent to CareCentrix. CareCentrix will require prior authorization for all durable medical equipment and medical supply services prescribed for BlueCare and TennCare*Select* members, and for use in the member's home. Requirements for authorization of services performed when a patient is receiving treatment in a physician's office, the emergency room or in an inpatient setting will not change.

More information will be forthcoming in future *BlueAlert* newsletters, on our websites, www.bcbst.com, and www.vshptn.com, and other communications as it becomes available.

Reminder: TennCare claims edits published online

Providers are reminded to review the Bureau of TennCare's claims edits listing published on our company website at http://www.bcbst.com/providers/ecomm/CompanionImplementationGuides/Supplemental_BlueCareTennCareSelect_Edits.pdf.

These edits are revised/updated by the State of Tennessee and may change frequently. Claims received that are non-compliant with these edits will be rejected on the provider's electronic confirmation report. VSHP is currently developing a process by which providers will be able to identify any edit changes according to effective dates, termination dates and lines of business.

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

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

ADMINISTRATIVE

Reminder: Risk Adjustment-Complete ICD-9 coding and documentation

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

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

Provider's role in this process:

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

BlueCard®

ADMINISTRATIVE

Correction: Access to out-of-area Blue members' medical policy and prior authorization requirements soon available online*

In the September issue of *BlueAlert*, we advised effective Oct. 1, 2010, you would be able to access medical policy and general prior authorization requirements for your out-of-area Blue patients.

However, implementation of this initiative has been delayed until 2011. We apologize for any inconvenience this matter may have caused.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

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

Commercial Lines **1-800-924-7141**
(includes CoverTN; CoverKids & AccessTN)
Operation Hours
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)
Medical Management Hours
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CHOICES	**1-888-747-8955**
SelectCommunity	**1-800-292-8196**

(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard

Benefits & Eligibility	**1-800-676-2583**
All other inquiries	**1-800-705-0391**

(Monday – 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 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/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. 11, 2010

- Ranibizumab
- Cabazitaxel
- Hematopoietic Stem Cell Transplantation in the Treatment of Germ Cell Tumors
- Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis
- Use of Common Genetic Variants to Predict Risk of Nonfamilial Breast Cancer
- Total Ankle Replacement
- Home Uterine Activity Monitoring (HUAM)
- Sacral Nerve Neuromodulation/Stimulation for Pelvic Floor Dysfunction

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

New drugs added to commercial specialty pharmacy listing

Effective Oct. 1, 2010, 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:

Implanon
Jevtana
Lumizyme
Ozurdex
Quetenza

Provider/Self-administered via medical or pharmacy benefit:

Veletri (PA)

Self-administered via pharmacy benefit:

Extavia
Samsca
Sucraid
Gilenya (PA)

Controlled substance prescribing

BCBST recognizes the use of pharmacologic and non-pharmacologic modalities in the treatment of chronic pain are prescribed according to the judgment of the practitioner. However, it is expected there be evidence in the member's medical record to support chronic controlled substance prescribing.

Network practitioners who engage in activities that violate the below listed recommendations for prescribing, administering, dispensing, monitoring, and/or documenting of controlled substances are subject to disciplinary review and/or action by BCBST that may result in termination from BCBST network and may be reported to HealthCare Integrity and Protection Data Bank (HIPDB) or other entities as mandated by law.

In accordance with the *Model Policy for the Use of Controlled Substances for the Treatment of Pain, May 2004*, BCBST recommends practitioners keep complete and accurate records to include:

- the medical history and physical examination;
- diagnostic, therapeutic and laboratory results;
- evaluations and consultations;
- treatment objectives;
- evidence of underlying pathology to support chronic controlled substance prescribing;
- use of/or contraindication of ongoing conservative treatment modalities;
- discussion of risks and benefits;
- informed consent and written pain contract between the patient and practitioner outlining patient responsibilities and consequences;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements;
- periodic reviews will include urine drug screens, pill counts and results from monitoring of the state controlled substance database; and
- records should remain current and be maintained in an accessible manner and readily available for review

Draft medical policies on company website

The following medical policies have been reviewed and revised, and are now consistent with MedSolutions Guidelines. A draft of these policies can be viewed online under "Draft Medical Policies" at http://www.bcbst.com/providers/mpm.shtml.:

- Computed Tomography Angiography for Coronary Artery Evaluation
- Computed Tomography Scanning for Lung Cancer Screening
- Computed Tomography for Virtual Colonoscopy
- Magnetic Resonance Imaging (MRI) of the Breast
- Positron Emission Tomography for Oncologic Applications

Toolkit now available to help fight childhood obesity

In the July issue of *BlueAlert*, BCBST announced a new good health toolkit would be available on our website in coming months. *The Good Health Club Physician Information and Toolkit*, which consists of materials to help combat childhood obesity and diabetes is now on the Provider page on our company website, www.bcbst.com. The toolkit, available in both English and Spanish contains tip sheets, wall posters, physician reference materials, tracking sheets and brochures for use in distributing to your patients.

BlueCross BlueShield of Tennessee, Inc. (BCBST) (Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Flu season is here

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

Providers are reminded not all Blues health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate BCBST or BlueCard Provider Service line†.

Each year the formulation of the "seasonal flu vaccine" is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control (CDC). This vaccine contains different "strains" of flu expected to be active for that year. **For the 2010-2011 flu season, the "regular" flu vaccine will contain the H1N1 strain so providers should continue to bill the "flu vaccine" codes normally billed for the seasonal flu vaccine**.

The following influenza immunization guidelines for BlueCross BlueShield of Tennessee apply:

Commercial

- ***Vaccine and administration***
  - Covered if offered under the member's health care plan
- ***FluMist® nasal spray*** (recommended for healthy individuals ages 2-49)
  - Covered if offered under the member's health care plan

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.

When verifying benefits check member eligibility screen closely

Some commercial group members have full coverage, but only carry dental and/or vision coverage on a dependent. When verifying eligibility via BlueAccess, BCBST's secure area on its website, www.bcbst.com, providers may see an "N" beside a dependent's name, however, this only means there is no medical coverage. Providers are encouraged to click on the dependent's name to verify if other benefits, e.g., dental/vision information is available.

Changes to readmission guidelines for commercial lines of business*

Effective Dec. 1, 2010, BCBST will no longer authorize unplanned readmissions occurring within 14 days to the same facility with like or related diagnosis.

Some examples of diagnoses that MAY NOT be authorized are:

- Upper respiratory admissions, e.g., asthma, COPD, pneumonia;
- Complications from surgical procedures; and
- Abdominal pain.

Some examples of diagnoses that MAY be authorized are:

- Cancer diagnoses for chemotherapy;
- Complications of pregnancy; or
- Admissions for CABG following an admission for chest pain.

Note: The member can not be held liable for payment of services received when not authorized.

BlueCare/TennCare*Select*

CLINICAL

New diabetes initiative helps close gaps in care

Volunteer State Health Plan, Inc. (VSHP) has partnered with LabCorp in a new initiative for BlueCare and TennCare*Select* members to use "Lab-In-An-Envelope", an alternative approach to closing gaps in comprehensive diabetes care. Our goal is to work with providers to increase the rate of members receiving HbA1c and LDL-C testing.

Some providers may receive an onsite visit from our clinical team and receive an educational packet that includes member details you might find useful in treating your BlueCare and TennCare*Select* patients who suffer from diabetes.

Please support this initiative by authorizing VSHP to send Lab-In-An-Envelope kits to your diabetes patients who show gaps in care. Providers may send individual or batch authorizations for identified members.

Upon receipt of your authorization, Lab-In-An-Envelope kits with easy-to-follow instructions will be mailed to diabetic members who have gaps in care for LDL-C and HbA1c testing. This is a dry spot testing kit that contains all the necessary collection supplies. The kit is then mailed back in a pre-paid envelope. Lab results will be faxed to your office to help in managing your patient's care.

If you have any questions, please call VSHP's Disease Management department at 1-888-416-3025, Monday through Friday, 9 a.m. to 6 p.m. (ET). The *Lab-In-An-Envelope MD Fax Form* may be found on our company website at http://www.bcbst.com/providers/forms/, or you may request a form from Disease Management.

BlueCare/TennCare*Select*

CLINICAL (cont)

Reminder: Lead screening required for TennCare children

Federal Medicaid regulations require all TennCare children aged twelve (12) and twenty-four (24) months have a capillary (finger or heel stick) blood test for lead screening. Additionally, the following guidelines apply:

- All children aged 36-72 months who have not previously undergone a blood test for lead screening should be tested.
- A lead risk assessment questionnaire should be completed at each well-child checkup on all children aged 6 -72 months. This will help determine the child's risk for lead exposure and identify any changes in the child's environment that could increase his/her risk level.
- Lead screening is a component of TENNderCARE examinations, and screening results must be included in the medical record documentation.

Primary care providers may review detailed lead screening information via the company website, www.bcbst.com, or directly on the Tennessee Department of Health's website at http://health.state.tn.us/lead/professionals.htm.

Our Elevated Blood Lead Management Program provides counseling and education to parents/caregivers and can assist with management and follow-up of members who have elevated blood lead levels (EBLLs). Providers are encouraged to call VSHP at 1-800-225-8698, or fax 423-535-7790 upon identifying members having EBLLs.

ADMINISTRATIVE

Reminder: TennCare member appeal poster must be displayed

The Bureau of TennCare requires the Member Appeal Poster be displayed in a visible location within provider offices in the event the member has a grievance with the managed care organization or the provider. The poster is available on the company website at http://www.bcbst.com/providers/forms/ and on the Bureau of TennCare's website at <http://www.tn.gov/tenncare/forms/medicalappeal.pdf.>

Please be sure to display this poster in your office for BlueCare and TennCare*Select* members.

Reminder: VSHP contracts with CareCentrix for DME services provided in member's home

Effective Nov. 1, 2010, , CareCentrix will administer and manage all Durable Medical Equipment (DME) and Medical Supply services used in the home by BlueCare and TennCare*Select* members. CareCentrix will authorize and arrange for delivery of all DME and medical supply services provided in the member's home.

Requirements for authorization of services performed when a member is receiving treatment in a physician's office, the emergency room or in an inpatient setting will not change.

All requests for **in-home** DME services should be submitted to CareCentrix via one of the following methods:

Phone 1-888-571-6022
Fax 1-888-571-6018
Web submission <https://www.carecentrixportal.com/ProviderPortal/>.

CHOICES

ADMINISTRATIVE

Reminder: Filing facility claims appropriately

When filing the CMS-1450 (UB-04) facility claim form for services provided to CHOICES members the following information is **required**:

- NPI Number (to ensure correct provider reimbursement)
- Appropriate Provider Number for the service rendered (nursing facilities, please remember to submit claims using the appropriate provider numbers and revenue codes for Level 1 and 2 services).
- Taxonomy Number for the service rendered (linked to the appropriate provider number)
- Tax ID Number

Make sure to include the required information listed above on each claim before submitting for payment. If you have any questions or need additional information, please contact your local Provider Network Manager.

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

ADMINISTRATIVE

Reminder to schedule annual examinations and preventive screenings initiative

Beginning late October through early November, BCBST will be contacting BlueAdvantage members via an automated voice system reminding them to schedule their annual examinations and preventive screenings. Additionally, we are offering to help members find a physician if needed. We will also be mailing members an informational booklet on preventive services and screenings that will be useful in documenting test results and to help them better manage their health care.

If you have any questions regarding this initiative, please call the BlueAdvantage Provider Service line†.

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

ADMINISTRATIVE (cont'd)

Risk Adjustment Data Validation

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

Because accurate documentation and coding are critical to the risk adjustment process, BCBST is publishing a series of articles with feedback from medical record reviews on some of the more common conditions that are seen in the Medicare Advantage population.

Part 1 - Cardiology

CAD or ASCVD are general terms. Coding and medical record documentation should be as specific as possible including underlying causes, e.g., A Fib, Old MI, etc.

Myocardial Infarction (MI)

- A *common* documentation problem for MI is that the site of the infarction isn't identified. For accurate code selection, the site of the infarction should also be documented.
- The 4th digit in the 410 category identifies the site of the acute MI as identified on the EKG.
  Example:
  - 410.0x Acute MI of anterolateral wall
  - 410.1x Acute MI of other anterior wall
  - 410.2x Acute MI of inferolateral wall –STEMI
  - 410.3x Acute MI of inferoposterior wall –STEMI
  - 410.7x Acute MI-NSTEMI

Old MI

- Documentation of an MI outside of the 8 week patient recovery period is coded to 412.

Example: Hx of MI in '04

- Past MI diagnosed on EKG or other special investigation, but currently presenting no symptoms.
- This refers to symptoms related to the previous MI, not cardiac symptoms in general.
- Any condition documented to 412 but presenting **with** symptoms after 8 weeks from date of infarction is coded to 414.8 (Chronic Ischemic Heart Disease) if the documentation states that it is the lasting affect of the MI.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

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

Commercial Lines **1-800-924-7141**
(includes CoverTN; CoverKids & AccessTN)
Operation Hours
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)
Medical Management Hours
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare **1-800-468-9736**
TennCare*Select* **1-800-276-1978**
CHOICES **1-888-747-8955**
SelectCommunity **1-800-292-8196**
(Monday – Friday, 8 a.m. to 6 p.m. ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
(Monday – 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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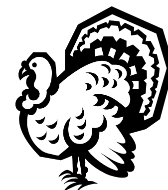
BlueCross BlueShield of Tennessee offices will be closed Nov. 25 & 26, 2010, in observance of the Thanksgiving Holiday.



*These changes will be included in the appropriate 4Q 2010 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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CPT® is a registered trademark of the American Medical Association

BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

December 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/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. 8, 2011

- Panitumumab
- Photodynamic Therapy for Dermatologic Conditions
- Array Comparative Genomic Hybridization (aCGH) for the Genetic Evaluation of Patients with Developmental Delay/Mental Retardation
- Negative Pressure Wound Therapy (NPWT) for Treatment of Acute/Chronic Wounds

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

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® 2010 results show more emphasis is needed to increase rates for the following measures:

	HEDIS Measure		
Product	**Retinal Eye**	**Mammo-gram**	**Pap Test**
BlueCare-East	44.52%	49.06%	64.15%
BlueCare-West	38.87%	39.54%	67.59%
TennCare*Select*	38.80%	32.39%	51.09%
Commercial	38.60%	68.98%	77.10%
Medicare Advantage-PFFS (H5884)	60.07%	74.54%	N/A
Medicare Advantage-PFFS (H4979)	59.01%	68.57%	N/A
Medicare Advantage–LPPO (H7917)	62.74%	N/A	N/A

Our Quality Improvement and Outreach Departments continually plan new initiatives for specifically promoting these screenings. Health 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 TennCare*Select* patients at their practice location.

The Preventive Services section on the Provider page on the company website, 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.

Changes to commercial 2011 preferred drug listing (PDL)

The PDL is reviewed annually to determine needed changes based on drugs' clinical effectiveness, safety and affordability. This review includes an analysis to determine a long-term "Lowest Net Cost" for members and groups.

The following drug changes were effective Oct. 1, 2010:

Drugs added to the formulary:
Extavia,
Saphris

Drugs moving to Tier 2:

Dulera	Januvia
Gelnique	Suboxone[PA]
Janumet	Twynsta

Refer to the October 2010 BlueAlert for additional formulary changes effective Oct. 15.2010.

The following changes are effective Jan. 1, 2011:

Drugs moving from Tier 3 to Tier 2:
- Bayer Diabetic strips

Drugs moving from Tier 2 to Tier 3:
- Actos and ActoPlus Met
- Avandia, Avandaryl and Avandamet
- Cymbalta
- LifeScan OneTouch diabetic strips
- Loestrin 24 Fe
- Nasonex

Drugs moving from Tier 2 to Tier 3 due to generic availability:
- Astelin Nasal Spray (azelastine)
- Pulmicort Respules (budesonide inhaler soln)
- Venlafaxine ER (venlafaxine ext-rel)

Requiring Step Therapy:
- Cymbalta (requires trial of Savella for fibromyalgia, or generic Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) or Lexapro for depression)

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

Changes to commercial 2011 preferred drug listing (PDL) (cont'd)

- Humalog products (requires trial of Novolog products)
- Diabetic Testing Strips (Abbott and LifeScan products require trial of Bayer and Roche products)
- Tier 3 Angiotensin–Receptor Blockers (ARBs) (require trial of generic Angiotensin-Converting Enzyme (ACE), generic ARB, Benicar, Benicar HCT, Micardis, Micardis HCT)
- Sedative Hypnotics: Ambien, Ambien CR, Lunesta, Rozerem, Sonata (require trial and failure of both zaleplon and zolpidem)

Add/Change to quantity limit (QL) list:

- Vimpat: 3 x 50mg; 3 x 100mg/day
- buprenorphine (Subutex): 24mg/day; max 6 months therapy
- buprenorphine/naloxone (Suboxone): 24mg/day; max 6 months therapy
- Diabetic supplies: 200 qty/30 days; 900 qty/90 days
- Insulin-pens: 3 pks/30 days; 9 pks/90 days; vials: 30 mL/30 days; 90 mL/90 days

ADMINISTRATIVE

Changes to dialysis billing guidelines *

Effective Jan. 1, 2011, for all dialysis providers, BCBST will no longer accept the HCPCS Level II Code J0886 for Epoetin (EPO) alfa injection, 1000 units. The replacement code will be Q4081 for Epoetin alfa injection, 100 units. This billing guideline has been in affect for the Centers for Medicare & Medicaid Services (CMS) since 2007. HCPCS code J0886, will be denied for dialysis providers (see billing guidelines) when filed on and after Jan. 1, 2011.

Please be advised that all related authorization requests for EPO injections should utilize code Q4081 as well for proper claim adjudication.

Reminder: Filing ancillary claims appropriately

Ancillary claims, e.g., laboratory, radiology, anesthesia, must be filed with the same place of service as the associated facility claim. If the ancillary charges are filed as inpatient and the facility claim is filed as outpatient, the ancillary provider must file a corrected bill with an outpatient place of service for the claim to be considered for payment.

Hospital outpatient code bundling edits reinstated

Effective Jan. 1, 2011, hospital outpatient National Correct Coding Initiative (NCCI) code bundling edits will be reinstated for all commercial lines of business. Those code edits, temporarily discontinued last year, will result in recoveries of any overpaid dollars.

The recovery of such dollars will be communicated and managed per established Provider Audit processes. An overview of those processes can be found in the BCBST Provider Administration Manual located on the company website, www.bcbst.com.

Changes to readmission policy for VSHP *

Effective Jan.1, 2011, Volunteer State Health Plan will no longer authorize preventable, unplanned readmissions occurring to the same facility with like or related diagnosis within fourteen (14) days. This is a change from the VSHP previous thirty (30) days requirement for readmissions. Members that are readmitted under these circumstances are not eligible for two payments.

Exceptions to this policy include, but are not limited to the following:

- cancer diagnoses for chemotherapy,
- complications of pregnancy, or
- admissions for coronary artery bypass surgery following an admission for chest pain.

This policy applies for Cover Tennessee, BlueCare and TennCare*Select* members effective Jan. 1, 2011, and was implemented Dec. 1, 2010, for commercial lines of business.

Note: The member can not be held liable for payment of services received when not authorized.

BlueCare/TennCare*Select*

CLINICAL

Health literacy and cultural competency information available

Health literacy occurs with mutual understanding between health care providers (or anyone communicating health information) and patients (or anyone receiving health information). Using plain language and ensuring the patient understands the information being conveyed is key.

Cultural competency is an important issue facing health care providers. It is important for organizations to have and utilize policies, have trained and skilled employees, and resources to anticipate, recognize, and respond to various expectations (language, cultural and religious) of members and health care providers.

The *Health Literacy and Cultural Competency Provider Tool Kit* is available on the Provider page on the company website, www.bcbst.com, under "Administration." This tool kit provides health care professionals additional resources to better manage patients with diverse backgrounds.

Providers may also utilize **Quality Interactions®**, an e-learning program that uses case-based instruction on cross-cultural health care and is accredited for up to 2.5 hours of CME, CEU or CCM credits. This training is also available at the same location on our website at no cost to BCBST providers. Click on the Quality Interactions link and follow the instructions for registration.

BlueCare/TennCare*Select*

CLINICAL (cont'd)

Clinical advisory panel releases helpful guide

The SelectCommunity Clinical Advisory Panel recently released a handbook to assist providers working with persons with Intellectual Disabilities. The guide may be found on the company website at <http://www.bcbst.com/providers/bluecare-tenncareselect/SelectCommunity/handbook_for_providers.pdf>.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Changes to transplant evaluation requirements*

Beginning Jan. 1, 2011, transplant evaluations will require notification. Notification requests may be submitted:

- via BlueAccess, BCBST's secure area on its websites, www.vshptn.com and www.bcbst.com,
- by facsimile to 1-423-535-1994, or
- by calling Transplant Case Management at 1-888-207-2421 prior to the service being rendered.

Transplants will continue to require prior authorization.

Reminder: TENNderCare Screenings

The importance of laboratory testing and immunizations

The Bureau of TennCare requires Medicaid-eligible individuals under twenty-one (21) years of age be provided TENNderCare age-specific screenings.

Two important elements of the seven required TENNderCare screenings that should be addressed with your patients are:

- Appropriate laboratory tests according to age and health history.
- Immunizations in accordance with current American Academy of Pediatrics (AAP) recommendations.

The American Society for Clinical Laboratory Science has a website with information and resources for you and your patients at www.ascls.org/labtesting/.

If parents question the need for immunizations, you may refer them to the Centers for Disease Control and Prevention website, www.cdc.gov/vaccines. Please take advantage of all these resources, as well as
the TENNderCare tool kit and other information available on our company websites, www.vshptn.com and www.bcbst.com.

Reminder: CareCentrix to provide DME services in member home

As communicated earlier, effective Nov. 1, 2010, CareCentrix will administer and manage all durable medical equipment (DME) and medical supply services used in the home by BlueCare and TennCare*Select* members.

Please note the following:

- Applicable DME claims for dates of service Nov. 1, 2010, and after should be submitted to CareCentrix. Claims for equipment used in the home that was authorized by VSHP before Nov. 1, 2010, should be submitted to VSHP.
- This arrangement with CareCentrix only affects DME, specialty DME and medical supply providers.

Reminder: National Drug Code (NDC) claim filing requirements

The Deficit Reduction Act of 2005 requires providers to include the NDC of any drug(s) administered, along with the correct NDC and quantity qualifiers, quantity, and unit. This drug information is required on all claims even if BlueCare or TennCare*Select* is a secondary or tertiary payer. The NDC number is not required for vaccines, inpatient services, or radiopharmaceuticals, unless the drug is billed separately from the procedure. Claims received on or after Jan. 1, 2011, that do not contain all of the required data elements for physician-administered drugs will be considered non-compliant, and will be returned to the provider unprocessed. This applies to both professional and institutional claims.

Due to the sensitive placement of the data required on UB04 and CMS-1500 claim forms, we strongly encourage providers to avoid submitting handwritten claim forms. To avoid potential delays in payments, we suggest all claims containing physician-administered drugs be submitted electronically, or via typed UB04 or CMS-1500 claim forms. Please refer to the NDC billing guidelines on the company website www.vshptn.com.

Change to medical management hours of operation*

VSHP Medical Management recently changed its hours of operation for obtaining prior authorization for its BlueCare and TennCareSelect members. For physical and behavioral health prior authorization services call 1-888-423-0131 for BlueCare and 1-800-852-2683 for TennCare*Select*, Monday through Friday, 8 a.m. to 6 p.m. (ET), 7 a.m. to 5 p.m. (CT), excluding holidays.

Update: National Correct Coding Initiative Edits

Under Health Care Reform, Medicaid plans are mandated to begin using the National Correct Coding Initiative edits (NCCI). In a letter dated Nov. 5, 2010, VSHP notified you we would edit all claims for dates of service as of Oct. 1, 2010 or later effective Dec. 1, 2010. **Under new legislative guidelines, VSHP will edit claims *processed* after Dec. 6, for dates of service Oct. 1, 2010 or later.**

These edits will integrate Facility and Professional claims and deny line items on the claims that fail the edit. These edits include Procedure-to-Procedure and Medically Unlikely Edits (MUEs). Procedure-to-Procedure edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Update: National Correct Coding Initiative Edits (cont'd)

Terminology (CPT®) codes that should not be reported together for a variety of reasons. MUEs are units-of-service edits that define for each HCPCS/CPT® code the number of units of service beyond which the reported number of units of service is unlikely to be correct. For example, there may not be claims for removal of more than one gallbladder.

NCCI edits are published on the Centers for Medicare & Medicaid (CMS) website, http://www.cms.gov/MedicaidNCCICoding/

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

ADMINISTRATIVE

Reminder: Changes to timely filing for private fee-for-service (PFFS)

As previously communicated in the August 2010 issue of BlueAlert, the Centers for Medicare & Medicaid Services (CMS) is updating timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. Claims with dates of service on or after Jan. 1, 2010, received later than one (1) calendar year beyond the date of service will be denied by Medicare and BlueCross BlueShield of Tennessee's BlueAdvantage PFFS plan. Please ensure your billing staff is aware of this important change.

This change does not affect BlueAdvantage Preferred Provider Organization (PPO) as those guidelines currently indicate claims must be submitted within three hundred sixty-five (365) days from the date of service.

For more detailed information on these timely filing requirements, visit the CMS website at <http://www.cms.gov/prospmedicarefeesvcpmtgen/downloads/Health_Reform_Timely_Filing_Provider_Notice.pdf

Reminder: Billing end stage renal disease (ESRD) 50/50 modifier appropriately

The Centers for Medicare & Medicaid Services (CMS) published a notification on March 23, 2010, validating the billing of ESRD 50/50 modifier. See document at <http://www.medicarefind.com/searchdetails/Transmittals/Attachments/R661OTN.pdf>

The payment of certain ESRD laboratory services performed by an independent laboratory is included in the composite rate calculation for ESRD facilities. When billing for Automated Multi-Channel Chemistry (AMCC) ESRD-related tests, laboratories must indicate which tests are included, or are not included within the ESRD facility composite rate.
To ensure proper reimbursement, the laboratory must include one of the following modifiers for each test:

- **Modifier "CD"** – part of the composite rate and is not separately billable;
- **Modifier "CE"** – a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity; or
- **Modifier "CF"** – not part of the composite rate and is separately billable.

AMCC ESRD-related laboratory test claims without the appropriate modifier will be denied as not separately billable.

Reminder: Screening colonoscopy coding expanded

In January 2010, BCBST expanded the configuration and code mapping for screening colonoscopy. The intent of this change was to more accurately identify screening colonoscopies and apply appropriate benefits. A *Description of Codes that Point to Screening Colonoscopy Benefits* flyer is available online at <http://www.bcbst.com/providers/news/Screening_Colonoscopy_09-0041.pdf>.

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†Provider Service lines

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

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

Medical Management Hours
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CHOICES	**1-888-747-8955**
SelectCommunity	**1-800-292-8196**

Monday – Friday, 8 a.m. to 6 p.m. (ET)

BlueCare/TennCareSelect Medical Management Hours
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 Dec. 23 & 24, and Dec. 31, 2010 in observance of the Holiday Season

*These changes will be included in the appropriate 1Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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