BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

January 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Feb. 13, 2011

- Fingolimod
- Temsirolimus
- Thalidomide
- Bronchial Thermoplasty
- Progenitor Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia

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

What are modified Milliman guidelines?

BlueCross BlueShield of Tennessee alters (modifies) Milliman Care Guidelines® when guidelines do not exist for certain conditions, when length of stay needs to be defined or when consideration is given to prevailing practice in a specific area.

The BCBST Modified Utilization Management (UM) Guidelines are reviewed annually or when an inquiry is received. UM guidelines give clinically-related information to assist with decision making.

These guidelines have been revised from the USA Milliman Care Guidelines®. Milliman USA has neither reviewed nor approved the modified material. Any statement to the contrary or association of the modified material with Milliman USA is strictly prohibited. If you wish to view the complete Milliman Care Guidelines®, please contact Milliman USA.

BCBST's Modified UM Guidelines can be found at: <https://www.bcbst.com/providers/UM_Guidelines/

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 Feb. 23, 2011

The following as relates to Inpatient and Surgical Care:

- Abdominal Hysterectomy
- Deep Venous Thrombosis of Lower Extremities
- Laparoscopic Hysterectomy
- Sacral Colpopexy, Abdominal Approach
- Vaginal Hysterectomy

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

Correction: Changes to commercial 2011 preferred drug listing (PDL)

In the December issue of *BlueAlert*, we stated Ambien CR and Lunesta would require step therapy effective Jan. 1, 2011. Please be advised due to the generic equivalents soon becoming available, BCBST **will not** require step therapy of these drugs at this time. We apologize for any inconvenience this matter may have caused.

ADMINISTRATIVE

Coding and billing tips for new immunization codes

New CPT® codes 90460 and 90461 for immunization administration are effective Jan. 1, 2011, replacing old codes 90465 – 90468. Parenthetical Guidelines published by the American Medical Association in the 2011 edition of the CPT® code book should be followed when billing these new codes.

Effective Jan. 1, 2011, providers may choose to submit either the new "Q" codes (Q2035, Q2036, Q2037, Q2038, and Q2039) or 90658 for influenza vaccines. Code 90658 will become invalid for Medicare billing after 12/31/2010 dates of service and therefore, will also be invalid for BCBST BlueAdvantage products.

ICD-9-CM code set update

On Aug. 21, 2008, the U.S. Department of Health and Human Services (HHS) proposed new code sets for use in reporting diagnoses and procedures on health care transactions.

Effective Oct.1, 2013, ICD-9-CM code sets will be replaced with the ICD-10-CM code sets. In preparation of these changes we have updated our system with the expansion to accept one (1) principal diagnosis and twenty-four (24) secondary diagnosis codes for a total of twenty-five (25) diagnosis codes and twenty-five (25) procedure codes. All of the diagnosis codes can be used for medical severity reporting and Diagnosis Related Grouping (DRG) reimbursement purposes. This granularity will also help to improve efficiencies by helping to identify specific health conditions.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

P4 Pathway Oncology Program update

P4 Pathway codes have been updated on the Provider page of the company website, www.bcbst.com. Please refer to the P4 code lists for current codes or changes to the pathways. The website also provides a link to the P4 website with additional information about the P4 Pathway Oncology Program.

Reminder: What is subrogation?

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

BlueCross BlueShield of Tennessee
Subrogation Department
1 Cameron Hill Circle, Ste 0008
Chattanooga, TN 37402-0008
423-535-5847

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

BlueCare/TennCare*Select*

CLINICAL

Reminder: Medications Dispensed in a Physician's Office

Certain self-administered medications should not be dispensed in a physician's office. Claims for certain oral, topical and self-administered injectable drugs should be submitted through the BlueCare and TennCare*Select* member's pharmacy benefits manager. Practitioners should write a prescription and have the member obtain these drugs from their pharmacy. A listing of these self-administered drugs can be found on the company websites at www.bcbst.com and www.vshptn.com.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Submitting authorization requests

BlueCare/TennCare*Select* does *not* perform predetermination reviews. All requests for elective services are reviewed as prior authorization. Authorization requests can be submitted by phone, fax, mail or electronically via Blue*Access*, the company's secure page on its websites, www.vshptn.com or www.bcbst.com.

Call:

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

Fax:

BlueCare	1-800-292-5311
TennCare*Select*	1-800-292-5311

Mail:
BlueCare/TennCare*Select*
UM Support CH 4.3
1 Cameron Hill Circle
Chattanooga, TN 37402

TennCare conducts quarterly telephone survey

QSource, the External Quality Review Organization for the TennCare program, conducts a quarterly telephone survey to validate provider information.

All BlueCare and TennCare*Select* providers are contractually obligated to cooperate and comply with audits performed by the Bureau of TennCare. Data accuracy of our network providers is essential in helping to ensure TennCare patients can reach their providers and provider practice information is up-to-date in both our claims processing system and Provider Directory.

If your office is contacted by *QSource*, we encourage you to participate in the survey. *QSource* will routinely ask to verify this information with the office manager. However, it is important you make your office staff aware of these quarterly surveys so they also can be ready to respond.

If you are unsure if your provider information is up-to-date, please call our toll-free Provider Service line†.

• • • • • • • • • • • • • • • • • • •

†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)

• • • • • • • • • • • • • • • • • • •

BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

February 2011

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

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective March 10, 2011

- Hyperbaric Oxygen Pressurization Therapy (HBO2)
- Thermal Shrinkage as a Treatment of Joint Instability

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

Clinical practice guidelines adopted

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

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>

Guide to Clinical Prevent. Services
<http://www.uspreventiveservicestaskforce.org/uspstopics.htm>

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents - Third Edition
<http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html>

Treatment of Patients with Panic Disorder, Second Edition
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_9.aspx>

Hyperlinks to these guidelines are also 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.

New drugs added to commercial specialty pharmacy listing

Effective Jan. 1, 2011, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
Halaven (PA)
Jevtana (PA)
Lumizyme (PA)
Prolia (PA)
Temodar Injection (PA)
Xeomin (PA)

Provider/Self-administered via medical or pharmacy benefit:
Cinryze (PA)

Self-administered via pharmacy benefit:
Benlysta (PA)
Telaprevir

Note: The drug Arcalyst has been removed from provider-administered specialty pharmacy products and added to our self-administered specialty pharmacy products.

Reminder: Separate prescription required for Schedule II medications

Effective Jan. 1, 2011, prescribers are reminded that new law requires every written, printed or computer-generated Schedule II prescription be on a separate prescription order‡. The new law, Public Chapter 795 enacted in 2010, can be found online at <http://state.tn.us/sos/acts/106/pub/pc0795.pdf>.

If pharmacies receive multiple prescription orders on the same prescription form as an order for a Schedule II controlled substance, the pharmacy should only use the form for the Schedule II prescription record and should contact the prescriber to make him or her aware of the law and to obtain either an additional written, faxed or verbal order for the other prescriptions.

‡This new law does **not** apply to:

- inpatients of a hospital;
- outpatients of a hospital where the prescription is written into the medical order and the written order is unobtainable to the patient or patient's agent or representative;
- a nursing home, or assisted care facility as defined in TCA 68-11-201;
- inpatients or residents of a mental health hospital; or
- residential facility licensed under Title 33 or individuals incarcerated in a local, state, or federal correctional facility.

ADMINISTRATIVE

Update: Hospital outpatient code bundling edits on paid claims reinstated

The National Correct Coding Initiative (NCCI) code bundling edits for all commercial lines of business are planned for February 28 rather than January 1 as

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Update: Hospital outpatient code bundling edits on paid claims reinstated (cont'd)

previously communicated in the December *BlueAlert*. The code edits will be applied to two-months' paid claims each month until up-to-date status is reached. The edits will be applied to claims paid after Jan. 1, 2010. Reference the December 2010 *BlueAlert* for more information.

2011 HEDIS® medical record review project set to begin

BlueCross BlueShield of Tennessee and Volunteer State Health Plan, Inc. will begin annual Healthcare Effectiveness Data and Information Set (HEDIS®) projects in March 2011. This initiative is required to meet National Committee for Quality Assurance (NCQA) accreditation, as well as Bureau of TennCare and The Centers for Medicare & Medicaid Services (CMS) reporting requirements for BlueCare, TennCare*Select*, commercial and Medicare Advantage members.

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

- childhood immunizations;
- adolescent well-care visits;
- prenatal and postpartum care;
- cervical cancer screening;
- controlling high blood pressure;
- comprehensive diabetes care; and
- cholesterol management for patients with cardiovascular conditions

A representative from BCBST will be calling your office in the near future to request documentation or schedule an onsite review of medical records for data abstraction. All information should be received prior to May 14, 2011, to meet strict reporting timeframes for this project.

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

P4 Pathway Oncology Program update

As previously communicated in the January 2011 *BlueAlert*, P4 Pathway codes have been updated. Code deletions effective Dec. 31, 2010, were based on quarterly coding changes. Upcoming deletions effective March 31, 2011, are due to incompatibility with our Specialty RX program coding guidelines.

For current code lists, please refer to the P4 Pathway Oncology Program section on the Provider page on the company website, www.bcbst.com.

Reminder: Accessing Physician Quality and Cost Reporting Program

The Physician Quality and Cost Information, including 2011 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 and clicking on "Register Now!" in the *BlueAccess* section, selecting "Provider" and following registration instructions available at https://www.bcbst.com/secure/providers/. You will need to "request a shared secret"[2] for all provider ID numbers you need to access.

For more information or *BlueAccess* training, contact eBusiness Solutions at (423) 535-5717 or e-mail at 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.

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 online on our company websites www.bcbst.com and www.vshptn.com.

BlueCross earns top ranking by National Business Coalition on Health

BlueCross BlueShield of Tennessee has earned a top ranking by the National Business Coalition on Health (NBCH) through its eValue8™ health plan performance evaluation process. eValue8 is the leading evidence-based tool available to health care purchasers to assess and manage the quality of their health care vendors.

Nationally, 64 health plans participated in the most recent eValue8 evaluation process, which gathers hundreds of benchmarks in critical areas such as the adoption of health information technology, member and provider communication and support, disease management, among other measurements.

BlueCross was the highest-ranking health plan in Tennessee, and in the top 15 percent of evaluated PPO health plans on a national level. BlueCross was ranked in the country's top 10 for five of the seven modules that make up the eValue8 evaluation.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

BlueCross earns top ranking by National Business Coalition on Health (cont'd)

With this recognition by the NBCH, BlueCross has been endorsed by HealthCare 21 Business Coalition as a health plan of high value in Tennessee, which requires meeting a set of performance standards, as well as completion of the NBCH's eValue8 tool.

Additional changes to readmission guidelines

A readmission is defined as a preventable, unplanned admission occurring within fourteen (14) days after a hospital discharge to the same facility for a condition related to, or complication of the original hospital stay or admission resulting from a modifiable cause. Claims for patients at either a DRG or Per Diem[t] facility that are re-admitted under these circumstances are not eligible for two payments.

Some examples of readmissions that MAY NOT be authorized are:

- respiratory admissions, e.g., asthma, COPD, pneumonia;
- complications from surgical procedures; or
- abdominal pain.

Some examples of readmissions that MAY be authorized are:

- NICU admissions;
- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain;
- children 18 years and under admitted to any facility; or
- admissions for complication due to rejection of transplant/implant surgery.

These guidelines apply to Commercial, BlueCare/TCS, and Cover Tennessee lines of business.

[t] Effective March 1, 2011, for Per Diem facilities.

Reminder: Nurse Practitioner modifier guidelines

Nurse Practitioners (NP) are reminded they are required to file the appropriate modifier in conjunction with their contracted agreement with BlueCross BlueShield of Tennessee. Claims that do not follow this guideline will be subject to audit recovery. For more information please refer to the Billing and Reimbursement section of the *BCBST Provider Administration Manual*, located on the company website at <http://www.bcbst.com/providers/manuals/bcbstPAM.pdf>.

BlueCare/TennCare*Select*

CLINICAL

Reminder: Filing claims appropriately for Abortion, Sterilization, Hysterectomy (ASH)

VSHP covers abortions, sterilization and hysterectomies pursuant to applicable federal and state laws and regulations. For a provider to receive payment, all requirements must be met, and the corresponding paperwork (forms, medical records, etc.) must be submitted and completed in their entirety.

Abortions and services associated with the abortion procedure are covered when the abortion is 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 not institutionalized. There must be 30 days between the date of the member's signature on the consent form and the date of the sterilization procedure. However, this timeframe is reduced to 72 hours when care involves premature delivery or emergency abdominal surgery.

Hysterectomy is a covered service if it is Medically Necessary. The member or her representative, if any, must be informed orally and in writing, by completing the acknowledgement form, 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 the company's websites www.bcbst.com and www.vshptn.com for complete rules and regulations regarding billing and required documentation for these services. Checklists of requirements for each of these procedures is available on the company website at <www.bcbst.com/providers/bluecare-tenncareselect>. Failure to provide the required forms and documentation will result in claim denial for ASH procedures as well as associated services.

Reminder: Request for lead screening results

Under the TennCare program, children receive a lead screening as part of their TENNderCARE exams. You may be contacted by phone or letter from Volunteer State Health Plan requesting lead screening results for use in following up with members where appropriate.

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

BlueCare/TennCare*Select*

ADMINISTRATIVE

Registration for Electronic Health Record incentive programs

Registration for Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, administered by The Centers for Medicare & Medicaid Services (CMS), began Jan. 3, 2011. The programs provide incentive payments to eligible health care professionals and hospitals as they demonstrate meaningful use of certified EHR technology.

For more information and how to participate see the CMS website at http://www.cms.gov/ehrincentiveprograms/.

Federal Vaccines for Children guidance on new CPT® Codes for vaccine administration

The Centers for Medicare & Medicaid Services released new information regarding the Vaccines for Children (VFC) program and the new CPT® vaccine administration codes 90460 and 90461.

According to the Department of Health, reimbursement for the administration codes will continue to be based on a per-vaccine (per unit) basis and NOT on a per antigen or per component basis.

Standard rates will be reimbursed for VFC administration code 90460 for those vaccines included in the VFC program. Reimbursement for the component administration code 90461 is $0 for the VFC program.

Fee-for-service reimbursement will apply to the administration of vaccines not included in the VFC program. Reimbursement according to components will only be applied to those vaccines not available through the VFC program.

Claims with no vaccine to match the administration fee will be denied with explanation code WB8: The number of administration services for these injections must equal injections billed.

Disclosure of Ownership and Control Interest Statement

In accordance with federal requirements under 42 USCA § 1396a(p) and 42 C.F.R. § 438 *et seq* requiring payments of Medicaid funds to providers be monitored, and the contract between Volunteer State Health Plan and the State of Tennessee Bureau of TennCare, VSHP must maintain disclosure information on all its providers.

The Bureau of TennCare chose to implement this provision by use of a *Disclosure of Ownership and Control Interest Statement* form which is designed to collect the information specified in 42 C.F.R. Part 455, Subpart B.

The form must be completed by **each** practitioner, using the instructions for an "Individual" (regardless of group affiliation). Groups of practitioners should complete the form for the group as a whole or unit using the instructions for "Group of Practitioners". Facilities should complete the form using the instructions for "Disclosing Entity".

For example:

If a group of practitioners contains ten (10) practitioners, each practitioner should complete one (1) form using the instructions for Individuals. Additionally, the group as a whole should complete one (1) form using the instructions for Group of Practitioners.

A total of eleven (11) disclosure forms would be required for the example above. One (1) form completed for the Group **WILL NOT** be sufficient for each practitioner in the group.

The form must be submitted at the time a provider is initially accredited or re-accredited by VSHP, at least once every three (3) years, or whenever there is a material change in the information required by this form.

The BlueCare/TennCare*Select Disclosure of Ownership and Control Interest*

Statement is available on the company website at www.bcbst.com/providers/Disclosure.pdf.

†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)

*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.

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

March 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective April 14, 2011

- Everolimus
- Temozolomide
- Mechanical Embolectomy for Treatment of Acute Stroke
- Continuous Passive Motion (CPM) Device in the Home Setting
- Genetic Testing for BRCA1, BRCA2 or CHEK2 for Breast or Ovarian Cancer
- Endothelial Keratoplasty
- Non-BRCA Breast Cancer Risk Assessment (OncoVue®)
- Autologous Hematopoietic Stem-Cell Transplantation for Malignant Astrocytomas and Gliomas

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

Smoking cessation support

BCBST offers support for our members who are trying to stop smoking. Through our Health Information Library, members are able to listen to educational information such as second-hand smoking, hazards of smoking and smoking during pregnancy. Members can contact BCBST Customer Service at the phone number on the back of their member ID card to learn if they are eligible for behavioral management and counseling to help with smoking cessation. Tennessee residents can access the Tennessee Tobacco Quit Line toll free at 1-800-QUITNOW (1-800-784-8669). The hearing impaired may call 1-877-559-3816. Callers can receive a FREE Tobacco Quit Kit, work with a FREE Quit Coach and learn to deal with tobacco cravings and other challenges. For more information access the Surgeon General's Guideline for treating tobacco use and dependence at <http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf>.

ADMINISTRATIVE

Reminder: Filing National Provider Identifier (NPI)

BCBST follows CMS guidelines as it pertains to requiring the submission of the Ordering/Prescribing Physician's NPI. If the NPI is not valid BCBST will return the claim.

Reminder: Filing surgical equipment claims correctly

Providers are reminded that charges for any device or medical equipment used in conjunction with a surgical procedure must be billed by the facility. Separate claims submitted by a DME supplier for any charges related to the facility service will result in zero reimbursement, i.e., pneumatic compression devices. The member cannot be held liable in these cases, as reimbursement for DME is part of the all-inclusive global payment for inpatient and/or outpatient surgeries to contracted facilities.

Should a facility choose to partner with a DME supplier to provide equipment/supplies associated with the facility services, the facility will be responsible for submitting all charges to BCBST as well as payment of the DME supplier.

These guidelines are in accordance with the BCBST Institution Agreement. Contact your local Network Manager for any questions concerning your provider contract.

Reminder: Filing corrected bills appropriately

Claims that have been processed and paid incorrectly because of an error or omission on the claim may be filed as a **"Corrected Bill"**. BCBST is receiving claims filed as a corrected bill with no indicated changes. A corrected bill must include additional/changed dates of service, codes, units, and/or charges that were not filed on the original claim.

Providers are encouraged to review the Billing and Reimbursements section of the BCBST and VSHP Provider Administration Manuals, located on the company websites, www.bcbst.com and www.vshptn.com for detailed information for filing corrected paper and electronic claims.

Claims subject to retrospective review

BlueCross BlueShield of Tennessee retrospectively audits BCBST Medicare Advantage, CoverKids and CoverTN claims for improper payments.

The identification of improper payments will occur for claims according to provider contractual requirements. Claims submitted by a provider to BCBST on a CMS-1450 (UB04) or CMS-1500 claim form are subject to audit.

BCBST will perform **Complex Reviews**, a thorough review of a medical record for coding validation and utilization review, and **Automated Reviews**, where no medical record is required. All complex reviews are performed with Corporate Medical Director oversight by physicians, RNs and certified coders.

For more information refer to Frequently Asked Questions (FAQs) available on the Provider page of the company website, www.bcbst.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Clarification: Nurse Practitioner modifier guidelines

Nurse Practitioners (NP), billing as an Assistant-at-Surgery, are required to file the appropriate modifier in conjunction with their contracted agreement with BlueCross BlueShield of Tennessee. Claims that do not follow this guideline will be subject to audit recovery. Refer to the Billing and Reimbursement section of the *BCBST Provider Administration Manual* found on the *BlueSource Provider Information* CD or on the company website, www.bcbst.com for appropriate billing guidelines.

Reminder: EC Gateway password

Your EC Gateway (ECG) communication system password expires every 45 days. The new password must be at least eight characters in length, contain at least one alpha and one numeric character, and can not be reused. To access the ECG Bulletin Board System (BBS) each user must have his/her own user ID and password. This can be requested by completing an electronic provider profile, available on our website at <http://www.bcbst.com/providers/ecomm/getting_started/profile_provider.pdf>.

For more information or ECG User ID and Password maintenance, contact eBusiness Solutions at (423) 535-5717.

BlueCare/TennCare*Select*

CLINICAL

Incontinence Supplies

Adult incontinence supplies are provided to prevent skin deterioration, ulceration, and other complications that may occur due to loss of bladder or bowel control. Requests for incontinence supplies require prior authorization. Requests will be reviewed by CareCentrix based on Medical Necessity and on the individualized needs of the member.

Important Reminder: LDL-C & HbA1c Initiative: Diabetes Gaps in Care

Volunteer State Health Plan, Inc. (VSHP) recently launched an initiative for BlueCare and TennCare*Select* members. As part of this initiative, VSHP partnered with LabCorp to use Lab-In-An-Envelope, an alternative approach to closing gaps in comprehensive diabetes care. Our goal is to work with providers to improve diabetes care by increasing HbA1c and LDL-C test rates.

Lab-in-an-Envelope kits, with easy-to-follow instructions, are mailed to non-compliant diabetic members who have gaps in LDL-C and HbA1c testing upon receipt of your authorization. This is a dry spot testing kit that contains all the necessary collection supplies. The test kit is then mailed back in a pre-addressed, pre-paid envelope. Lab results will be faxed to your office to help in managing your patient's care.Some providers may receive an on-site 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 patients with diabetes that show gaps in care for HbA1c-and/or LDL-C.

Providers may send individual or batch authorizations for identified members. If you have any questions, call VSHP Disease Management 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 website at <http://www.bcbst.com/providers/forms/Lab-in-an_Envelope_MD_Fax.pdf>, or you may request the authorization form from Disease Management.

Reminder: TENNderCare screenings

The importance of laboratory testing and immunization

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.

Federal Vaccines for Children guidance on new CPT® Codes for vaccine administration

The Centers for Medicare & Medicaid Services released new information regarding the Vaccines for Children (VFC) program and the new CPT® vaccine administration codes 90460 and 90461.

According to the Department of Health, reimbursement for the administration codes will continue to be based on a per vaccine (per unit) basis and NOT on a per antigen or per component basis.

Standard rates will be reimbursed for VFC administration code 90460 for those vaccines included in the VFC program. Reimbursement for the component administration code 90461 is $0 for the VFC program.

Fee-for-service reimbursement will apply to the administration of vaccines not included in the VFC program. Reimbursement according to components will only be applied to those vaccines not available through the VFC program.

BlueCare/TennCare*Select*

CLINICAL (cont'd)

Federal Vaccines for Children guidance on new CPT® Codes for vaccine administration (cont'd)

Claims with no vaccine to match the administration fee will be denied with explanation code WB8: The number of administration services for these injections must equal injections billed.

ADMINISTRATIVE

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. Your policies and procedures should include verbiage to address whistleblower protection. You should also have training available for all your staff to include this information.

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

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 websites at <http://www.bcbst.com/providers/forms/Member_Appeal_Poster.pdf> or <http://www.vshptn.com/providers/Member_Appeal_Poster.pdf> Please be sure to display this poster in your office for BlueCare and TennCare*Select* members.

Cover Tennessee

CLINICAL

Maternity/Newborn Benefits

Women covered under CoverTN are eligible for maternity benefits through CoverKids/HealthyTNBabies. This coverage also provides routine care for the newborn while the mother is confined to the hospital. Non-routine services are not covered, therefore, the parent/guardian must obtain coverage for the newborn for these services. If no coverage options are available, the parent/guardian may apply for coverage through CoverKids for the newborn.

BlueAdvantage®

ADMINISTRATIVE

Resource available for new physicians

The U.S. Department of Health & Human Services Office of Inspector General has published a roadmap for new physicians: *Avoiding Medicare & Medicaid Fraud and Abuse*. This resource assists physicians in understanding how to comply with federal laws by identifying red flags that could lead to potential liability in law enforcement and administrative actions. The key issues addressed in this brochure are relevant to all physicians, regardless of specialty or practice setting and can be downloaded free of charge at <www.oig.hhs.gov/fraud/PhysicianEducation>.

CAHPS survey results are in! Plan H4979, H5884 & H7917

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. On average 70.9% of BCBST members surveyed, responded.

The 2010 CAHPS survey of MA and MA Prescription Drug (MA-PD) plans was conducted from February 2010 through June 2010. One of thirty-seven (37) Private-Fee-For-Service (PFFS) MA plans and one out of ten Preferred Provider Organization (PPO) plans in Tennessee participated in the survey. This summary highlights the results of the survey for all BlueAdvantage health plans.

BlueAdvantage scored above the national average on all measures, including:

- Health Plan Customer Service
- Getting Needed Care
- Getting Needed Prescription Drugs

Even though all BlueAdvantage health plans exceeded the national average on all measures, we believe that opportunities for improvements exist. The areas that remained the same between 2009 and 2010 include:

- Getting Care Quickly
- Doctors Who Communicate Well
- Rating of Care Received
- Rating of Personal Doctor
- Overall Rating of Prescription
- Drug Coverage

Survey results reflect not only the member's satisfaction with our overall plan, but about services they received from you, their physician. To review the CAHPS data further, refer to the Provider page of our company website, www.bcbst.com.

Readmission guidelines for BlueAdvantage PPO*

A readmission is defined as a preventable, unplanned admission occurring within fourteen (14) days after a hospital discharge to the same facility for a condition related to, or complication of the original hospital stay or admission resulting from a modifiable cause. Claims for patients at either a DRG or Per Diem± facility that are re-admitted under these circumstances are not eligible for two payments.

BlueAdvantage®

ADMINISTRATIVE (cont'd)

Readmission guidelines for BlueAdvantage PPO (cont'd)*

Some examples of readmissions that MAY NOT be authorized are:

- respiratory admissions, e.g., asthma, COPD, pneumonia;
- complications from surgical procedures; or
- abdominal pain.

Some examples of readmissions that MAY be authorized are:

- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain; or
- admissions for complication due to rejection of transplant/implant surgery.

These guidelines apply to BlueAdvantage PPO line of business. Members cannot be held liable for charges associated with a readmission within 14 days of a previous admission

± Effective April 1, 2011,

Changes to prior authorization requirements for therapy services*

Effective April 1, 2011, BlueAdvantage PPO will require prior authorization for all

therapy services performed in a home or outpatient setting. This includes all physical therapy, occupational therapy and speech therapy. An advanced determination is recommended for these services for BlueAdvantage PFFS members.

To process your initial request quickly, 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. If additional visits are needed, all concurrent review requests should be faxed to BlueAdvantage utilization management at 1-888-535-5243.

BlueCard®

ADMINISTRATIVE

Out-of-area Blue member's medical policy and prior authorization requirements now easier to access

BCBST provides you easy access 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. We have now added additional access points to this information.

Three options are now available to access medical policy and prior authorization requirements from the Provider page of the company website, www.bcbst.com:

Option 1.
- Logon to BlueAccess
- Click the **BlueCard/FEP** link
- Click on **Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization**

Option 2 (Direct access via Quick Links)
- Click **Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization**

Option 3 (Under BlueCard)
- Choose **More>**
- Under the Additional Information tab Click **Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization**

With any of the three options 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. For questions or feedback, contact us at 1-800-705-0391.

Health Reimbursement Account (HRA) information now available on the Patient Inquiry screen of BlueAccess.

• • • • • • • • • • • • • • • • • • •

†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)

• • • • • • • • • • • • • • • • • • •

*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.

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

April 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective May 14, 2011

- Eribulin Mesylate
- Botulinum Toxin
- Naltrexone (Vivitrol™)
- Hematopoietic Stem-Cell Transplantation for Miscellaneous Solid Tumors in Adults
- Manipulation of the Musculoskeletal System Under Anesthesia
- Deep Brain Stimulation
- Electrical Stimulation and Electromagnetic Therapy for the Treatment of Wounds/Ulcers
- Plasma Exchange
- Proteomics-based Testing for the Evaluation of Ovarian (Adnexal) Masses

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

Clinical Practice Guidelines adopted

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

ACC/AHA 2007 Guidelines for the Mgt. of Patients with Unstable Angina/Non–ST-Elevation MI
<http://circ.ahajournals.org/cgi/reprint/116/7/e148>

Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack. A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association
<http://stroke.ahajournals.org/cgi/reprint/STR.0b013e3181f7d043v1>

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

2009 Focused Updates: ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction (Updating the 2004 Guideline and 2007 Focused Update) and ACC/AHA/SCAI Guidelines on Percutaneous Coronary Intervention (Updating the 2005 Guideline and 2007 Focused Update)
<http://circ.ahajournals.org/cgi/content/full/120/22/2271>

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

Standards of Medical Care in Diabetes - 2011
<http://care.diabetesjournals.org/content/34/Supplement_1/S11.full.pdf+html>

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

Helping Patients Who Drink Too Much: A Clinician's Guide, Updated 2005 Edition
<http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm>

Treatment of Patients with Major Depressive Disorder, Third Edition
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx>

Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder
<http://www.aacap.org/galleries/PracticeParameters/JAACAP_ADHD_2007.pdf>

Hyperlinks to these guidelines are also available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company Web site at http://www.bcbst.com/providers/hcpr/.

Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Reminder: IV flush solutions not separately reimbursed

BlueCross BlueShield of Tennessee considers heparin, saline, and fluids utilized to mix, facilitate administration of primary medication therapy, flush or maintain intravenous access devices to be supplies included in professional infusion services or home infusion therapy (HIT) per diems.

Based on CPT® guidelines, "if performed to facilitate" an infusion or injection, the flush at conclusion, standard tubing, syringes and supplies are included in the service provided and "fluid used to administer the drug(s) is considered incidental".

Historically, allowances for fluids used to facilitate administration, heparin and saline flushes were included in calculations for development of HIT per diem allowances.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

Personal Health Analysis (PHA)

BlueCross BlueShield of Tennessee offers members a Personal Health Analysis to help them become aware of potential health risks and things they can do to help avoid future illness or health concerns. Members can print their analysis and bring it to their next visit with you. BCBST does not consider the PHA a substitute for a physical check-up or for identification of specific illnesses. We encourage our members to talk to their doctor about any specific health concerns. In addition, the PHA may show members they are eligible for certain lifestyle and health coaching programs.

For more information about PHA refer to our company website at <http://www.bcbst.com/tools/personal-health-analysis/overview.shtm>

Billing guidance for necessary medication wastage

When necessary to discard a portion of a single dose vial, documentation of time, date, drug name, dosage administered, amount wasted and route of administration in the medical record is expected.

Wastage amounts may be billed for medications only manufactured in single dose vials (SDV). The provider is responsible for using the most economical packaging to achieve the required dosage with the least amount of wastage necessary.

Bill the total amount of the discarded and administered medication on a single line with a "JW" modifier appended. The units are to be billed in accordance with the amount defined by the code description.

Preconception counseling

When preconception counseling is provided, you will find the Centers for Disease Control and Prevention (CDC) is a rich source of information for men and women in their child bearing years. The CDC's recommendations are considered evidence based and designed for optimal reproductive health outcomes for women and couples. The CDC provides resources for women with pre-existing conditions, and recommends a reproductive life plan to set personal goals about having (or not having) children. Access the CDC's website at <http://www.cdc.gov/ncbddd/preconception/QandA_providers.htm>.

Additional information is available through the March of Dimes at http://www.marchofdimes.com/pregnancy/getready_indepth.html.

New crisis hotline announced

The Tennessee Department of Mental Health (TDMH) announced a new statewide phone number for mental health and substance use crisis services. Please visit their website at <http://news.tennesseeanytime.org/node/6719> for the announcement and complete information.

ADMINISTRATIVE

Submission of claims for covered and non-covered services is a requirement and not a courtesy to members

BlueCross BlueShield of Tennessee and Volunteer State Health Plan contracted providers assure that all legitimate charges for covered services will be submitted for payment. It is the provider's contractual obligation to make sure claims are submitted in a timely manner for the member. Submission of claims is not a courtesy to the member, it's a requirement.

If a provider renders a non-covered service, or the member requests a non-covered service that is considered investigational or cosmetic, it is recommended the provider have the member complete the **Acknowledgement of Financial Responsibility** form for the cost of the services**.** This form will make the member aware the services will not be covered under their health benefit plan. The Acknowledgement of Financial Responsibility form can be found in the BCBST and VSHP Provider Administration Manuals located on the company website, www.bcbst.com or on the Blue*Source* Provider Information CD.

Valid member ID required for phone inquiries

When calling BlueCross BlueShield of Tennessee Provider Service for benefits, eligibility or claims information, you are asked to give a valid member identification number. This information is necessary for us to help you in the most efficient manner. Beginning April 12, you will no longer be able to access member information without a valid member ID.

Reminder: Accessing Physician Quality and Cost Reporting Program

The Physician Quality and Cost Information, including 2011 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 and clicking on "Register Now!" in the *BlueAccess* section, selecting "Provider" and following registration instructions available at https://www.bcbst.com/secure/providers/. You will need to "request a shared secret"[2] for all provider ID numbers that you need to access.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Accessing Physician Quality and Cost Reporting Program (cont'd)

For more information or *BlueAccess* training, contact eBusiness Solutions at (423) 535-5717 or e-mail at 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.

State of Tennessee public sector plan outpatient authorization requirements

Effective Jan. 1, 2011, all outpatient invasive procedures require prior authorization. This does not apply to procedures performed in an office setting. The requirement applies to all State of Tennessee commercial members with member ID prefixes of STA, STT, STG and STL under Group # 80860.

BlueCare/TennCare*Select*

CLINICAL

Reminder: Request for lead screening results

Under the TennCare program, children receive a lead screening as part of their TENNderCARE exams. You may be contacted by phone or letter from Volunteer State Health Plan requesting lead screening results so we can follow up with members where appropriate.

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

BlueCare/TennCare*Select*

ADMINISTRATIVE

Clarification: National Drug Code (NDC) claim filing requirements

Providers were previously notified that any claim **received** after Jan. 1, 2011, that did not have the correct NDC codes would not be processed and returned to the provider unpaid. According to the Bureau of TennCare this applies to all claims **processed** after Jan. 1, 2011. Therefore, any claim received, or processed after Jan. 1, 2011, must have the NDC screening. If the information was not included, there may be recoupment for funds previously paid on incomplete claims. This applies to claims that were returned to VSHP for adjustments or reconsideration with requested medical information.

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.

BlueAdvantage®

ADMINISTRATIVE

Reminder: Filing BlueAdvantage claims appropriately

For BlueAdvantage members who have elected the Medicare hospice benefit, services that are not related to the member's terminal diagnosis should be billed to the provider's Intermediary or Medicare Administrative Contractor. Services that should be filed to your local BlueAdvantage Plan and not to the Intermediary or Medicare Administrative Contractor during a hospice election include non-Medicare covered services, such as routine dental, vision and hearing services.

Reminder: Guidelines for reopening, reconsideration and appeal of adverse determinations/denials

Reopening
A Reopening is filed when a provider disagrees with a denial related to medical necessity. A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

There must be new material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.

BlueAdvantage®

ADMINISTRATIVE (cont'd)

Reminder: Guidelines for reopening, reconsideration and appeal of adverse determinations/denials (cont'd)

The following are guidelines for a reopening request:

- The request must be made in writing
- Must be clearly stated;
- Must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted).
- Timely submission of additional information (CMS 130.2)

For additional information on **Guidelines for a Reopening** go to The Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/manuals/downloads/mc86c13.pdf>

Reconsideration

Reconsiderations are filed when a provider disagrees with a denial related to coding or reimbursement.

The Inquiry/Reconsideration Level is the first step in the Provider Dispute Resolution Procedure.

A written request for a standard reconsideration of the denial must be submitted within sixty (60) calendar days from the date of the notice of the determination. If applicable, include all pertinent information including prior correspondence, medical records, and all documentation you wish to have considered in the final determination of the dispute.

Appeal

If dissatisfied with the outcome of the reconsideration review, providers can file an appeal request within 30 days of receipt of the reconsideration response.

The appeal request should state:

- The reason for the appeal
- Why the provider is dissatisfied with the reconsideration response
- Any additional information the provider would like considered in support of the appeal request

Guidelines for requesting a reconsideration or appeal are outlined in the *Provider Dispute Resolution Procedure* (PDRP).

The procedure and Provider Dispute Form are available in the *BlueCross BlueShield of Tennessee Provider Administration Manual* located on the *BlueSource Provider Information CD* and also on the Provider page of the company website, www.bcbst.com.

---

†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)

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

May 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective June 11, 2011

- Minimally Invasive Coronary Artery Bypass Graft Surgery
- Cervical Traction Devices for Home Use
- Bariatric Surgery for Morbid Obesity
- Electrical Bone Growth Stimulation
- Ultrasound Accelerated Fracture Healing Device
- Radioembolization for Primary and Metastatic Tumors of the Liver

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

Non-preferred Angiotensin II Receptor Agonists (ARB) Step Therapy.

Several months ago, you were notified that members taking non-preferred ARBs and combination drugs will be placed on a Step Therapy process starting Jan. 1, 2011. However, members currently taking a non-preferred ARB were grandfathered until April 1, 2011, to give the prescriber an opportunity to evaluate alternative drug treatments.

We did not apply the step edit on April 1, 2011, for members who were grandfathered. Grandfathered members can continue their current medication with no disruption.

Any members who are a new start on an ARB will have to meet the Step Therapy requirements as outlined in the formulary booklet.

New codes established for ophthalmological services

Effective Jan. 1, 2011, AMA published three (3) new CPT® codes (92132, 92133 and 92134) for special ophthalmological services.

92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

The description for each of these codes includes the wording "unilateral or bilateral." It is not appropriate billing to report these codes on multiple lines or with multiple units to indicate a bilateral procedure. The correct way to report these services, whether performed on one or both eyes, is with one (1) code and one (1) unit.

New drugs added to commercial specialty pharmacy listing

Effective April 1, 2011, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
Krystexxa (PA)
Gemzar
Makena (PA)
Xgeva (PA)

The drug Benlysta (PA) has been removed from self-administered specialty pharmacy products and added to our provider-administered specialty pharmacy products.

BCBST agreement with Progeny expands to self-funded groups

Beginning May 1, 2011, BlueCross BlueShield of Tennessee is pleased to announce that under our agreement with ProgenyHealth, benefits provided to fully insured members will also be available to self-funded groups.

ProgenyHealth is a company specializing in neonatal care management services throughout the first year of life. Under our 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 fully insured members with premature and medically complex newborns.

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

If you have questions or need additional information, please contact Beverly West, Manager Condition Management at 423-535-3523, or e-mail Beverly_West@bcbst.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Guidelines for submitting claims with neoplasm diagnoses

Providers are reminded there are specific guidelines to follow when coding for malignancies. The following is a synopsis of ICD-9-CM coding guidelines and is not meant to encompass the guidelines in their entirety. Please refer to your ICD-9-CM coding guidelines for further clarification.

ICD-9-CM classifies neoplasms by system, organ, and/or site. But, the alphabetic index should first be checked to see if there is a specific code assigned to a morphological type, such as sarcoma, adenoma, or melanoma.

- If the reason for admission is determined to be a neoplasm, then the focus of the treatment can be utilized to select the correct code for the principal diagnosis. If treatment is directed at the primary neoplasm, then the malignancy is the principal diagnosis. If the reason for treatment is directed only at a secondary site, the metastatic site is the principal diagnosis and the primary site is the secondary diagnosis.
- An exception to the above is when the admission is ONLY for administration of radiotherapy, immunotherapy or chemotherapy. In this event, the principal diagnosis or first-listed diagnosis is V58.x, followed by the secondary code(s) for the site(s) of the malignancy.
- Frequently, a patient with a malignancy may need to be admitted with an acute condition or complication, such as anemia or dehydration. This may be due to the malignancy itself or the therapy being received. If treatment is being directed toward the acute condition, list the treatment as the principal diagnosis with the malignancy listed as the secondary diagnosis.
- If the patient is admitted for definitive therapy such as: surgical removal of a neoplasm, diagnostic procedures or to determine the extent of a malignancy and the patient receives radiotherapy, immunotherapy or chemotherapy during the admission, the malignancy is listed as the principal diagnosis or first-listed diagnosis with V-codes not being assigned.
- If a patient is admitted with a symptom, sign, or ill-defined condition associated with an existing primary or secondary site malignancy, the malignancy is the principal or first-listed diagnosis.
- When the reason for an admission is management of pain due to the neoplasm, the principal or first-listed diagnosis is 338.3 followed by the underlying neoplasm. When the admission is management of the neoplasm and pain is also documented as related to the neoplasm, code 338.3 can be submitted as a secondary diagnosis with the primary or first-listed diagnosis being the neoplasm.

Note: These guidelines are in accordance with the BCBST Institution Agreement and are referenced from *Ingenix 2011 ICD-9-CM for Hospitals Coding Guidelines*, Chapters 2 and 6 and *The Coding Edge Archives*. Contact your local Provider Network Manager for any questions concerning your provider contract.

Reminder: Collection of member copayments

A copayment is the amount a member pays each time he or she receives services at a participating provider's office. Some member copayment amounts may be $0 on annual Well Visits. Member copayments vary based on the member's health benefit plan. You can collect a copayment from the member at the time of the office visit, however, you may only collect the amount specified in the member's health benefit plan.

You can verify the member copayment by calling our Provider Service line, 1-800-924-7141, Monday through Friday, 8 a.m. to 5:15 p.m. (ET). When you speak with a representative, please have available the member's identification number that is reflected on the member ID card.

You can also obtain the member copayment amounts on BlueAccess, BCBST's secure area on its website, www.bcbst.com. You will need a shared secret number to access this site. If you have not registered, just click "Register Now" and follow the easy instructions.

Pathology and laboratory coding updates

A new code, CPT® 80104, effective Jan. 1, 2011, was created to report a qualitative drug screen of multiple drug classes (other than chromatographic method). The description of CPT® 80104 is *Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure.* This new code was established to allay confusion when reporting qualitative analysis using a multiplexed method for 2-15 drugs or drug classes (e.g., multi-drug screening kit).

CPT® code 80104 represents a kit and is used once per kit. The language of the code says "each procedure" so it would be reported for each procedure that is used. It isn't billed by drug or drug class but rather by procedure(s) used other than chromatography.

These test kits are commercially available for twelve (12) or more analytes, and are often called "multiplexed" because of the ability to qualitatively assay multiple drugs simultaneously. It is effectively running multiple tests at once, in a single procedure, due to the test kit design. In 2010, the HCPCS code G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay) was created to describe a non-chromatographic method wherein multiple drug classes were screened in a single procedure. The new 2011 CPT® code 80104 represents this same procedure, more accurately reflecting the resources used in a multiplex test kit as compared to multiple runs using a single class methodology. Medicare does not recognize 80104 but rather accepts G0431. CPT® 80104 would be used for commercial carriers. G0431 would be used for Medicare Advantage. Either should be billed with one unit per encounter. Additional information can be obtained at the CMS website, www.cms.gov/ or the *AMA CPT® Assistant.*

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: BCBST refund requests

For all BCBST provider networks, other than those supporting the TennCare Program, BlueCross' request for reimbursement shall be made no later than eighteen (18) months after the paid date, except in the case of provider fraud, in which case no time limit shall apply. This is in accordance with Tennessee State Statute TCA 56-7-110.

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

Changes to Patient Protection and Affordable Care Act (PPACA)

With the recent passage of the Patient Protection and Affordable Care Act, commonly known as the Health Care Reform Act, there are some changes that address the topic of "Overpayments." The provision entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act (FERA).

This provision of the Health Care Reform Act applies to providers of services, suppliers, Medicaid Managed Care Organizations (MCOs), Medicare Advantage organizations, and Medicare Prescription Drug Program Sponsors. It does not apply to beneficiaries.

The provision directly links the retention of overpayments to false claim liability and makes explicit that overpayments must now be reported and returned to States within sixty (60) days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After sixty (60) days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including damages of three times the amount in penalties. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the Affordable Care Act.

Please follow the link to the State of Tennessee website for further materials on the issue. http://www.tn.gov/tenncare/

Note: This information applies to BlueCare, TennCare*Select* and BlueAdvantage only.

Reminder: Screening colonoscopy is covered at 100 percent by most benefit plans±

Under the Affordable Care Act, preventive services with an A or B rating from the U.S. Preventive Services Task Force are covered with no member cost share. Colorectal cancer screening is one of the A or B rated items. Prior to the Affordable Care Act, many employer groups chose to cover colorectal cancer screenings with no member cost share, or minimal cost share such as a modest copay. However, some members in these groups complained that when presenting for a screening colonoscopy they received benefits for a diagnostic colonoscopy, often subject to deductible and coinsurance.

In 2010, code mapping was expanded for screening colonoscopy so that members obtaining colonoscopy procedures **intended** to be screenings will receive benefits for screenings.

For a description of codes that point to screening colonoscopy benefits see the Provider page on the company website at www.bcbst.com.

± May not apply to grandfathered plans as defined in the Affordable Care Act

BlueCare/TennCare*Select*

CLINICAL

Smoking cessation support for pregnant women

TennCare and Volunteer State Health Plan have joined together to tackle the issue of smoking among pregnant women in Tennessee, and we need your help. As a health care provider, you are in the best position to assist in this endeavor. It could be as easy as asking two key questions: "Do you smoke?" and "Would you like to quit?"

Did you know that if a pregnant woman answers yes to those key questions, you can refer them the very same day for counseling through the Tennessee Tobacco QuitLine's fax referral service? All that is required is for the provider and patient to complete the *TN Tobacco QuitLine Fax Referral Service Enrollment Form* that is found online at http://health.state.tn.us/tobaccoquitline.htm, then fax the completed referral form to 1-800-646-1103.

Many patients may not be aware of the consequences of smoking while pregnant. They may not know their baby may be at a greater risk for ear infections, asthma, bronchitis, sinus infections, colds and even learning disabilities if they continue to smoke. So, they may just need someone to point out these risks to them.

They may also be unaware of the resources available to them. For instance, did you know the Tennessee Tobacco QuitLine is a FREE program that will work with expecting mothers? The QuitLine will send you a status report of your enrolled patients to keep you informed of their progress.

The toll free number to the Tennessee Tobacco QuitLine is 1-800-QUIT-NOW (1-800-784-8669).

TennCare Specialty Pharmacy Master Clinical Drug List updated

Please note there have been updates to the TennCare ***Specialty Pharmacy Master Clinical Drug List***, and an addition of ***Specialty Pharmacy Medication Requiring Prior Authorization*** on company websites, www.vshptn.com and www.bcbst.com on the BlueCare/TennCare*Select* Provider page.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Hearing aid replacement batteries

Hearing aid replacement batteries are covered for BlueCare and TennCare*Select* members under the age of 21. Audiologists should provide batteries to members as part of their covered services. If you have questions, please call the appropriate BlueCare or TennCare*Select* Provider Service line†.

Reminder: Behavioral health services

Behavioral health services are based on a fiscal year (July to June) and not the calendar year. Outpatient services that fall in the "by pass" category should be reviewed for the need for authorization. Please contact Provider Network Services if you have any questions.

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.

Note: 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.

BlueAdvantage®

ADMINISTRATIVE

BlueAdvantage provider questions

Have questions? We have answers! No matter what is on your mind, don't hesitate to call our BlueAdvantage Provider Service team for help. When you need us, we're only a phone call away. You may reach us at 1-800-841-7434, Monday through Friday, 8 a.m. to 5 p.m. (ET).

Medicare home health face-to-face encounter

The Centers for Medicare and Medicaid Services (CMS) issued an update to the Home Health Prospective Payment System for 2011. One provision of interest is the face-to-face encounter. Under the new rule, a physician certifying a patient's eligibility for Medicare's home health benefit must have a face-to-face encounter with the patient prior to certification of the patient's eligibility for home health services. As a condition of payment, documentation regarding the face-to-face encounter must be present starting April 1, 2011. The face-to-face encounter must occur within ninety (90) days **prior** to the start of home care or within thirty (30) days **after** the start of care.

Although this rule pertains to Medicare, it is optional for Medicare Advantage plans. As a Medicare Advantage plan, Blue Advantage will require the face-to-face encounter and will validate through random audits.

For more information on this rule, home health agencies can go online to www.cms.gov/center/hha.asp.

Cover Tennessee

ADMINISTRATIVE

Reminder: Refer patients to in-network providers

Patients with coverage through CoverKids or the HealthyTNBabies Programs must see providers participating in Blue Network S to receive benefits. Unless the visit is determined to be an emergency, there will be no benefits payable for services rendered by a provider who does not participate in Blue Network S. This includes pregnant women who see an in-network OB-GYN but deliver at an out-of-network facility. Therefore, we ask that you please refer these patients to providers and/or facilities participating in Blue Network S.

Overpayments for maternity services

A number of providers were recently made aware of overpayments made by BCBST for multiple office visits for maternity services that were provided to pregnant women for various lines of business, but primarily CoverKids. These overpayments were identified as a result of a recent claims audit. Although we are currently implementing system changes which should help identify possible overpayments before payment is made to the provider, we encourage providers to ensure they bill for these services according to BCBST and nationally accepted billing guidelines.

• • • • • • • • • • • • • • • • • • •

†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)

• • • • • • • • • • • • • • • • • • •

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

June 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective July 9, 2011:

- Dasatinib
- Denosumab
- Alemtuzumab
- Neuromuscular Electrical Stimulation
- Cytoreduction and Hyperthermic Intraperitoneal Chemotherapy for the Treatment of Pseudomyxoma Peritonei and Peritoneal Carcinomatosis of Gastrointestinal Origin
- Extracorporeal Photopheresis
- Interferential Stimulation for the Treatment of Pain
- Hematopoietic Stem Cell Transplant for Breast Cancer
- Positron Emission Mammography

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

New Medication Assisted Treatment Program Announced

Beginning July 1, 2011, BlueCross BlueShield of Tennessee is pleased to announce a new Medication Assisted Treatment (MAT) program for BCBST members who have their pharmacy benefit administered by BCBST. This program is designed for those members who are challenged with chemical dependency to such substances as narcotic-containing pain medication (e.g. hydrocodone, oxycodone, etc.) and/or alcohol. It was developed to provide safe and effective management of medication(s) used for sobriety management.

The program includes doctorate-level pharmacist review and care management to support member participation in therapy and community programs such as AA/NA. The program will begin July 1, 2011.

Changes to prior authorization requirements for select procedures

For dates of service July 5, 2011 and after, additional prior authorization will be required for commercial lines of business for the following procedures in an inpatient or outpatient setting:

- Panniculectomy
- Varicose Veins
- Blepharoplasty
- Tonsillectomy and Adenoidectomy
- Tonsillectomy under age three (3)
- Bariatric Surgery
- Breast Surgery for Augmentation or Reduction
- 72-hour Ambulatory Glucose Monitoring
- Neurobehavioral Status Exam
- Destruction of Cutaneous Vascular Proliferative Lesions less than 10 sq. cm (laser technique)
- Gastrointestinal Tract Imaging
- Hysterectomy
- Spinal Surgery

Effective July 5, 2011 retrospective review will be eliminated for cardiac rehabilitation.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

All Blue 2011 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.

Appropriate billing for Eculizumab (Soliris®)

Eculizumab is considered medically necessary and eligible for coverage for the treatment of paroxysmal nocturnal hemoglobinuria for the purpose of reducing hemolysis. Eculizumab is considered investigational for all other uses. Note, a medical policy does not determine benefits, the member's health benefit plan must be reviewed.

All claims subject to audit

All claims submitted to BlueCross BlueShield of Tennessee and any of its affiliates and/or its subsidiaries for

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

All claims subject to audit (cont'd)

reimbursement are subject to audit for the purpose of verifying the information submitted is correct, complete, in accordance with provider contract requirements, and supported by established coding guidelines.

Claims audited are subject to the Provider Dispute Resolution Process. If you wish to dispute a claim adjustment resulting from an audit, please remember: When submitting your reconsideration or appeal, medical records for the date of service must be included to support all lines billed on the claim. Codes billed but not supported by documentation will be denied.

DRG threshold updates*

Effective immediately commercial business, excluding Cover Tennessee, will be decreasing DRG threshold updates from seven (7) days to five (5) days, in an effort to be more proactive with discharge planning.

Provider contract enrollment information available on BCBST website

A new Provider Contracting Enrollment Information page has been added to the BlueCross BlueShield of Tennessee website. Included in this page is a link to the *Provider Online Contract Request* form and *Provider Network Enrollment Frequently Asked Questions*. This information explains the Provider Contract Enrollment process and breaks down the departments involved including important information for completing an application for participation in BlueCross BlueShield of Tennessee provider networks.

Go to the company website at http://www.bcbst.com/providers/ and look down the middle of the page, then click on Provider Contracting.

Skilled Nursing Facility (SNF) billing reminder

Skilled Nursing Facility (SNF) claims must be billed on a CMS-1450/ANSI 8371, following the UB format. Inpatient services must be billed with a Type of Bill 21X or 22X and Outpatient services must be billed with a Type of Bill 23X in Form Locator 4.

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 these 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 on registering for the class. This is a great way to get valuable professional credits, at 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†.

Correction: Pathology and laboratory coding updates

In the May issue of *BlueAlert*, we advised effective Jan. 1, 2011, a new CPT® code, 80104 was created to report a qualitative drug screen of multiple drug classes (*other than chromatographic method*).

The article additionally reported that Medicare prefers the use of HCPCS code G0431 created in 2010 to describe a non-chromatographic method within multiple drug classes screened in a single procedure. However, the appropriate HCPCS code effective Jan. 1, 2011, for billing Medicare should have been stated as **G0434** (*Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter*).

We apologize for any inconvenience this matter may have caused.

BlueCare/TennCare*Select*

CLINICAL

Pediatric asthma 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 to help improve the health outcomes for their BlueCare and TennCare*Select* members. These members were identified as receiving treatment in the past twelve (12) months and diagnosed with asthma. VSHP is requesting assistance from providers in identifying and enrolling BlueCare and TennCare*Select* members in our CareSmart® Asthma Program.

Some providers may receive an onsite visit from our asthma team who will present the provider with chronological data on asthma related inpatient admissions, asthma related emergency department visits, and HEDIS

BlueCare/TennCare*Select*

CLINICAL (cont'd)

Pediatric asthma initiative (cont'd)

measures for the appropriate use of controller medication for people with persistent asthma.

VSHP's goals are to work with members and providers to increase the use of appropriate medications, reduce asthma emergency department (ED) visits, reduce asthma inpatient hospital admissions, increase enrollment in the Asthma Disease Management (DM) Program, and promote member compliance in an asthma action plan.

To refer members to the CareSmart® Asthma Program, call 1-888-416-3025.

Reminder: TENNderCare screenings: *The importance of laboratory testing and immunization*

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 (7) 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: LDL-C & HbA1c Initiative: Diabetes Gaps in Care

Volunteer State Health Plan, Inc. (VSHP) recently launched an initiative for BlueCare and TennCare*Select* members. As part of this initiative, VSHP partnered with LabCorp to use Lab-In-An-Envelope, an alternative approach to closing gaps in comprehensive diabetes care. Our goal is to work with providers to improve diabetes care by increasing HbA1C and LDL-C test rates.

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

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 patients with diabetes that show gaps in care for HbA1c-and/or LDL-C. Providers may send individual or batch authorizations for identified members. If you have any questions, please call VSHP Disease Management 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 website at <http://www.bcbst.com/providers/forms/Lab-in-an_Envelope_MD_Fax.pdf>, or you may request the authorization form from Disease Management.

BlueAdvantage®

CLINICAL

Changes to authorization requirements

Prior authorization/advance determination is no longer required for PFFS and PPO lines of business for outpatient facilities if one of the following revenue codes is indicated.

- Revenue codes 0911, 0912, 0913, 0914, 0916, 0917 and 0919 for partial hospitalization
- Revenue code 0915 for intensive outpatient treatment
- CPT® code 90870 for electroconvulsive therapy (ECT)

ADMINISTRATIVE

BlueAdvantage contracts with CareCentrix℠ for PPO Members

Beginning July 12, 2011, BlueAdvantage PPO has contracted with CareCentrix to administer and manage all durable medical equipment (DME)/medical supplies, home health, orthotic and prosthetic services through their network of credentialed and contracted providers. All requests for authorization of these services should be sent to CareCentrix.

CareCentrix will require prior authorization for the above-referenced, in-network services prescribed for BlueAdvantage PPO members. 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.

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

BlueAdvantage®

ADMINISTRATIVE (cont'd)

Reminder: Guidelines for reopening, reconsideration and appeal of adverse determinations/denials*

Reopening
A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

There must be new material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.

The following are guidelines for a reopening request:

- The request must be made in writing
- Must be clearly stated;
- Must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted).
- Timely submission of additional information (CMS 130.2)

For additional information on **Guidelines for a Reopening** go to The Centers for Medicare & Medicaid (CMS) website at <http://www.cms.gov/manuals/downloads/mc86c13.pdf >

Reconsideration
The Inquiry/Reconsideration Level is the first step in the Provider Dispute Resolution Procedure.

A written request for a standard reconsideration of the denial must be submitted within sixty (60) calendar days from the date of the notice of the determination. If applicable, include all pertinent information including prior correspondence, medical records, and all documentation you wish to have considered in the final determination of the dispute.

Providers may submit a verbal or written request for an expedited reconsideration in situations where applying the standard of procedure could seriously jeopardize the member's life, health, or ability to regain maximum function.

Appeal
If dissatisfied with the outcome of the reconsideration review, providers can file an appeal request within thirty (30) days of receipt of the reconsideration response.

The appeal request should state:

- The reason for the appeal
- Why the provider is dissatisfied with the reconsideration response
- Any additional information the provider would like considered in support of the appeal request

Guidelines for requesting a reconsideration or appeal are outlined in the *Provider Dispute Resolution Procedure* (PDRP).

The procedure and Provider Dispute Form are available in the *BlueCross BlueShield of Tennessee Provider Administration Manual* located on the *BlueSource Provider Information CD* as well as the Provider page of the company website, www.bcbst.com.

†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)

eBusiness Technical Support
Phone: **423-535-5717**
e-mail: ecomm_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

*These changes will be included in the appropriate 3Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

July 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Aug. 13, 2011

- Azacitidine
- Bendamustine
- Belimumab
- Phototherapy for the Treatment of Skin Disorders

Effective Aug. 17, 2011

- Rituximab

Note: These effective dates also apply to BlueCare® and 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 Aug. 17, 2011

The following as relates to Ambulatory Care:

- Tonsillectomy, Adenoidectomy, Adenotonsillectomy

The following as relates to Home Care:

- Preterm Labor, Threatened

The following as relates to Inpatient and Surgical Care:

- Angina: Observation Care
- Cesarean Section
- Chest Pain: Observation Care
- Vaginal Delivery
- Vaginal Delivery, Operative

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

New drugs added to commercial specialty pharmacy listing

Effective July 1, 2011, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
Arzerra (PA)
Folotyn (PA)
Treanda (PA)
Yervoy (PA)

Self-administered via pharmacy benefit:
Corifact
Incivek
Sylatron
Victrelis
Zytiga

Clinical Practice Guidelines adopted

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

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

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

Pediatric Immunizations
<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>

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

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

Global Strategy for the Diagnosis, Management and Prevention of COPD
http://www.goldcopd.org/

ACOG: Guidelines for Perinatal Care, 6 Edition
<http://www.acog.org/bookstore/Guidelines_for_Perinatal_Care__P262.cfm>

ICSI: Health Care Guideline: Routine Prenatal Care, 14th edition
<http://www.icsi.org/prenatal_care_4/prenatal_care__routine__full_version__2.html

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

Clinical Practice Guidelines adopted (cont'd)

Hyperlinks to these guidelines are also 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.

Update: Changes to prior authorization requirements for select procedures*

Implementation of prior authorization requirements as of July 5, 2011, as stated in the June *BlueAlert*, is being delayed.

The requirement for prior authorization for the following procedures performed in an **outpatient setting** is delayed:

- Hysterectomy (Prior Authorization continues to be required on a hysterectomy in an inpatient setting and when an outpatient hysterectomy results in an inpatient admission.)
- Spinal Surgery
- Bariatric Surgery
- Tonsillectomy and Tonsillectomy/Adenoidectomy
- Breast Surgery for Augmentation or Reduction

Additionally, the requirement for prior authorization of the following procedures is delayed:

- Panniculecotmy
- Varicose Veins
- Blepharoplasty
- 72-hour Ambulatory Glucose Monitoring, Neurobehavioral Status Exam
- Neurobehavioral Status Exam
- Destruction of Cutaneous Vascular Proliferative Lesions Less than 10 sq. cm, (Laser Technique)
- Gastrointestinal Tract Imaging

This does not apply to State of Tennessee business which requires all outpatient surgeries performed in an outpatient or free-standing surgical facility to obtain prior authorization.

Note: All inpatient admissions continue to require prior authorization.

New requirements for members who need medication assisted treatment (MAT)

Effective Aug. 1, 2011, members who need MAT for chemical dependency will have new prior authorization requirements for prescription drugs. This requirement is for members who are challenged with chemical dependency to narcotic-containing pain medication (e.g. hydrocodone and oxycodone) and/or alcohol. This program safely and effectively manages medicine(s) used for sobriety. The program includes a doctorate-level pharmacist review and care management to support member participation in therapy and community programs such as Alcoholics Anonymous and Narcotics Anonymous.

Research shows treating chemical dependency is more successful when medicine and behavioral therapies are combined. The new prior authorization requirements will help members get the most appropriate level of care.

The following guidelines highlight the new treatment requirements:

- BlueCross BlueShield of Tennessee Pharmacy Management will conduct ongoing reviews of the member's program treatment medicine(s) and all other pharmaceutical agents/drugs used
- A behavioral care manager will assist and monitor the member during the program, as well as:
  - Establish a treatment plan
  - Confirm the member gets adequate psychotherapy and counseling
  - Make sure the member is involved in group support with an appropriate level group (i.e., Alcoholics Anonymous and/or Narcotics Anonymous)
  - Contact the doctor when appropriate
  - Help the member comply with the treatment program. *Non-compliance may result in the loss of the member's pharmacy benefit for treatment medications.*

Note: This pharmacy management program applies only to members whose prescription drug coverage is provided by BlueCross BlueShield of Tennessee.

ADMINISTRATIVE

Website change for DME Medicare Administrative Contractor

Effective June 1, 2011, BlueCross BlueShield of South Carolina purchased the Medicare Administrative Contractor, Cigna Durable Medical Equipment. The name is now Cigna Government Service, LLC. Providers are asked to access the following website for any information regarding the Jurisdiction C Durable Medical Equipment: http://www.cgsmedicare.com.

State of Tennessee website update

Beginning July 1, 2011, the official State of Tennessee web address will be www.tn.gov. The web addresses "state.tn.us" and "Tennessee.gov" will not be available after this date. Users will no longer be automatically redirected from those sites to www.tn.gov as they are now.

"Contact Us" more efficiently

The routing of emails sent through *Contact Us* is changing on July 1, 2011. To streamline email inquiries, you will be prompted to choose the BlueCross BlueShield of Tennessee line of business (LOB) to direct your inquiry. Simply choose the appropriate LOB and enter the text for your inquiry.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Reminder: Skilled Nursing Facility (SNF) claims

SNF claims must be billed on a CMS-1450/ANSI 8371, following the UB format. Inpatient services must be billed with a Type of Bill 21X or 22X and outpatient services must be billed with a Type of Bill 23X in Form Locator 4.

BlueCare/TennCare*Select*

CLINICAL

Behavioral health services available

Volunteer State Health Plan (VSHP) would like to assist you in managing your BlueCare and TennCare*Select* patients with mental health and substance abuse treatment needs by offering the following services:

- VSHP Referral Assistance is available at 1-800-367-3403 Monday through Friday, 8 a.m. to 5 p.m., ET.
- Telephone consultation services provided by ValueOptions® Peer Advisors, who are Board Certified Psychiatrists, are available to discuss all aspects of mental health and substance abuse treatment including medications. Call 1-877-241-5575 Monday through Friday, 9 a.m. to 5 p.m., (ET). Identify yourself as a TennCare primary care provider seeking psychiatric consultation services.
- VSHP members and providers may call the State of Tennessee crisis hotline at 1-855 CRISIS-1 (1-855-274-7471) for direction to their local crisis team if needed.

Medical records for members with behavioral health diagnosis should reflect efforts that support coordination of medical and behavioral health. Records may include written correspondence to and/or from behavioral health providers, or inquiries regarding such services, and referrals if appropriate.

Behavioral health and developmental screening

Information will be shared with Volunteer State Health Plan members regarding behavioral health and developmental screening. The VSHP Outreach Program will be educating members regarding the signs of ADHD, and encouraging parents or caregivers to follow up with the child's primary care provider.

Age/risk appropriate assessments should be performed for members under age 21 years per American Academy of Pediatrics (AAP) guidelines found at <http://practice.aap.org/content.aspx?aid=1599>.

Providers should submit CPT® code 96110 for developmental/behavioral screenings performed utilizing standardized screening tools which are located on the Tennessee Chapter of AAP's website at <www.tnaap.org/DevBehScreening/devbehscreening.htm>.

ADMINISTRATIVE

Reminder: Individualized Education Plan (IEP) requirements

The Individuals with Disabilities Education Act (IDEA) requires public schools to develop an IEP for every student with a disability who is found to meet federal and state requirements for special education. The State of Tennessee requires IEPs for public, private and home-schooled students with a disability. IEPs are designed to meet the unique educational needs of a child who may have a disability. The goals are tailored to the individual child's needs to help them reach educational goals. IEPs may or may not include medical services.

When medical services are included, TennCare requests the schools share information with the appropriate Managed Care Organization (MCO), such as Volunteer State Health Plan . The Director of Schools is also requested to have school personnel work with MCOs to coordinate care and the delivery of medically necessary services for TennCare school age children with an IEP.

If a VSHP member has an IEP and it is determined that he/she requires medical services, a care manager will be assigned. If necessary, the care manager will assist the parent/guardian in making an appointment to have the child evaluated by their primary care provider (PCP) or a specialist. A copy of the IEP will be provided to the PCP/specialist. VSHP asks for assistance in treating our members who have an IEP, and in following guidelines for documenting their medical care and treatment.

Reminder: Monthly federal exclusion list screening

BlueCare and TennCare*Select* providers have a **monthly** obligation to screen all employees and contractors against the U.S. Department of Health and Human Services', Office of Inspector General's List of Excluded Individuals/Entities (located at www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (located at www.epls.gov).

If an employee or contractor is found to be on the list, Medicaid providers must immediately report any exclusion information discovered to Volunteer State Health Plan and remove such employee or contractor from responsibility for, or involvement with a provider's operations related to federal health care programs. Appropriate actions must be taken to ensure the responsibilities of such employee or contractor have not or will not adversely affect the quality of care rendered to any VSHP member of any federal health care program.

Additional information may be found in the *Volunteer State Health Plan Provider Administration Manual* in the **Highlights of Provider Agreement** section.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Prior authorization for hyperbaric oxygen therapy

Effective Aug. 1, 2011, prior authorization will be required for BlueCare and TennCare*Select* members for hyperbaric oxygen therapy (HBO), procedure code C1300. Follow normal procedures to request prior authorization.

BlueAdvantage®

ADMINISTRATIVE

Billing and reimbursement guidelines for radiopharmaceuticals and contrast agents

Effective July 1, 2011, when billing radiopharmaceuticals and contrast materials on a CMS-1500/ANSI-837P professional claim for MedAdvantage products, providers should refer to guidelines found in the *BlueCross BlueShield of Tennessee Provider Administration Manual* in the Billing and Reimbursement section.

Reminder: BlueAdvantage contracts with CareCentrix℠ for certain services

Effective July 12, 2011, CareCentrix will manage complete benefit administration of all durable medical equipment (DME)/ medical supplies, home health, orthotic and prosthetic services prescribed for BlueAdvantage PPO members. Contact CareCentrix for prior authorization, provider service and claims administration of these services via one of the following methods:

Phone: 1-866-776-1123
Fax: Initial Authorization 1-866-501-4665
Fax: Reauthorization 1-866-501-4666
Web submission:
<https://www.carecentrixportal.com/ProviderPortal/>**

**To gain access to CareCentrix' secure site for web submission, email portalinfo@carecentrix.com or fax your request to 1-919-792-6823. To establish electronic claims submission, email ediinfo@carecentrix.com or fax your request to 1-919-792-6822.

BlueCard®

ADMINISTRATIVE

Quick guide to BlueCross and/or BlueShield member ID cards

A new quick guide is available for providers that gives information on member ID cards to help ensure prompt and accurate claims processing.

The quick guide provides an overview of various Blue ID cards and symbols on the cards. It also provides other information on the ID cards such as how to identify the member's product, obtain contact information from health plans and assistance with claims processing.

This guide is available in the provider section of the company website, www.bcbst.com on the BlueCard page. For additional information, please contact us at 1-800-705-0391.

BlueCard claim filing guidelines for lab, durable/home medical equipment and specialty pharmacy

Ancillary claims for independent clinical lab, DME/HME and specialty pharmacy should be filed to the local plan. The local plan is the plan in the service area where the ancillary services are rendered. File claims according to the specific ancillary service listed below.

Independent Clinical Labs
Lab providers should file claims to the Blue Plan in the service area where the specimen was drawn. If the lab specimen was collected in a Tennessee location, file to BlueCross BlueShield of Tennessee. The claim will be paid based on your participation status with the local plan.

DME/HME Providers
DME/HME providers should file claims to the Blue Plan in the service area the equipment or supply was shipped to, or purchased from. If the equipment was delivered to a member in Tennessee, file to BlueCross BlueShield of Tennessee. The claim will be paid based on your participation status with the local plan.

Specialty Pharmacies
Specialty pharmacy generally includes injectables and infusion therapies. Examples of major conditions these drugs treat include, but are not limited to, cancer, HIV/AIDS, and hemophilia. Specialty pharmacies should file the claim to the Blue Plan where the ordering physician is located. If the ordering physician is in Tennessee, file to BlueCross BlueShield of Tennessee. The claim will be paid based on your participation status with the local plan.

For more information, 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	**1-888-747-8955**
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)

eBusiness Technical Support

Phone:	**423-535-5717**
e-mail:	ecom_techsupport@bcbst.com

Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

*These changes will be included in the appropriate 3Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

August 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at<http://www.bcbst.com/providers/mpm.shtml> under the "Upcoming Medical Policies" link.

Effective July 18, 2011

- Home Apnea Monitoring/Home Cardiorespiratory Monitoring

Effective Sept. 11, 2011

- Intravenous Immune Globulin (IVIG) Therapy
- Ipilimumab
- Sorafenib
- Radioembolization for Primary and Metastatic Tumors of the Liver
- Electromagnetic Navigation Bronchoscopy
- Keratoprosthesis
- Outpatient Pulmonary Rehabilitation
- Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses
- Angioplasty and/or Stenting for Intracranial Arterial Disease
- First-Trimester Detection of Down Syndrome Using Fetal Ultrasound Markers Combined with Maternal Serum Assessment
- Neuromuscular Electrical Stimulation

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

Medical policy for bariatric surgery

The medical policy titled **Bariatric Surgery for Morbid Obesity** has been reviewed and the medical appropriateness criteria has been revised. A draft of this revised policy can be accessed on BlueCross BlueShield of Tennessee's Draft Medical Policies site available for 30 days at: http://www.bcbst.com/DraftMPs/.

Effective July 1, 2011, **VSHP** (**BlueCare/TennCare*Select***) began utilizing BlueCross BlueShield of Tennessee's medical policy for bariatric surgery. This change was made because the Bureau of TennCare retired its medical policy and directed all TennCare managed care organizations (MCOs) to apply their own.

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 Sept. 16, 2011
BlueCross BlueShield of Tennessee will begin using Milliman Care Guidelines® 15th edition for its homecare guidelines.

The following Modified Utilization Management Guidelines related to Home Health Care will be archived:

- Medical Social Service Visits
- Skilled Nursing Visits - Education
- Skilled Nursing Visits - Interventional
- Skilled Nursing Visits – Invasive
- Occupational Therapy
- Speech Therapy

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

Clinical Practice Guidelines Adopted

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

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society (2007)
http://www.annals.org/content/147/7/478

Hyperlinks to these guidelines are also 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.

Readmission guidelines update

Effective July 18, 2011, readmission guidelines for all BlueCross BlueShield of Tennessee products (Commercial business, **BlueCare, TennCare*Select***, BlueAdvantage, and Cover Tennessee) changed. The current guidelines are Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and any Class I Clean Surgical Wound Classification as identified by the American College of Surgeons as adapted by the CDC, and is applied to adults only.

Readmissions within 14 days of a hospital discharge for any of the above diagnoses to the same or similar facility or facility operating under the same contract will not be approved for payment. Claims for patients at either a DRG or Per Diem facility that are re-admitted under the above circumstances will not be eligible for multiple payments.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

5010 Compliance – Ready for testing

BlueCross BlueShield of Tennessee's web-based testing for 5010 Compliancy testing is now available. Please take this opportunity to begin testing the compliancy of your 837 claim files. Your vendors and clearing houses are also welcome to use while testing the compliancy of their electronic files. Remember, BCBST will only accept HIPAA version 5010 transactions beginning Jan. 1, 2012. For more information, please visit our self-testing page at <https://www.bcbst.com/providers/ecomm/HIPAA/5010-tool/FileChecker.asp>.

State of Tennessee public sector plan information now on our website

You can now access State of Tennessee public sector plan information on the Provider Page of our company website, www.bcbst.com.

BlueCare/TennCare*Select*

CLINICAL

Reminder: VSHP durable medical equipment (DME) and medical supply services

Effective 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 used in the member's home should be sent to CareCentrix.

CareCentrix requires prior authorization for all durable medical equipment and medical supply services prescribed for BlueCare and TennCare*Select* members 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 hospital acute care facility setting have not changed.

Non-DME providers should obtain prior authorizations through VSHP Utilization Management for DME requests over $500, orthotics over $200, prosthetics over $200, and out-of-network requests. For a SelectCommunity member, requests should go through the SelectCommunity member's care coordinator. For a CHOICES member, please coordinate with the CHOICES member's care coordinator.

Contact CareCentrix at 1-888-571-6022, or by fax at 1-888-571-6018. Web requests can be submitted to <https://www.carecentrixportal.com/ProviderPortal/>.

ADMINISTRATIVE

Reminder: Monthly Federal Exclusion List Screening

BlueCare and TennCare*Select* Providers have a **monthly** obligation to screen all employees and contractors against the U.S. Department of Health and Human Services', Office of Inspector General's List of Excluded Individuals/Entities (located at www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (located at www.epls.gov).

If an employee or contractor is found to be on the list, Medicaid providers must immediately report any exclusion information discovered to Volunteer State Health Plan and remove such employee or contractor from responsibility for, or involvement with a provider's operations related to federal health care programs. Appropriate actions must be taken to ensure
the responsibilities of such employee or contractor have not or will not adversely affect the quality of care rendered to any VSHP member of any federal health care program.

Additional information may be found in the *Volunteer State Health Plan Provider Administration Manual* in the **Highlights of Provider Agreement** section.

Cover Tennessee

ADMINISTRATIVE

DRG Threshold Updates

Effective Sept. 1, 2011, Cover Tennessee business will be decreasing DRG threshold updates from seven (7) days to five (5) days, in an effort to be more proactive with discharge planning.

Prior authorization requests for inpatient services

Effective Sept. 1, 2011, Cover Tennessee will accept clinical information for prior authorization requests for inpatient services when the member is currently in the hospital via our Provider Service Line at 1-800-924-7141 or through *BlueAccess* only.

If prior authorization requests are received by fax for inpatient services when the member is currently in the hospital, we will redirect the provider to either a phone call or *BlueAccess*. We feel this will better serve our providers and members by ensuring they receive faster turnaround times for decisions.

• • • • • • • • • • • • • • • • • • •

†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)

eBusiness Technical Support

Phone:	**423-535-5717**
e-mail:	ecom_techsupport@bcbst.com

Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

• • • • • • • • • • • • • • • • • • •

*These changes will be included in the appropriate 3Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

September 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at <http://www.bcbst.com/providers/mpm.shtml> under the "Upcoming Medical Policies" link.

Effective Sept. 29, 2011

- Electroencephalograms (EEG) by Telemedicine Transmission
-

Effective Oct. 8, 2011

- Bevacizumab
- Leuprolide Acetate
- Cervical Cancer Screening Technologies (Pap/HPV/ Speculoscopy/Cervicography)
- Intraoperative Radiation Therapy (IORT)
- KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy
- Microarray-Based Gene Expression Testing of Cancers of Unknown Primary Malignancy
- Radiofrequency Ablation for the Treatment of Tumors
- Gene Expression Testing for Coronary Artery Disease
- Left-Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
- Orthoptic Training for the Treatment of Vision or Learning Disabilities
- Testing and Treatment for Lyme Disease

Effective Nov. 16, 2011

- Hip Resurfacing
- **Interferential Current Therapy (BCBST will retain the historical policy statements)**

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

Changes to the commercial specialty pharmacy listing

Effective Aug. 1, 2011, the following drugs require prior authorization.

Provider-administered via medical benefit:
Provenge

Self-administered via pharmacy benefit:
Incivek
Infergen
Intron A
Pegasys
Peg-Intron
Ribavirin
Victrelis

The prior authorization requirement of the self-administered drug, Actiummune, has been removed effective Aug. 1, 2011.

Medication Assisted Treatment (MAT) update

As announced in the July *BlueAlert* the Medication Assisted Treatment (MAT) program for chemical dependency began on Aug. 1, 2011. This pharmacy management program is a contract exclusion for TRH members.

Implant billing guidelines*

Effective Oct. 1, 2011, BlueCross BlueShield of Tennessee will require providers to file the most appropriate HCPCS codes in accordance with the National Uniform Billing Guidelines on CMS-1450/ANSI 8371 facility claim forms for Implant Revenue Codes 274, 275, and 278. When a claim is received without an appropriate HCPCS code, the claim line item will be denied y74 "revenue code requires HCPCS code". The provider must then submit a corrected claim that includes the appropriate HCPCS code. This guideline is applicable to outpatient claims.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

New Mandate Requires Hearing Aid Benefit for Children

Recent legislation mandated coverage of up to $1,000 per hearing aid, per ear every three years for children under age 18. According to the mandate, "hearing aid" includes ear molds and services to select, fit and adjust the hearing aid. That means fittings are covered and included in the $1,000 limit. Any accessories, including batteries, cords and other assistive listening devices – such as FM systems – are excluded.

This benefit is effective for fully insured and non-ERISA self-funded groups upon new sale or renewal and for members with individual products on or after Jan. 1, 2012. Benefits are subject to deductible and coinsurance.

In order to process claims, providers will need to include the RT or LT (right or left) modifiers with the hearing aid codes. Hearing aid claims filed without one of these modifiers will be returned to providers.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (cont'd)

Preparing for ICD-10

Effective Oct. 1, 2013, ICD-10 will replace ICD-9 and require business and system changes throughout the health care industry. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

To prepare for the transition from ICD-9 to ICD-10:

- **Complete** an assessment of impacts to your current systems and work processes that use ICD-9 codes.
- **Develop** an implementation strategy to include a detailed timeline and budget.
- **Identify** your current systems, potential changes to work flow and business processes.
- **Initiate** an open dialogue with vendors, clearinghouses, billing services and BlueCross BlueShield of Tennessee to ensure a smooth transition.
- **Assess** staff training needs.
- **Budget** for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials, and training.
- **Conduct** test transactions using Version 5010/ICD-10 codes.

BlueCross BlueShield of Tennessee will keep you informed of future steps toward becoming ICD-10 compliant.

For more information regarding ICD-10 implementation, please visit <http://www.bcbst.com/providers/ecomm/ICD10%20Frequently%20Asked%20Questions.pdf>.

New Mandate Requires Hearing Aid Benefit for Children

Recent legislation mandated coverage of up to $1,000 per hearing aid, per ear every three years for children under age 18. According to the mandate, "hearing aid" includes ear molds and services to select, fit and adjust the hearing aid. That means fittings are covered and included in the $1,000 limit. Any accessories, including batteries, cords and other assistive listening devices – such as FM systems – are excluded.

This benefit is effective for fully insured and non-ERISA self-funded groups upon new sale or renewal and for members with individual products on or after Jan. 1, 2012. Benefits are subject to deductible and coinsurance.

In order to process claims, providers will need to include the RT or LT (right or left) modifiers with the hearing aid codes. Hearing aid claims filed without one of these modifiers will be returned to providers.

BlueCare/TennCare*Select*

CLINICAL

Health literacy and cultural competency information and training 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 conveyed is an important part of health literacy.

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

A *Health Literacy and Cultural Competency Provider Tool Kit* is available on the provider page of our company website at <http://www.bcbst.com/providers/08-538CulturalCompProvToolKit.pdf>. This tool kit provides health care professionals additional resources to better manage members with diverse backgrounds.

Providers may also register for Quality Interactions® Cross Cultural Training on the same website. This training is available at no cost to BlueCross BlueShield of Tennessee/VHSP providers.

Pediatric asthma 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. The initiative was designed to provide relevant and timely member-specific clinical information to providers to help improve the health outcomes for **BlueCare** and **TennCare*Select*** members. 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 our CareSmart® Asthma Program.

Some providers may receive an on-site visit from our asthma team who 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. VSHP's goals are to work with members and providers to increase the use of appropriate mediations, reduce asthma emergency department (ED) visits, reduce asthma inpatient/hospital admissions, increase enrollment in the Asthma Disease Management (DM) Program, and promote member compliance in an asthma action plan. To refer members to the CareSmart® Asthma Program, please call 1-888-416-3025.

Text4Baby program

VSHP and CoverKids/Healthy TNBabies have partnered with *Text4Baby* to increase healthy birth outcomes. *Text4Baby* is an educational program of National Healthy Mothers, Healthy Babies Coalition. Your patients can get **FREE** healthy pregnancy and healthy baby information by text each week during pregnancy, and through the baby's first year. To get started, your

BlueCare/TennCare*Select*

CLINICAL (cont'd)

Text4Baby program (cont'd)

patient just needs to text the word "BABY" (or "BEBE" for Spanish) to the number 511411. Additional information as well as registration information is available online at text4baby.org/.

September is Infant Mortality Month

Hospice update*

Effective Oct. 1, 2011, **BlueCare/ TennCare*Select* will no longer** require prior authorization for Hospice services, but **will** require notification except for Medicare dual eligible members who will not require prior authorization nor notification. Notification must include demographic and clinical information, and identify who will be performing the service(s). This information is necessary for accurate claims processing and payment.

All notifications of service are screened for non-covered, out-of-network and investigational procedures. Notifications of services are not subject to prospective medical necessity review, but may be subject to retrospective review based on Medical Policy.

Please notify the Utilization Manager of Hospice services by phone or fax at:

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

TennCare*Select*
Phone: 1-800-711-4104
Fax 1-800-292-5311

Hysterectomy update*

Effective Oct. 1, 2011, **BlueCare/ TennCare*Select* will no longer** require prior authorization for hysterectomy, but **will** require notification for both inpatient and outpatient services. Notification must include demographic and clinical information, and identify who will be performing the service(s).

Hysterectomy claims require submission of an *Acknowledgement of Hysterectomy Information* form, operative report, pathology report, history and physical, and office notes that include documentation of conservative measures prior to the hysterectomy. All notifications of service are screened for non-covered, out-of-network, abortion, sterilization, hysterectomy, and investigational procedures. Requests for notification are not subject to prospective medical necessity review, but are subject to retrospective review.

To notify us of hysterectomy services please fax information to :
Notification fax 1-800-292-5311

ADMINISTRATIVE

Plain language initiative

The Bureau of TennCare "Plain Language" initiative is part of a national program to encourage 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 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 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 follow your instructions better.

For additional information on Health Literacy, please refer to the Department of Health and Human Services website at <http://www.hrsa.gov/publichealth/healthliteracy/>.

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 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: TENNderCare Screenings
The Importance of Laboratory Testing and Immunization

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.

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.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Reminder: Submitting authorization requests for skilled nursing (SNF) facility, long term acute care (LTAC) and Inpatient Rehab Facility

BlueCare/TennCare*Select* does not perform predetermination reviews, however all SNF/LTAC/Inpatient Rehab services require prior authorization. Authorization requests should be submitted by fax to 423-535-7790. For additional information call 423-535-5095 Monday through Friday, 8 a.m. to 6 p.m. (ET).

BlueAdvantage

ADMINISTRATIVE

Reminder: CareCentrix provides certain services for BlueAdvantage PPO members

As previously communicated, effective July 12, 2011, CareCentrix now manages complete benefit administration of all durable medical equipment (DME)/medical supply services, home health, orthotic and prosthetic services prescribed for BlueAdvantage PPO members. Contact CareCentrix for prior authorization, provider service and claims administration of the above services via one of the following methods:

Phone: 1-866-776-1123
Fax: Initial Authorization 1-866-501-4665
Fax: Reauthorization 1-866-501-4666
Web submission:
www.carecentrixportal.com/ProviderPortal/

Note: To gain access to CareCentrix' secure site for web submission, e-mail portalinfo@carecentrix.com or fax your request to 1-919-792-6823. To establish electronic claims submission, e-mail ediinfo@carecentrix.com or fax your request to 1-919-792-6822.

New behavioral health program for Medicare Advantage members

Effective Oct. 1, 2011, BlueCross, in partnership with Magellan Health Services, will implement a new behavioral health program for Medicare Advantage members. Along with behavioral health services this program will provide coaching for case management and disease management.

Services requiring prior authorization include acute care, residential treatment, and electroconvulsive therapy. Effective Nov. 1, 2011, partial hospitalization and intensive outpatient treatment will also require authorization. We look forward to working with you to provide the best treatment outcomes for Medicare Advantage members.

Federal Employee Program (FEP)

ADMINISTRATIVE

Federal Employee Program (FEP) health benefit plan reminders

Observation Stays vs. Inpatient Admissions
Claims are paid based on the type of care billed. Outpatient observation care is payable at 85 percent of the plan allowance for standard option FEP members, possibly leaving the member a substantial 15 percent coinsurance. For inpatient care FEP members pay only a flat co-payment of $250. Members in an "Outpatient" status may be responsible for additional coinsurance, deductibles or certain medications in accordance with their FEP health benefit plan.

Charging Facility Co-Payments for an Office Visit
If an FEP member visits a doctor whose office is located in a facility/hospital, the member should only be charged the office visit co-payment amount. Some members are incorrectly being charged the hospital co-payment in addition to the office visit co-payment.

Generic Drugs Save Money for Members
Please explain to our members that generic drugs are FDA approved and are a safe and effective treatment for their condition. Also continue to prescribe generic drugs when available. When a generic equivalent drug is not available to substitute for a brand-name drug, there may be a generic alternative used to treat the same condition. You can help FEP members save a substantial amount of money due to the lower cost and higher benefit levels for generic drugs covered under their health benefit plan.

Dental Co-Payments
In 2011 the FEP basic option co-payment increased from $20 to $25 for covered dental care. As part of the MyBlue Wellness incentive program, FEP members can use their earned funds to pay dental charges including the co-payment amount. As long as the actual $25 co-payment is charged during the card transaction, the member will not have to provide a receipt or explanation of benefits in order to be reimbursed.

• • • • • • • • • • • • • • • • • • •

†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)

eBusiness Technical Support

Phone:	**423-535-5717**
e-mail:	ecom_techsupport@bcbst.com

Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

• • • • • • • • • • • • • • • • • • •

*These changes will be included in the appropriate 3Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

October 2011

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

CLINICAL

Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Oct. 17, 2011
- Lung Volume Reduction Surgery for Severe Emphysema

Effective Nov. 12, 2011
- Botulinum Toxin
- Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Individuals with Non-Small Cell Lung Cancer (NSCLC)
- Meniscal Allografts and Collagen Meniscus Implants
- Negative Pressure Wound Therapy

Effective Nov. 13, 2011
- Chemical Peels

Effective Nov. 16, 2011
- Tocilizumab
- Rituximab

Note: Interferential Current Therapy - BlueCross will retain the historical policy statements.

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. 16, 2011
The following as relates to Ambulatory Care:
- Allogeneic Bone Marrow and Peripheral Blood Stem Cell Transplants

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

New drugs added to commercial specialty pharmacy listing

Effective Oct. 1, 2011, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
Adcetris (PA)

Self-administered via pharmacy benefit:
Firazyr (PA)
Gammagard Liquid (PA)
Orencia, Sub-Q (PA)
Xalkori (PA)
Zelboraf (PA)

Changes to commercial drug formulary

Effective Oct. 1, 2011, BlueCross BlueShield of Tennessee's Pharmacy and Therapeutics Committee will implement the following changes to its commercial drug formulary:

Drugs moving from 3rd tier to 2nd tier
Acanya
Apriso
Asacol, Asacol HD
Byetta (Step Therapy removed)
Evamist
Tradjenta
Victoza
Xarelto (QL)

Drugs requiring prior authorization (PA)
Xyrem

New prescriptions to drugs below require Step Therapy with Embrel or Humira
Cimzia,
Orencia Sub-Q
Kineret
Simponi

Changes to prior authorization requirements for select procedures

For dates of service Jan. 1, 2012 and after, additional prior authorization will be required for commercial lines of business, including Cover Tennessee, for the following procedures in an inpatient or outpatient setting:

- Panniculectomy
- Varicose Veins
- Blepharoplasty
- Tonsillectomy and Adenoidectomy
- Tonsillectomy under age three (3)
- Bariatric Surgery
- Breast Surgery for Augmentation or Reduction
- 72-hour Ambulatory Glucose Monitoring
- Neurobehavioral Status Exam
- Destruction of Cutaneous Vascular Proliferative Lesions less than 10 sq. cm (laser technique)
- Gastrointestinal Tract Imaging
- Hysterectomy
- Spinal Surgery

Note: This change is not applicable to Tennessee Rural Health line of business.

Radiopharmaceutical allowance updated for code A9552

Effective Oct. 1, 2011, supplemental information will no longer be required for HCPCS Code A9552 filed on a HCFA 1500. Based on direction from CMS, radiopharmaceutical allowances for codes without established fees are determined "by report", which has been historically implemented as "by invoice".

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (Cont'd)

Radiopharmaceutical allowance updated for code A9552 (Cont'd)_

To address professional provider concerns regarding the process to obtain reimbursement for A9552 - Fluorodeoxyglucose F-18 FDG, BlueCross BlueShield of Tennessee has conducted an in-depth analysis of code A9552. In this analysis, data from paid claims was reviewed along with invoice documents provided by professional providers to establish a reasonable allowable. This allowable was further validated with a review of various CMS carrier pricing information.

Case management available to members with Hepatitis C

BlueCross BlueShield of Tennessee has **Preferred Specialty Pharmacies** that provide case management services to assist commercial and Cover Tennessee members with Hepatitis C with their medication, treatment plan and care needs during a member's treatment. Preferred Specialty Pharmacies are:

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: 1-800-424-9002
Fax: 1-800-874-9179

BlueCross BlueShield of Tennessee Case Management can help members with Hepatitis C to select and contact one of our Preferred Specialty Pharmacies. Providers and/or members may call the BlueCross BlueShield of Tennessee Case Management office at 1-800-225-8698, Monday through Friday, 9 a. m. to 6 p. m. (ET) for more information.

ADMINISTRATIVE

Reminder: Flu season is here

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

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).

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

Commercial

- *Vaccine and administration* Covered if offered under the member's health benefit plan.
- *FluMist® nasal spray* (recommended for healthy individuals ages 2-49) Entire cost may not be covered and member may be responsible for any charges that exceed the standard reimbursement amount.
- *Fluzone® Intradermal, Influenza Virus Vaccine* (recommended for persons 18 through 64 years of age) Entire cost may not be covered and member may be responsible for any charges that exceed the standard reimbursement amount.

Benefits can be verified by calling the appropriate BCBST or BlueCard Provider Service line. If your commercial or Cover Tennessee patients elect to have either the *FluMist®* nasal spray or *Fluzone® Intradermal*, a financial acknowledgement form is available online for provider use at http://www.bcbst.com/providers/forms/.

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

BlueCare or TennCare*Select*

- *Vaccine and administration* Covered

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

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

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

Reminder: OB/GYN Services

OB/GYN services should be reported in accordance with the nationally accepted billing guidelines of the American College of Obstetricians and Gynecologists (ACOG) and CPT® coding guidelines in effect for the date of service. Providers can obtain a copy of ACOG's CPT® *Coding in Obstetrics & Gynecology* guidebook by writing to:

ACOG
409 12th Street, SW
Washington, DC 20024-2188

Reminder: Requesting urgent concurrent reviews for inpatient stays and emergent admissions

Submit online requests for commercial lines of business, including Cover Tennessee, for urgent concurrent reviews and emergent admissions through BlueAccess 24-hours-a-day, 7-days-a-week. For *immediate* attention outside regular business hours (Monday through Thursday 9 a.m. to 6 p.m. ET and 9 a.m. to 4 p.m. ET on Fridays) requests must be submitted by phone. Requests will also be accepted within 24 hours or the next business day by calling the prior authorization number listed on the member's ID card or the Utilization Management Department at 1-800-924-7141.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (Cont'd)

Reminder: Prior authorization fax requests no longer accepted on weekends and holidays

Fax transmission may be submitted to the Utilization Management Department Monday through Thursday, 24-hours-a-day and on Friday until 4 p. m. (ET).

Commercial Fax	1-866-558-0789
Cover Tennessee Fax	1-800-851-2491

Discontinuation of Blue Network K*

Effective Nov. 1, 2011, BlueCross BlueShield of Tennessee will discontinue its Blue Network K based product and network. There are no members currently utilizing Network K.

When Network K was established, BCBST adopted a policy wherein Network K practitioners were gold carded. The policy further established that a practitioner gold carded in Network K was also gold carded for all BCBST commercial networks. As Network K ceases to exist on Nov. 1, 2011, the policy that established gold carding based on Network K also ceases to exist. Effective Nov. 1, there will no longer be gold card status for practitioners in BCBST commercial networks based upon their participation in Network K.

BlueAccess web authorization - We want your feedback

To better understand the needs of our provider community that access our medical management services online, BlueCross BlueShield of Tennessee is collaborating with several area hospital facilities to develop pathways and activities that improve process efficiencies for both the provider and BlueCross. Through these pathways and activity exercises, we have learned of challenges encountered with our web authorization tool and general authorization services.

BCBST and the partnering facilities are working to improve the overall quality and efficiency of our processes. We are very enthusiastic about the potential outcomes and are committed to transforming the way we do business. If you have experienced process issues that you would like to bring to our attention in a collaborative manner, please contact eBusiness Solutions at (423) 535-5717 or email us at ecomm_marketing@bcbst.com.

BlueCare/TennCare*Select*

CLINICAL

Reminder: TENNderCare Screenings

The importance of laboratory testing

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

The screens shall include, but not limited to:

- Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
- Comprehensive unclothed physical examination, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender);
- Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;
- Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;
- Appropriate laboratory tests;
- Health education which includes anticipatory guidance based on the findings of all screening.

Note: When reviewing medical records it was noted that in some visits appropriate lab test(s) were not documented. Please note that appropriate laboratory test, one of the above seven required screening components, should be addressed with your patients as appropriate for age, risk factors and health history (ex: Hematocrit or Hemoglobin, Lead Toxicity Screening, Dyslipidemia Screening).

The TENNderCare provider tool kit is located on the company website at <http://www.bcbst.com/providers/TENNderCARE/>

The American Academy of Pediatrics Periodicity Schedule is a great tool for which labs are age appropriate. You may access this information at <http://www.aap.org/healthtopics/commped.cfm>.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Monthly federal exclusion list screening

BlueCare and TennCare*Select* Providers have a **monthly** obligation to screen all employees and contractors against the U.S. Department of Health and Human Services', Office of Inspector General's List of Excluded Individuals/Entities (located at www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (located at www.epls.gov).

If an employee or contractor is found to be on the list, Medicaid providers must immediately report any exclusion information discovered to Volunteer State Health Plan and remove such employee or contractor from responsibility for, or involvement with a provider's operations related to federal health care programs. Appropriate actions must be taken to ensure the responsibilities of such employee or contractor have not or will not adversely affect the quality of care rendered to any VSHP member of any federal health care program.

Additional information may be found in the *Volunteer State Health Plan Provider Administration Manual* in the **Highlights of Provider Agreement** section.

BlueCare/TennCare*Select*

ADMINISTRATIVE (Cont'd)

Reminder: Providers receiving federal payment must meet state and federal requirements

Any provider, subcontractor or other entity who receives federal payment by TennCare or through a managed care organization (MCO), must comply with a number of state laws and federal regulations, including, but not limited to, the Federal anti-kickback statute, the Stark law and federal requirements on disclosure, debarment and exclusion screening.

BlueAdvantage

CLINICAL

REMINDER - New behavioral health program for Medicare Advantage members

Effective Oct. 1, 2011, a new behavioral health program, in partnership with Magellan Health Services, was implemented.

What is changing? Starting Nov.1, 2011 the partial hospitalization and intensive outpatient levels of care will require review and authorization for medical necessity.

What did not change? We will continue to review and authorize medical necessity for the acute, residential treatment, and electroconvulsive therapy levels of care. Members will be offered case management services. Outpatient office sessions will not be reviewed for medical necessity.

How to contact us? If you have questions about the new program or want to talk to a behavioral health clinician please call 1-800-841-7434, 24-hours-a-day, 7-days-a-week.

Cover Tennessee

CLINICAL

BCBST focuses on improved preventive care and wellness

BlueCross BlueShield of Tennessee's Preventive Screening Programs focus on improving the quality of preventive clinical care and service received by its Cover Tennessee members. As part of the clinical improvement process, BlueCross conducts member education and other activities to promote prevention and ensure continued health and wellness within our member populations and to improve the preventive screening rates as determined by HEDIS®.

Preventive screening reminders are disseminated through various avenues including, but not limited to, postcards, explanation of benefit (EOB) messages, telephone reminder messages and Care Management education. However, despite such efforts by BlueCross BlueShield of Tennessee and our network providers to increase screenings, several rates continue to be below national benchmarks. The following HEDIS 2011 results show that more emphasis is needed to improve Chlamydia screening rates.

Cover Tennessee Plan	HEDIS 2011 Chlamydia Screening in Women: 16-24 years	Benchmark
AccessTN	43.48%	50.98%
CoverTN	33.01%	50.98%*
CoverKids	33.56%	69.54%**

*National PPO benchmark from the 90th percentile of NCQA's Commercial HEDIS 2011 Quality Compass

**National HMO benchmark from the 90th percentile of NCQA's Medicaid HEDIS 2010 Quality Compass

The Clinical Improvement and Outreach Departments at BlueCross BlueShield of Tennessee continually plan new initiatives to specifically promote these screenings. It is hoped that these interventions will improve screening rates, as has been the case for other areas of preventive care, such as annual well-care visits and immunizations. Though rates of Chlamydia screening have been steadily rising, on average, only one third of women are receiving the recommended annual screening. A major obstacle to detecting Chlamydia infection is that those at risk neither have symptoms nor are aware of the likelihood of infection.

Preventive screenings are a covered benefit of Cover Tennessee plans. Heath care providers, due to their direct patient contact, play an essential role in actively encouraging patients to undergo appropriate screenings. Providers who perform these screenings are eligible for reimbursement at their contracted rates. 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.

• • • • • • • • • • • • • • • • • • •

†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)

eBusiness Technical Support
Phone: **423-535-5717**
e-mail: ecom_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

• • • • • • • • • • • • • • • • • • •

*These changes will be included in the appropriate 4Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

November 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Nov. 16, 2011

- Bariatric Surgery for Morbid Obesity
- Erythropoiesis-Stimulating Agents (ESAs)

Effective Nov. 19, 2011

- Cochlear Implant
- Intradialytic Parenteral Nutrition (IDPN)

Effective Dec. 10, 2011

- Ablation Treatments for Barrett's Esophagus
- Biochemical Markers for Alzheimer's Disease
- Biventricular Pacemakers for the Treatment of Heart Failure
- Digital Breast Tomosynthesis
- Intracavitary Balloon Catheter Brachytherapy for Malignant Gliomas or Metastases to the Brain
- Sacroiliac Joint Arthrography and Injection
- Acoustic Cardiography
- Computed Tomography (CT) Perfusion Imaging
- Plugs for Fistula Repair
- Serum Tumor Markers for Breast Malignancies
- Stem Cell Therapy for Peripheral Artery Disease

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

Clinical Practice Guidelines Adopted

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

2009 Focused Updates: ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction (Updating the 2004 Guideline and 2007 Focused Update) and ACC/AHA/SCAI Guidelines on Percutaneous Coronary Intervention (Updating the 2005 Guideline and 2007 Focused Update)
<http://circ.ahajournals.org/cgi/content/full/120/22/2271>
Use in correlation with:
2007 Focused Update of the ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction
<http://circ.ahajournals.org/content/117/2/296.full.pdf+html>
ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction
<http://circ.ahajournals.org/content/110/5/588.full.pdf+html>

Guide to Clinical Preventive Services
<http://www.uspreventiveservicestaskforce.org/recommendations.htm>

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents - Third Edition
<http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html>
Periodic Table:
<http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>

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

2011 ACCF/AHA Focused Update of the Guidelines for the Management of Patients With Unstable Angina/ Non–ST-Elevation Myocardial Infarction (Updating the 2007 Guideline)
<http://circ.ahajournals.org/cgi/content/full/123/18/2022>

Use in correlation with:
2007 Guidelines for the Management of Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction
<http://circ.ahajournals.org/content/116/7/803.full.pdf>

Guidelines for the Prevention of Stroke in Patients With Stroke or Transient Ischemic Attack. A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association (2010)
<http://stroke.ahajournals.org/cgi/reprint/STR.0b013e3181f7d043v1>

Hyperlinks to these guidelines are also 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.

Reminder: The Good Health Toolkit available on our website

BlueCross BlueShield of Tennessee recognizes the critical role physicians have in motivating patients to be healthier. We encourage you to visit our website, <http://www.bcbst.com/providers/Good_Health_Toolkit/default.shtml> to print the Good Health Club Physician Information and Toolkit.

The toolkit, which contains materials about childhood obesity and diabetes, is available in both English and Spanish for you to print and offer to your commercial patients.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (Cont'd)

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 RSV 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 company website at <http://www.bcbst.com/providers/forms/synagis.pdf>.

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 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: 1-800-874-9179

ADMINISTRATIVE

BCBST is ready for 5010

BlueCross BlueShield of Tennessee is in production with HIPAA 5010 EDI transactions. This includes Electronic Claims (837), Electronic Remittance Advice (835) and Claim Acknowledgements (277CA). It is important for you to begin conducting these transactions prior to the Jan. 1, 2012, federally mandated date. If you have questions about 5010, please contact the eBusiness Service Center at 423-535-5717 or e-mail at ecomm_technicalsupport@bcbst.com. For more information about moving to production, visit <https://www.bcbst.com/providers/ecomm/hipaa-5010-upgrade.shtml >.

BlueCross BlueShield of Tennessee handles 30,000 claims-related documents daily

There can be over 120,000 pieces of paper in a 24-hour period with a 99.90 percent accuracy rate.

Visit www.bcbst.com for a video tour of the process Enterprise Document Management (EDM) goes through to insure your claims and documents are processed and routed timely at <http://www.bcbst.com/providers/video/lifecycle-of-a-claim.shtml>

Reminder: Practice Pattern Analysis available online

BlueCross BlueShield of Tennessee periodically performs a Practice Pattern Analysis (PPA), which is a quality management study designed to provide practitioners with important information about their utilization practices and quality of care.

The PPA is available online through BlueAccess. If you have not yet registered to use BlueAccess, please call 1-800-924-7141 to complete the process. For additional assistance regarding your PPA, contact your local Network Manager.

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 claim form.
- 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 should equal 15 minutes NOT an hour. 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.*

Reminder: Discontinuation of Blue Network K

Effective Nov 1, 2011, BlueCross BlueShield of Tennessee will discontinue its Blue Network K based product and network. Also, the policy that established Gold Carding based on Network K, will also cease to exist. We would like to extend our appreciation for your participation in support of our members during this process.

*These changes will be included in the appropriate 4Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (Cont'd)

Upcoming enhancements for Real-Time Claims Adjudication

Real-Time Claims Estimation/Adjudication (RTCA) allows providers to develop accurate patient liability at the point of service through claim estimation. Soon providers will be allowed to include a National Drug Code (NDC) with a procedure code. Additionally, providers will have a place to enter patient account number.

Look for the announcement about these new enhancements coming soon to RTCA in the **Updates** section of the Provider page on www.bcbst.com.

BlueCare/TennCare*Select*

CLINICAL

Breast cancer screening

American Congress of Obstetricians and Gynecologists (ACOG) have a new statement on mammography released on July 20th, 2011. The complete information is located at <http://www.acog.org/from_home/publications/press_releases/nr07-20-11-2.cfm>. According to a CNN article in May, the use of mammograms has dipped since a medical task force made controversial recommendations that women in their 40s may not need to get breast cancer screenings every year.

Breast cancer screening is a covered benefit for VSHP members. VSHP would like to encourage providers to discuss breast cancer screening or recommend mammograms for their patients.

VSHP medical policy is as follows:

Mammography screening for women will be considered **medically appropriate** with **ANY ONE** the following:

- Women at average risk with **ANY ONE** of the following:
  - A baseline mammogram for women thirty-five (35) to forty (40) years of age
  - Annual mammogram for women ages forty (40) and over
- Women at high risk with the **ANY ONE** of the following:
  - Breast changes that persist, such as a lump, thickening, swelling, dimpling, skin irritation, distortion, retraction or scaliness of the nipple, nipple discharge, or a previous abnormal mammogram
  - Diagnosis of a breast disease that may predispose a woman to breast cancer
  - Family history of breast cancer (mother, daughter, sister), or having two or more close relatives, such as cousins, with history
  - Menopause at 55 years or older
  - No childbearing or late childbearing (age 30 or older at first birth)
  - Personal history of breast cancer
  - Personal history of two or more biopsies for benign breast disease
  - Start of menses at or before age 10
  - Unclear, difficult mammogram reading due to denseness (above 75 percent)

Billing Guidelines for wound care services*

In keeping with current correct coding criteria, effective Nov. 1, 2011, the Volunteer State Health Plan (VSHP) will amend the wound care reimbursement fee schedule to include eligible CPT® codes 11042-11047. Facilities may bill the wound care related CPT® codes in conjunction with revenue code 0519 (Clinic-Other Clinic). If services are performed in the operating room, providers should file with the appropriate Revenue Code to receive surgery grouper allowable. This applies to all acute care/freestanding facilities.

Wound care guidelines may be found in the Provider Administration Manuals which are available on the Provider page of company websites, www.vshptn.com and www.bcbst.com.

Changes to outpatient billing guidelines for acute care providers*

In keeping with current correct coding standards, Volunteer State Health Plan (VSHP) will amend the minor surgery reimbursement fee schedule to include any active revenue codes (RCs) for outpatient services filed on a CMS-1450 facility claim. For example, eligible minor surgery HCPCS/CPT codes may be billed with RC 0361, RC 0450, etc. regardless of date of service. This change will assist providers in billing for acute care minor surgery.

Current billing guidelines may be found in the *VSHP Provider Administration Manual* which is available on the provider page of the VSHP website, www.vshptn.com.

CHOICES

ADMINISTRATIVE

Reminder: Plan of care for CHOICES member

As a participating provider in the CHOICES program primary care providers have an obligation to collaborate with a member's care coordinator in establishing a Plan of Care. A large part of this collaboration involves supplying the member's history and physical in a timely manner when requested. Authorization of services and the member's Plan of Care are dependent on the information contained in the physician's history and physical documentation. When a VSHP CHOICES representative contacts you for a history and physical, please provide the requested information as quickly as possible.

BlueCare/TennCare*Select*

ADMINISTRATIVE

End of claims processing for BlueCare "Non-Risk" contract

After Dec. 1, 2011, neither VSHP nor the Bureau of TennCare will process claims for dates of service July 1, 2002 through Dec. 31, 2008, under the BlueCare "Non-Risk" Contract. If you have questions, please contact your Provider Network Manager, or call the BlueCare Provider Service line†.

*These changes will be included in the appropriate 4Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueCare/TennCare*Select*

ADMINISTRATIVE (Cont'd)

Webinar link regarding 5010 implementation

On Sept. 28, 2011, ValueOptions, in partnership with VSHP, held a webinar regarding 5010 changes and how they impact outpatient facility providers. To view the webinar, go to <http://www.valueoptions.com/providers/Network/TennCare.htm> . Please continue to check the company websites www.vshptn.com and www.bcbst.com for additional information regarding 5010 implementation and how it impacts **all** providers.

Claims subject to retrospective review

BlueCross BlueShield of Tennessee retrospectively audits VSHP claims for improper payments. The identification of improper payments will occur for claims according to provider contractual requirements. Claims submitted by a provider to BlueCross on a CMS-1450 (UB04) or CMS-1500 claim form are subject to audit.

BlueCross will perform **Complex Reviews**, a thorough review of a medical record for coding validation and utilization review, and **Automated Reviews**, where no medical record is required. All complex reviews are performed with VSHP Medical Director oversight by physicians, RNs and certified coders.

For more information refer to Frequently Asked Questions (FAQs) available on the Provider page of the company website, www.bcbst.com.

BlueAdvantage

CLINICAL

Reminder: Notification of Hospice services required

In the September *BlueAlert* we advised that effective Oct. 1, 2011, **BlueCare/TennCare*Select* will no longer** require prior authorization for Hospice services, but **will** require notification except for Medicare dual eligible members who will not require prior authorization nor notification. Notification must include demographic and clinical information, and identify who will be performing the service(s). This information is necessary for accurate claims processing and payment. **Notification will be accepted by FAX ONLY.**

All notifications of service are screened for non-covered, out-of-network, and investigational procedures. Notifications of services are not subject to prospective medical necessity review, but may be subject to retrospective review based on Medical Policy.

Please notify the Utilization Manager of Hospice services via fax at:

East Grand Region Fax: 1-800-292-5311
West Grand Region Fax: 1-800-919-9213
TennCare*Select* Fax 1-800-292-5311

Cover Tennessee

CLINICAL

New Medication Assisted Treatment Program announced

Effective Dec. 1, 2011, BlueCross BlueShield of Tennessee is pleased to announce a new Medication Assisted Treatment (MAT) program for members who have their pharmacy benefit administered by AccessTN. This program is designed for those members who are challenged with chemical dependency to such substances as narcotic containing pain medication (e.g. hydrocodone, oxycodone, etc.) and/or alcohol.

The program was developed to provide safe and effective management of medication(s) used for sobriety management and includes doctorate-level pharmacist review and care management to support member participation in therapy and community programs such as AA/NA.

†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)

eBusiness Technical Support

Phone:	**423-535-5717**
e-mail:	ecom_techsupport@bcbst.com

Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

BlueCross BlueShield of Tennessee offices will be closed Nov. 24 & 25, 2011, in observance of the Thanksgiving Holiday.

*These changes will be included in the appropriate 4Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

December 2011

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective Oct. 20, 2011
- Small Bowel/Small Bowel-Liver/Multivisceral Transplantation

Effective Nov. 16, 2011
- Bariatric Surgery for Morbid Obesity

Effective Dec. 12, 2011
- Lipid Risk Factors in risk Assessment and Management of Cardiovascular Disease

Effective Jan. 8, 2012
- Breast Duct Endoscopy

Effective Jan. 14, 2012
- Pemetrexed
- Home Hyperalimentation (Total Parenteral/Enteral Nutrition)
- Platelet Rich Plasma as a Treatment for Wound Healing or Other Conditions
- Retinal Telescreening for Diabetic Retinopathy
- Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
- Fecal Calprotectin Testing
- Intracellular Micronutrient Analysis

Effective Feb. 22, 2012
- Corticotrophin Therapy
- Endovascular Stent Grafting for Treatment of Abdominal Aortic Aneurysm and Thoracic Aortic Aneurysm and Dissections

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

Clinical Practice Guidelines adopted

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

(APA) **Treatment of Patients With Panic Disorder, Second Edition** (2009) <http://www.psychiatryonline.com/pracGuide/pracGuideTopic_9.aspx>

(NIAAA) Helping Patients Who Drink Too Much: A Clinician's Guide, Updated 2005 Edition <http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm>

Treatment of Patients With Eating Disorders, Third Edition (2006) <http://www.psychiatryonline.com/pracGuide/pracGuideTopic_12.aspx>

(AACAP) **Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder** (2007) <http://www.aacap.org/galleries/PracticeParameters/JAACAP_ADHD_2007.pdf>

(APA) **Treatment of Patients With Major Depressive Disorder, Third Edition** (2010) <http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx>

Hyperlinks to these guidelines are also 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.

Changes to 2012 commercial drug formulary

The following drug changes are effective Jan. 1, 2012:

Drugs added to the formulary:
- Sumavel DosePro (Quantity Limit)

Drugs requiring prior authorization (PA):
- Xyrem

Drugs requiring step therapy (ST):
- Antara, Lipofen, Fenoglide, Tricor, Triglide, Trilipix: requires trial of fenofibrate or gemfibrozil
- Beconase AQ, Nasonex, Omnaris, Rhinocort Aqua, Nasacort AQ: requires trial of flunisolide, fluticasone, triamcinolone or Veramyst
- Lantus SoloSTAR: requires trial of Levemir pens
- Lunesta, Rozerem: requires trial of zolpidem, zolpidem ext-rel or zaleplon
- Tekturna, Tekturna HCT: requires trial of generic ACE, generic ACE combo, generic ARB, Azor, Benicar, Benicar HCT, Micardis, Micardis HCT, Tribenzor or Twynsta
- Testim: requires trial of Androderm or Androgel

Drugs moving from 2nd tier to 3rd tier
- Lantus vials
- Noritate
- Tricor (ST)
- Trilipix (ST)
- Climara
- Cyclessa
- Nasacort AQ (ST)
- Xalatan
- Yaz

Drugs being excluded from formulary:
- Aciphex
- omeprazole/sodium bicarbonate (Zegerid)
- Oracea
- Provigil
- Veltin
- Ziana

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (Cont'd)

Reminder: Changes to prior authorization requirements for select procedures

As previously communicated, for dates of service Jan. 1, 2012, and after, prior authorization is required for commercial lines of business, including Cover Tennessee, for the following procedures in an inpatient or outpatient setting:

- Panniculectomy
- Varicose Veins (color photos required)
- Blepharoplasty (color photos required)
- Tonsillectomy and Adenoidectomy under age three (3)
- Tonsillectomy under age three (3)
- Bariatric Surgery
- Breast Surgery for Augmentation or Reduction
- 72-hour Ambulatory Glucose Monitoring
- Neurobehavioral Status Exam
- Destruction of Cutaneous Vascular Proliferative Lesions less than 10 sq. cm (laser technique)
- Gastrointestinal Tract Imaging
- Hysterectomy
- Spinal Surgery

Prior authorization is not required for outpatient procedures for TRH members.

ADMINISTRATIVE

Prenatal ultrasound payment policy change

In keeping with American Congress of Obstetricians and Gynecologists (ACOG) recommendations, BlueCross BlueShield of Tennessee and Volunteer State Health Plan are changing the number of approved prenatal ultrasounds. Effective Feb. 1, 2012, **one** routine prenatal ultrasound for fetal anatomic survey per member per pregnancy will be covered. This affects procedural codes 76801, 76805 and 76811.

Consistent with ACOG guidelines, additional prenatal ultrasounds for fetal and maternal evaluation or follow up of suspected abnormality require a medical diagnosis and will be paid only with the appropriate diagnosis.
Current billing guidelines may be found in the *BlueCross BlueShield of Tennessee Provider Administration Manual* which is available on the company website www.bcbst.com/providers/manuals/, and in the *Volunteer State Health Plan Provider Administration Manual* available on the VSHP website, www.vshptn.com/providers/.

BlueCross focuses on improved quality care and service

The BlueCross BlueShield of Tennessee's 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, BlueCross 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® 2011 results show more emphasis is needed to increase rates for the following measures:

Product	HEDIS Measure		
	Retinal Eye	Mammogram	PAP Test
BlueCare - East	46.13 %	48.78%	66.05%
BlueCare - West	38.95%	45.19%	71.04%
TennCare*Select*	52.85%	24.81%	37.97%
Commercial	50.55%	67.26%	76.55%
CoverTN	23.66%	55.47%	63.31%
AccessTN	39.41%	68.17%	66.46%
Medicare Advantage - PFFS (H5884)	59.06%	72.43%	N/A
Medicare Advantage - LPPO	62.29%	78.4%	N/A

The Quality Improvement and Outreach Departments at BlueCross BlueShield of Tennessee continue to plan new initiatives to specifically promote 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 offer 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 of 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.

Reminder: New mandate requires hearing aid benefit for children

Recent legislation mandates coverage of up to $1,000 per hearing aid, per ear every three years for children under age 18. According to the mandate, "hearing aid" includes ear molds and services to select, fit and adjust the hearing aid. That means fittings are covered and included in the $1,000 limit. Any accessories, including batteries, cords and other assistive listening devices – such as FM systems – are excluded.

This benefit is effective for fully insured and non-ERISA self-funded groups upon new sale or renewal and for members with individual products on or after Jan. 1, 2012. Benefits are subject to deductible and coinsurance.

In order to process claims, providers will need to include the RT or LT (Right or Left) modifiers with the hearing aid codes. Hearing aid claims filed without one of these modifiers will be returned to providers.

Reminder: Continue to take action for ICD-10 readiness

Previously, we communicated about preparing for implementation of ICD-10. Although the implementation date, October 2013, seems far away, the necessary work that needs to be done prior to this date needs to happen now.

By now you should have an implementation plan and timeline of the potential impacts of

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE (Cont'd)

Reminder: Continue to take action for ICD-10 readiness (Cont'd)

the transition from ICD-9 to ICD-10. The ICD-10 implementation includes changes in the number of codes, number of characters per code, and increased code specificity. Key action items for you to consider:

- Reach out to your trading partners (clearinghouses, billing services, and other vendors) to determine their readiness
- Evaluate internal systems to determine need for upgrades and/or replacements
- Perform impact assessment to identify work flow, forms and business processes changes
- Prepare to train staff on any document changes and requirements
- Train coding and clinical staff that use ICD codes

BlueCross BlueShield of Tennessee will keep you informed as we move toward becoming ICD-10 compliant. For more information regarding ICD-10 implementation, please visit <http://www.bcbst.com/providers/ecomm/ICD10%20Frequently%20Asked%20Questions.pdf>

State of Tennessee member ID number

In January 2011, BlueCross BlueShield of Tennessee members covered under the State of Tennessee Public Sector plan (Group # 80860) had a change in how their member ID number was created. Every member was issued a new ID card in December 2010 reflecting this change.

This December, BlueCross will again issue all public sector members new ID cards containing the same new member ID number. All State of Tennessee Public Sector member claims filed after Dec. 31, 2011, must contain the new member ID number or the claim will be denied. Make sure you have a current copy of the new ID card. You will know it is the current card by the date (1/12) found in the bottom right hand corner on the back of the ID card (see picture below).

Drug prior authorization forms now available

Drugs requiring prior authorization can be requested by completing and faxing the forms that are available on the Provider page on bcbst.com: <http://www.bcbst.com/providers/pharmacy/Utilization_Management_Forms.shtml>

DRG threshold update *

Effective Jan. 1, 2012, DRG facilities will no longer be required to call in threshold reviews except on stays greater than eight (8) days. Discharge dates need to be called in or entered via the web on the day of discharge. If entered via the web, users can document in the same manner in which threshold reviews would normally have been entered. Transition of care nurses are available to assist with any discharge arrangements. Call 1-800-225-8698 for assistance with discharge arrangements or to initiate a referral to case management.

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 member ID card. Providers may refer patients to either program by calling one of the following numbers:

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

ADMINISTRATIVE

New maternity referral form available *

Effective immediately, the Global OB Form has been replaced with the new Maternity Care Management Notification Form. The new form may be used for three Managed Care Organizations including **BlueCare/TennCare*Select*** and has been approved by the Bureau of TennCare. The form is located on the Provider page of the company website www.bcbst.com under forms. If you have any questions, please call JoAnne Foster, Member and Provider Clinical Education Consultant at (423) 535-7737.

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueCare/TennCare*Select*

CLINICAL (Cont'd)

Outpatient emergency room facility billing guidelines *

In keeping with current correct coding standards, effective Jan. 1, 2012, Volunteer State Health Plan (VSHP) will require all providers to file the most appropriate HCPCS code in accordance with the National Uniform Billing Guidelines on CMS-1450/ANSI 8371 facility claim forms for emergency room revenue code 450. When an outpatient emergency room facility claim is received without an appropriate HCPCS code, the claim will be rejected with reject reason code 150155 "PROC CD MISSING/REV CD 0450 PRESENT". The provider must then submit a corrected claim that includes the appropriate HCPCS code. This guideline is applicable to outpatient facility claims.

New BlueCare/TennCare*Select* supplemental edits

Effective Jan. 1, 2012, two additional supplemental edits will be added as listed below:

8E0127 QUANTITY CANNOT BE < OR = TO ZERO

- Service Line Quantity cannot be less than or equal to zero.

8E0129 COUNTRY CODE INVALID

- Country Code (N404) is invalid (the N404 is a segment not a value)
- TennCare requires services to be provided in the United States
- This will apply to:
  - Billing, Pay-To and Service Facility Providers on **Institutional** claims
  - Billing, Pay-To, Service Facility, Service Facility Location and Ordering Providers on **Professional** Claims

Additional information may be found at <www.bcbst.com/providers/ecomm/CompanionImplementationGuides/Supplemental_BlueCareTennCareSelect_Edits.pdf>

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

New explanation code created for corrected bills

Effective Jan. 1, 2012, claims not filed according to corrected claim billing guidelines will be denied using EX WD1: *this service is not eligible since it was not filed according to the corrected billing guidelines; please submit a corrected claim.*

Prior to May 2008, these claims were denied EX TT: *Possible Corrected Bill-additional information is needed* and since then have been returned to the provider on the front-end with no EX code.

Corrected claim billing guidelines may be found in the *VSHP Provider Administration Manual* available online at www.vshptn.com/providers/.

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†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)

eBusiness Technical Support

Phone:	**423-535-5717**
e-mail:	ecom_techsupport@bcbst.com

Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

BlueCross BlueShield of Tennessee offices will be closed Dec. 23 & 26, 2011 and Jan. 2, 2012 in observance of the Holiday Season