BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

January 2012

# 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 Feb. 12, 2012**

- Auricular Electrostimulation
- Chelation Therapy
- Lymphedema Devices
- Surgical Treatment of Femoroacetabular Impingement

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

### Modified Utilization Management Guideline 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. 22, 2012**
***The following as relates to Inpatient and Surgical Care:***

- Renal Transplant

***BlueCross BlueShield of Tennessee will begin using Milliman Care Guidelines® 15th edition for Wound Care. The following Modified Utilization Management Guideline related to Wound Care will be archived:***

- Wound Care

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

### New drugs added to commercial specialty pharmacy listing

Effective Jan. 1, 2012, 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:***
Alimta (PA)
Erwinaze (PA)
Eylea (PA)
Nexplanon

***Self-administered via pharmacy benefit:***
Caprelsa (PA)
Ferriprox
Jakafi (PA)
Targretin (PA)

To obtain prior authorization for provider-administered specialty drugs call BlueCross at 1-800-924-7141.

For prior authorization of self-administered specialty drugs call Caremark at 1-877-916-2271.

## ADMINISTRATIVE

### Reminder: Prior authorization not required for anesthesia

Anesthesiology claims filed for outpatient surgeries will not be denied if no authorization is on file. Prior authorization is the responsibility of the outpatient facility and surgeon.

### Reminder: Acknowledgement of financial responsibility

If a BlueCross BlueShield of Tennessee network participating provider renders a service that is investigational or does not meet Medically Necessary and Appropriate criteria, the provider must obtain a written statement from the member prior to the service(s) being rendered. The written statement will acknowledge the member understands he/she will be responsible for the cost of the service(s) and any related service(s). This can also be used for member requests for non-emergency cosmetic or elective services specifically excluded under the member's health benefit plan.

To assist providers in this process, BlueCross has developed the *Acknowledgement of Financial Responsibility for the Cost of Services* form. This form can be found in the provider administration manuals, on B*lueSource*, our quarterly provider information CD and on the company website, www.bcbst.com. BlueCross strongly encourages providers to use this form as it meets contractual obligations of our network providers.

### 2012 HEDIS® medical record review project set to begin

BlueCross BlueShield of Tennessee and Volunteer State Health Plan, Inc. will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS®) project in February 2012. This is required to meet National Committee for Quality Assurance (NCQA) accreditation, as well as Bureau of TennCare and Centers for Medicare and Medicaid reporting requirements.

The Bureau of TennCare has expanded the measures that must be reported using medical record review this year. We will be seeking records for 17 different measures that focus on prevention and screening, diabetes care, cardiovascular care, access and availability and utilization.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### 2012 HEDIS® medical record review project set to begin (cont'd)

A BlueCross BlueShield of Tennessee representative will be contacting 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 18, 2012, to meet strict reporting timeframes for this project.

If you use a copy service, please notify them of the need to respond promptly to requests for records. BlueCross providers are required to submit copies of requested medical records without charge.

Note that BlueCross BlueShield of Tennessee and providers **can** continue to share information related to a member's protected health information (PHI) without a 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).

### Reminder: Dialysis center provider billing requirements

The composite rate, revenue codes: 0821, 0831, 0841, or 0851 should only be billed to BlueCross BlueShield of Tennessee when an actual dialysis treatment visit has been performed within the clinic. BlueCross allows the lesser of total covered charges or a percentage of all-inclusive composite rates negotiated in the contract. Except where specifically noted in the contract, the composite rate includes all services, drugs and supplies associated with dialysis, dialysis training or a combination of dialysis and training. In the event an inappropriate payment has been made, BlueCross reserves the right to recover the reimbursement.

### Getting the best impression

The first person your patients usually see is the Medical Receptionist. The journal, *Social Science and Medicine*, recently published a study on their work. The study found receptionists are not just the "gatekeepers" or "person behind the desk." Their responsibilities often extend way beyond their administrative duties. They are a vital part of patient care.

Medical receptionists deal directly with everyone coming into the office from patients to pharmaceutical representatives, mail men, lab couriers, etc. In addition to their administrative function, they may confirm prescriptions with an angry patient, congratulate a new mother, console a patient whose spouse just died or help a mentally ill patient make an appointment. A significant portion of their work involves managing the emotions and care of patients and families.

Medical receptionists are a key part of the relationship between patients and doctors and patients' feelings about the receptionist may be reflected in their opinions of their doctor.

### P4 Pathway Oncology Program update

P4 Pathway codes have been updated on the Provider page of the company website at http://www.bcbst.com/providers. Please refer to the P4 code list for current program codes and the generic incentive list effective Jan. 1, 2012. The website also provides a link to the P4 website with additional information about the P4 Pathway Oncology Program.

### 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, or the day before a BlueCross BlueShield of Tennessee holiday, until 4 p. m. (ET).

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

### 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 and holidays) requests must be submitted by phone.

Requests will be accepted within 24 hours or the next business day after admission by calling the prior authorization number listed on the member's ID card or the Utilization Management Department at 1-800-924-7141.

### Musculoskeletal management*

As previously communicated, select procedures now require prior authorization. Musculoskeletal is one of the areas in focus to help patients to receive higher quality care and improve clinical outcomes for patients suffering from musculoskeletal pain.

Effective March 1, 2012, BlueCross BlueShield of Tennessee will begin requiring prior authorization for the following musculoskeletal procedures for both commercial fully-insured and MedAdvantage plans.

- Pain Management
- Spinal Surgery
- Joint Surgery (Hip, Knee & Shoulder)
- Physical Medicine (MedAdvantage only)

Please note medical records may be required for the **initial** authorization review. Requests for authorization can be submitted by calling 1-800-388-8978, via www.bcbst.com web authorization or by fax to 1-800-520-8045. Musculoskeletal codes requiring prior authorization may be subject to change.

*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.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Reminder: Reimbursement of overpayment

If there is a payment from an auto insurance or Workers' Compensation that results in an overpayment, it is the responsibility of the provider to reimburse BlueCross BlueShield of Tennessee the overpaid amount. Providers should clearly state "auto paid claim" or "workers' comp paid claim" on the reimbursement to indicate the reason for the payment.

If a provider receives more than he/she should have when benefits are provided by a third party carrier, the provider will be expected to repay any overpayment to the appropriate insurer.

### Reminder: Importance of taxonomy codes

Some providers are contracted with BlueCross BlueShield of Tennessee under multiple specialty types, but have only one National Provider Identifier (NPI). A taxonomy code helps BlueCross identify the correct BlueCross Provider Identifier Number (PIN) for claims payment.

To avoid delayed claims payment, or payments being issued to the wrong PIN, submit claims using the appropriate taxonomy code.

# BlueCare/TennCare*Select*

## CLINICAL

### Appropriate antibiotic treatment

It is the time of year when your office will be filled with patients sniffling and coughing. Is it a cold or an infection? Studies have shown most patients expect to leave their doctor's office with a prescription, especially for antibiotics. If the patient has had the symptoms less than three days, you may want to provide educational materials and share your treatment rules to explain the risks of antibiotics outweigh the benefits. The Centers for Disease Control and Prevention (CDC) estimates that more than 100 million antibiotic prescriptions are written each year in the ambulatory care setting. With so many prescriptions written each year, inappropriate antibiotic use will promote resistance. In addition to antibiotics prescribed for upper respiratory tract infections with viral etiologies, broad-spectrum antibiotics are used too often when a narrow-spectrum antibiotic would have been just as effective. Volunteer State Health Plan continually plans new initiatives to specifically promote Best Practices. It is hoped that these interventions will improve rates, as has been the case for other areas of preventive care, such as annual well-care visits and immunizations.

The following Healthcare Effectiveness Data and Information Set (HEDIS®) measures of focus have been identified as priorities to improve the quality and health of our population. Our goal is to work with providers and members to increase the use of appropriate antibiotic treatment in adults with acute bronchitis (AAB) and children with upper respiratory infections (URI). It is our hope to promote an increase in understanding for our members with member mailings, newsletter articles and the development of provider posters. You may receive an onsite visit from a clinical team to discuss how we can work together toward this goal.

Sources:
<http://www.cdc.gov/getsmart/campaign-materials/info-sheets/child-approp-treatmt.pdf>

<http://www.cdc.gov/getsmart/campaign-materials/info-sheets/adult-acute-cough-illness.html>

**HEDIS appropriate treatment for children with URI = the percentage of children 3 months-18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.**

| | HEDIS 2011 | *Goal 2012 | **Benchmark |
|---|---|---|---|
| BlueCare East | 73.11% | 78.11% | 94.81% |
| BlueCare West | 74.67% | 79.67% | 94.81% |
| TennCare*Select* | 72.24% | 77.24% | 94.81% |

**HEDIS Avoidance of antibiotic treatment in AAB = the percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.**

| | HEDIS 2011 | *Goal 2012 | **Benchmark |
|---|---|---|---|
| BlueCare East | 19.22% | 25.22% | 31.61% |
| BlueCare West | 22.29% | 28.29% | 31.61% |
| TennCareSelect | 20.65% | 26.65% | 31.61% |

*Goal represents a meaningful improvement over the prior year as stated in the National Committee for Quality Assurance's (NCQA) minimum Effect Size Change Methodology

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

### Reminder - LDL-C & HbA1c initiative: Diabetes gaps in care

Volunteer State Health Plan, Inc. (VSHP) has partnered with LabCorp to use Lab-in-an-Envelope, an alternative approach to closing gaps in comprehensive diabetes care.

Lab-in-an-Envelope kits, with easy-to-follow instructions, will be mailed to non-compliant diabetic members who have gaps in LDL-C Screening and HbA1c Testing upon health plan receipt of physician order. This is a dry spot testing kit that contains all the necessary collection supplies and may be mailed to the member's home. The dry spot is then mailed back in a pre-addressed, pre-paid envelope. The lab results will be faxed to your office to help you 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 that you might find useful in treating your BlueCare and TennCare*Select* patients who suffer from diabetes. Our goal is to work with providers to increase HbA1c testing rates, LDL-C screening rates, reduce diabetes gaps in care, and improve diabetes care.

Please support this initiative by authorizing VSHP to send Lab-in-an-Envelope kits to

# BlueCare/TennCare*Select*

## CLINICAL (Cont'd)

### Reminder - LDL-C & HbA1c initiative: Diabetes gaps in care (Cont'd)

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's Disease Management department at 1-888-416-3025, Monday through Friday, 9 a.m. to 6 p.m. (ET). The MD order Lab-In-An-Envelope Authorization 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 a form from disease management.

### Changes to diabetic supplies order process*

To be consistent with TennCare's Pharmacy Benefit Management (PBM) billing guidelines, effective Jan. 1, 2012, providers will begin ordering supplies listed below through SXC Health Solutions, Inc.

Members currently receiving their supplies through VSHP will need to transition to SXC by March 1, 2012. **After March 1, 2012, diabetic supplies will no longer be available through VSHP.**

During this transition, for new members or members that have not previously received supplies through VSHP, providers should feel free to use SXC to avoid having members make another change on March 1, 2012.

- Alcohol Pads
- Blood Glucose Meters
- Blood Glucose Test Strips
- Glucose Control Solution
- Insulins
- Insulin Syringes
- Ketone Testing Strips (i.e. Ketostix®)
- Lancets
- Pen Needles- Syringe Needles

To order diabetic supplies, complete the *Prior Authorization Form for Diabetic Supplies* located on the SXC Health Solutions website at <https://tnm.providerportal.sxc.com/rxclaim/TNM/TC%20PA%20Request%20Form%20(Diabetic%20Supplies).pdf>

Fax the completed form to SXC at 1-**866-434-5523.**

**Contact Provider Service for BlueCare at 1-800-468-9736 or TennCare*Select* at 1-800-276-1978 if you have any questions or need assistance in transitioning existing members to SXC.**

## ADMINISTRATIVE

### OB delivery admission information*

Effective Feb. 1, 2012, network facilities will no longer be required to notify **BlueCare/TennCare*Select*** of maternity delivery admissions. These services are not subject to prior authorization/notification requirements, but may be subject to retrospective review based on Medical Policy. **All** services provided by **out-of-network** providers require prior authorization. **All** NICU admissions require authorization regardless of network status.

### 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.

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

### Reminder: Important claims information

**BlueCare/TennCare*Select*** claims must meet the following requirements or they will be rejected in their entirety and returned to the provider.

**Type of bill (TOB) 089x**

- Dates of service on a claim cannot span calendar months.
- Dates of service billed on line items must be within the claim header 'From & To' dates.
- The header "From" date must equal the earliest detail "From" date and the header "To" date must equal the latest detail date.

**TOB 066x**

- Dates of service on a claim cannot span calendar months.
- For room and board codes 0183, 0185, 0189, 0191, 0192, dates of service billed on line items must be within the claim header "From" and "To" dates.
- The header "From" date must equal the earliest detail "From" date and the header "To" date must equal the latest detail date.

### Clarification: SelectCommunity included in TennCare*Select* network

Recently, there have been questions about whether or not TennCare*Select* providers are part of the SelectCommunity network and vice versa. **All** participating **TennCare*Select*** providers are eligible to provide services to SelectCommunity members.

*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*

## ADMINISTRATIVE (Cont'd)

### Clarification: SelectCommunity included in TennCare*Select* network (Cont'd)

The SelectCommunity Network is composed of Primary Care Providers (PCPs) who have agreed to fulfill special roles and responsibilities associated with the management and care of SelectCommunity members. In exchange for fulfillment of these roles and responsibilities, an enhanced care management fee is paid for each SelectCommunity member who is assigned to their practice. SelectCommunity PCPs utilize the **TennCare*Select*** Network for specialty, facility and ancillary care.

If you are a **specialty, facility or ancillary care provider** in the **TennCare*Select*** Network, you are considered in network for SelectCommunity members. If you receive a call from a member asking if you accept SelectCommunity, the answer is, "Yes."

Please contact **TennCare*Select*** Provider Service† if you have any additional questions.

### SelectCommunity expansion

Effective Oct. 1, 2011, the Bureau of TennCare's program for persons with intellectual and/or developmental disabilities (I/DD) called SelectCommunity expanded in the West Grand Region. SelectCommunity will expand to the East Grand Region during the first quarter of 2012, and to the Middle Grand Region later in 2012.

Individuals covered by the State MR (Main) Waiver and Self-Determination Waiver programs are eligible to enroll into SelectCommunity's Integrated Health Services Delivery model by *opting in*. An "opt in letter" will be mailed to eligible individuals by the Bureau of TennCare, with a designated time frame for individuals to respond.

SelectCommunity members are assigned a Nurse Care Manager (NCM) who will serve as the member's and provider's primary point of contact for physical and behavioral health needs.

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

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

### Reminder: Utilization Management Reviews

To perform timely reviews of your faxed requests and avoid submission of duplicate requests, please be advised that VSHP has up to 14 days to complete non-urgent requests. Please allow up to 14 days to receive a response. If at that point you have not received a response, please feel free to contact us at:

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

### Reminder: Non-discrimination compliance training

Non-discrimination compliance training may be found on the company website at <http://www.bcbst.com/providers/bluecare-tenncareselect/index.shtml>. The training includes information about Title VI, and requirements for providing translation services for VSHP members. It is a self-guided training so you may view the information at your leisure.

### Reminder: VSHP home health agency requirements

As a reminder, home health agencies providing services to VSHP members should strictly adhere to the coding requirements as mandated by the Bureau of TennCare when billing for services. Failure to comply with the billing guidelines will delay payment for services and could subject agencies to recovery of payments.

Additionally, home health agencies caring for VSHP members are required to notify VSHP immediately of missed visits or shifts. Agencies should always have someone on call after normal business hours to notify VSHP so backup care can be arranged. Please call **800-262-2872** and notify VSHP as soon as you become aware of a potential missed visit or shift so we can help ensure our members receive the care they need. Family members should not be considered an appropriate backup for authorized home health care.

# BlueCard®

## Administrative

### Quick tips for a smooth out-of-area claims experience

At BlueCross BlueShield of Tennessee we strive to process claims quickly and accurately. Did you know you can make a difference in how quickly claims are processed? You can!

Following these helpful tips will improve your claim experience:

- **Include the member's complete identification number** when you submit the claim. This includes the three-character alpha prefix.
- **Ask members for their *current* member ID card** and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.

# BlueCard®

## Administrative (Cont'd)

### Quick tips for a smooth out-of-area claims experience (Cont'd)

- **Check eligibility and benefits** electronically at www.bcbst.com or by calling 1-800-676-BLUE (2583). Be sure to provide the member's alpha prefix.
- **Verify the member's cost sharing amount** before processing payment. Please do not process full payment upfront.
- **Indicate on the claim any payment you collected from the patient.** In cases where there is more than one payer and a Blue Cross and/or Blue Shield Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim.
- **Do not send duplicate claims.** Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- **Check claim status** by submitting an electronic HIPAA 276 transaction (claim status request) to BlueCross BlueShield of Tennessee or by contacting us at 1-800-705-0391.
- If you have any questions about claims filing for Blue members, refer to *BlueCross BlueShield of Tennessee Provider Administration Manual* or:
  - ***Talk to your Network Manager***
  - ***Visit us online at:*** http://www.bcbst.com/providers/bluecard/
  - ***Contact us at 1-800-705-0391***

# Cover Tennessee

## CLINICAL

### Performing CoverKids developmental screenings

The State of Tennessee's CoverKids plan provides comprehensive health coverage for children 18 years of age and under. Emphasis is placed on preventive care and services most needed by children, including vaccinations, well-child visits, healthy babies program, and developmental screenings.

Providers performing developmental/ behavioral screenings for CoverKids children should:

- use a standardized screening tool with interpretation and report;
- indicate in child's medical record a developmental screening was performed;
- document in child's medical record screening date, tool utilized and results; and
- file charges on a CMS-1500 claim form utilizing CPT® code 96110.

For more information on the CoverKids plan, visit the State of Tennessee website at http://www.covertn.gov/web/coverkids_benefits.html.

### Reminder: Disclosure form requirement

If you are a provider that participates in BlueNetwork S, one of the programs you service is CoverKids. Because the CoverKids program is funded in part by federal dollars, regulations require BlueCross BlueShield of Tennessee to maintain disclosure information on all its CoverKids providers.

BlueNetwork S providers not participating in the BlueCare/TennCare*Select* network with no disclosure form on file will soon receive a letter regarding this requirement. Failure to provide a completed disclosure form may lead to sanctions and exclusion from federal health care programs, including CoverKids.

The disclosure form will soon be available in the provider section of the company website, www.bcbst.com.

# BlueAdvantage®

## ADMINISTRATIVE

### BlueAdvantage out-of-area claims

For quick tips on a smooth out of area Blue Advantage claims please see our BlueCard section of the newsletter. Additionally, check the Provider page on our website at www.bcbst.com/providers/news/ for new information on other Blue plans whose groups have joined our network.

*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: Select Option 2 at **423-535-5717**
e-mail: ecom_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

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**February 2012**

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## CLINICAL

### Medical Policy updates/changes

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**Effective March 9, 2012**

- Biofeedback and Neurofeedback
- NOTCH 3 Genetic Testing for the Presence of Mutations Associated with CADASIL

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

### High-tech imaging medical policy revised

The medical policy, **Magnetic Resonance Imaging (MRI) of the Breast,** has been reviewed and revised, and is now consistent with MedSolutions guidelines. A draft of this revised policy is available on BlueCross BlueShield of Tennessee's web site at: http://www.bcbst.com/providers/mpm.shtml

## ADMINISTRATIVE

### Accessing Physician Quality and Cost Reporting Program

Updates to the Physician Quality and Cost Information will soon be made available for private physician[1] review on our secure BlueAccess Web portal.

Physicians will once again have a 45-day review period to update their data before it is released to our customers.

In order to access their quality and cost information, physicians must have a *BlueAccess* user ID and password.

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 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: Credentialing/ Recredentialing application submissions

Providers are reminded their credentialing and/or recredentialing applications can be submitted via the following methods.

Email : Credentials@bcbst.com

Fax: 1-423-535-8357
1-423-535-6711

Mail: BlueCross BlueShield of TN
Credentialing Dept – CH 2.4
1 Cameron Hill Circle, Suite 0007
Chattanooga, TN 37402-0007

### Reminder: Documentation requirement for Evaluation & Management (E&M) services

BlueCross BlueShield of Tennessee audit functions uphold recognized coding and billing guidelines. The CPT® Manual and both the 1995 and 1997 Centers for Medicare & Medicaid Services *Documentation Guidelines for Evaluation & Management Services* specify the documentation that must be present in a provider's medical records to support the level of office visit billed for professional services. For most visits, practitioner documentation must include the required elements for the key components History, Examination, and Medical Decision Making.

BlueCross auditors have identified one element frequently missing in practitioner office notes is the patient's past, family, and social history (PFSH). A PFSH obtained during an earlier encounter does not need to be re-recorded **IF** there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:

- describing in the note any new PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier PFSH.

PFSH may be recorded by ancillary staff or on a form completed by the patient. To document the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

In addition to individual requirements of E/M services, medical necessity of the service is the overarching criterion for code selection. It would not be medically necessary or appropriate to bill a higher level of E/M based solely on the volume of documentation, when a lower level of service was provided to the patient.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Reminder: Documentation requirement for Evaluation & Management (E&M) services (Cont'd)

It may be appropriate to bill some E/M visits based on contributory components including counseling, time, and other factors. These require specific and thorough documentation.

To review all elements required to support an E/M level and its medical necessity, please access the CMS Documentation Guidelines at www.cms.gov or review your current CPT® manual.

### 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*, BlueCross's quarterly provider information CD and online on our company web sites www.bcbst.com and www.vshptn.com.

### Reminder: Musculoskeletal Management

As previously communicated, select procedures now require prior authorization. Musculoskeletal is one of the areas in focus to help patients receive higher quality care and improve clinical outcomes for patients suffering from musculoskeletal pain.

Effective March 1, 2012, BlueCross BlueShield of Tennessee will begin requiring prior authorization for the following musculoskeletal procedures for both commercial fully-insured and Medicare Advantage plans.

- Pain Management
- Spinal Surgery
- Joint Surgery (Hip, Knee & Shoulder)
- Physical Medicine (MedAdvantage only)

Blue Cross is focusing on helping patients receive higher quality care and improving clinical outcomes for patients suffering from musculoskeletal pain.

Please note medical records may be required for the **initial** authorization review. Requests for authorization can be submitted by calling 1-800-388-8978, via www.bcbst.com web authorization or by fax to 1-800-520-8045. Musculoskeletal codes requiring prior authorization may be subject to change.

For questions about this program, please contact Beverly West at 423-535-3523.

### Reminder: Predetermination of benefits provided as a courtesy

Predeterminations are never required, but are performed as a courtesy for Commercial, Cover Tennessee and BlueAdvantage lines of business. Providers can request a predetermination review to check benefits/coverage, exclusions/riders, possible pre-existing conditions and to ensure services meet medical criteria/ guidelines. Predetermination reviews do not take the place of any prior authorization requirements. Failure to obtain any necessary authorization may result in a denial or reduction in benefits. Predeterminations are normally handled within 15 days of receiving the request.

### Promote health literacy through plain language

Have you heard of "Plain Language?" This is part of a national program encouraging health care providers to promote health literacy among their patients by ensuring they **understand** written and oral health information.

The National Adult Literacy Survey found that 66 percent of adults age 60 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 sixth 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 better follow your instructions. This is also important for your patients who do not speak English as their primary language.

For additional information on health literacy, please refer to the Department of Health and Human Services web site at http://www.hrsa.gov/publichealth/healthliteracy/.

### February is American heart month/national wear red day

Heart disease is the leading cause of death in the United States. Coronary heart disease is the most common, and often appears as a heart attack. 785,000 Americans had a new coronary attack in 2010, and roughly 470,000 had a recurrent attack. (Statistics from the Centers for Disease Control and Prevention).

National Wear Red Day is Feb. 3, 2012. Please support this initiative to raise awareness about women and heart disease among your patients, family and friends. More information about National Wear Red Day may be found at the National Heart Lung and Blood Institute web site <http://www.nhlbi.nih.gov/educational/hearttruth/materials/wear-red-toolkit.htm>.

*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.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Web authorization system enhanced

The following improvements have been made to the web authorization process based on comments from network providers:

- The web authorization form timeout for idol behavior has been increased from 20 minutes to 35 minutes, which allows the clinician more time to gather clinical information and complete the authorization form without receiving a timeout message. To reset the session timeout, either save your authorization or simply use the back button to maneuver to a different screen inside the web authorization system. Moving from one screen to another within the system will continue to reset the session timeout and prevent your receiving the timeout message.
- Authorizations submitted through the web authorization system are housed in the clinical update section of the Authorization/Advance Determination Submissions section of eHealth Services. The system has been enhanced to expand the authorization history to 35 days past the last clinical update date.
- You have spoken, and we have listened! eHealth Services has been enhanced to include an "Announcement" section as the Home page header. Updates and changes to the eHealth Services forms will be listed in this section as well as in monthly *BlueAlert* newsletters.
- Recently, the confirmation numbers surpassed seven (7) characters and are now the automatically assigned confirmation numbers are eight (8) characters. This enhancement increases the confirmation number field to allow eight (8) characters instead of the current seven (7) character limitation throughout the web authorization application.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE

### Reminder: 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 two types of reviews, Complex and Automated.

**Complex Reviews** are a thorough review of a medical record for coding validation and utilization review. **Automated Reviews** do not require a medical record. All complex reviews are performed with Corporate Medical Director oversight by physicians, RNs and certified coders. For more information, please refer to the Frequently Asked Questions (FAQs) available on the Provider page of the company web site, www.bcbst.com.

### Reminder: Non-emergency medical transportation

Non-emergency transportation services are provided for **BlueCare** and **TennCare*Select*** members to and from their health care appointments. All non-emergency transportation should be scheduled and receive prior authorization from Southeastrans, Inc. before a service is provided. A notice of at least seventy-two (72) hours is requested prior to the member's appointment.

Volunteer State Health Plan communicates how to arrange non-emergency transportation services to members via the member handbook.

Members are not required to travel excessive distances. Examples of possible excessive distance requests include a request for transportation services to a provider that is not in the area where the member resides, or a request for Medicaid transportation services to a provider that is not in the same county, bordering county or metropolitan area in a bordering state for beneficiaries living in rural areas. The general guideline is that PCP appointments greater than 30 minutes or 30 miles or appointments for specialty services greater than 90 miles must be evaluated by the plan.

### Reminder: Non-urgent prior authorization requests

Telephone inquiries regarding prior authorization requests should be directed to Provider Service at 1-800-468-9736 for **BlueCare** and 1-800-276-1978 for **TennCare*Select***. Please have the reference number available so we can quickly assist you.

Also have your reference number available when contacting the **BlueCare/ TennCare*Select*** Prior Authorization Department. Due to high call volume, it may be necessary to leave a message including your reference number. Your call will be returned by the next business day.

Remember that non-urgent prior authorization request decisions may take up to fourteen (14) calendar days from the receipt of the request.

### Reminder: Disclosure of Ownership and Control Interest Statements

**BlueCare/TennCare*Select*** providers are required by federal guidelines to complete a current disclosure form with Volunteer State Health Plan (VSHP). The disclosure form must be submitted at the time the provider is initially accredited or re-accredited by VSHP at least once every three years. **Effective April 1, 2012, claims payments will be suspended until such time as a current form is on file**.

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 VSHP and the State of Tennessee Bureau of TennCare, VSHP must maintain disclosure information on all its providers and tax reporting entities with billing activities.

*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*

## ADMINISTRATIVE (Cont'd)

### Reminder: Disclosure of Ownership and Control Interest Statements (Cont'd)

Tax reporting entities with billing activities (groups and facilities) and each rendering practitioner under the entities tax identification number are required to complete a disclosure form in accordance with federal guidelines. **For example:** If a group (entity) contains ten (10) practitioners, each practitioner should complete one (1) *Disclosure Form for a Provider Person*. Additionally the group as a whole (tax-reporting billing entity) should complete one (1) *Disclosure Form for Provider Entities*. A total of 11 disclosure forms would be required in this example.

If you have any questions please call BlueCross BlueShield of Tennessee's Provider Service line† and choose the "Network Contracting" option.

The **BlueCare/TennCare*Select*** disclosure forms and FAQs are available on the company web site at www.bcbst.com/providers/bluecare-tenncareselect/index.shtml under the **BlueCare/TennCare*Select*** Disclosure section.

# Cover Tennessee

## ADMINISTRATIVE

### Reminder: Disclosure form requirement for CoverKids

If you are a provider that participates in BlueNetwork S, one of the programs you service is CoverKids. Effective immediately, CoverKids providers must complete a disclosure form. This is in keeping with federal regulations in 42 C.F.R. § 457.935 and Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) federal health care programs pursuant to Sections 6504 {et seq.} of the Affordable Care Act, which amends § 1902 (a)(39) of the Social Security Act. Federal regulations require that the CoverKids/Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) program monitor the payments of federal funds to Providers. CoverKids will implement these federal requirements by the use of a disclosure form (*CoverKids Provider Disclosure Form* and/or the *Bureau of TennCare Disclosure Form*) to collect the information required in 42 C.F.R. § 455 et seq, as well as other information deemed necessary by the State. Failure to provide the disclosure form or to accurately supply the required information may lead to sanctions and exclusion from federal healthcare programs, including CoverKids.

Providers in BlueNetwork S who do not participate in the **BlueCare/ TennCare*Select*** Networks with no disclosure form on file were sent letters in December with this information, an instruction sheet, and disclosure form. If the requested information has not returned, please do so immediately. Disclosure forms are available in the Cover Tennessee section on the Provider page of the company web site, www.bcbst.com. They may be faxed to Medicaid Network Strategy – OWDC at (423) 535-5808, (423) 535-3066, or (423) 591-9342.

If you have any questions, please contact the BlueCross BlueShield of Tennessee Provider Service Line† and choose the "Network Contracting" option.

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### Non-discrimination compliance training

Non-Discrimination Compliance Training may be found on the company web site at http://www.bcbst.com/providers/ under Cover Tennessee. The training includes information about Title VI, and requirements for providing translation services for CoverKids members. This training is self-guided so you may view the information at your leisure.

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*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.

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### †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

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

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

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

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

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

***BlueCare/TennCareSelect Medical Management Hours***
Monday-Friday, 8 a.m. to 6 p.m. (ET)

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

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

***eBusiness Technical Support***
Phone: Select Option 2 at **423-535-5717**
e-mail: ecom_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

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# BlueAlert
provider news flash

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Please Route to all Providers & Office Staff

**March 2012**

## 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 April 13, 2012**

- Analysis of Proteomic Patterns in Serum for Early Detection of Cancer
- Functional MRI
- Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy
- Cytoreduction and Hyperthermic Intraperitoneal Chemotherapy
- DNA-Based Testing for Adolescent Idiopathic Scoliosis
- Ventricular Assist Devices (VAD) and Total Artificial Heart

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

### ICD-10 Implementation Guides available

Although the ICD-10 implementation effective date of October 2013 seems far away, it is important that you have already begun preparations and are taking the necessary steps to be ready.

To help with your preparation for ICD-10, The Centers for Medicare & Medicaid (CMS) has developed Implementation Guides and has made them available on the CMS website. These guides are for those who are just beginning the process or in the middle of preparing for the transition. There is a guide available for large group providers, small/medium group providers and vendors.

Each guide provides systematic plans and relevant templates for planning and executing the ICD-10 transition process. You can download the templates in either Excel or PDF files. They are customizable and created to help entities clarify staff roles, set internal deadlines/responsibilities and assess readiness.

Look for the ICD-10 Implementation Guides and other ICD-10 information available through our website at <http://www.bcbst.com/providers/ecomm/hipaa-5010-upgrade.shtml>.

### Changes to commercial specialty pharmacy listing

Effective March 1, 2012, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

***Self-administered via pharmacy benefit:***
Erivedge (PA)
Kalydeco (PA)
Inlyta (PA)

Berinert® can now be obtained as provider-administered (PA) or self-administered (PA).

Soliris® is provider-administered and requires prior authorization effective March 1, 2012.

## ADMINISTRATIVE

### Reminder: State of TN vision services

Please remember that the State of TN does not have routine vision benefits. The member is only eligible for one non-refractive vision screening per calendar year. The State of TN has been configured so that only CPT® Code 99174 counts as the member's annual non-refractive vision screening. All other codes and routine vision diagnosis codes have been configured to deny as a non-covered service.

### Reminder: Filing corrected bills appropriately

Providers often times find themselves needing to make changes to a previously submitted claim. When this is necessary, ALWAYS remember to file a corrected bill according to guidelines in the Billing and Reimbursement Sections of both the BlueCross BlueShield of Tennessee and Volunteer State Health Plan provider administration manuals.

Corrected claims not submitted according to these guidelines can result in the charges being denied as a duplicate rather than being processed as 'corrected', or in some cases even paid a second time in error.

It may then be necessary for the provider's office to call the Provider Service Line† and speak with a Consumer Advisor to correct the situation, or submit a refund to BlueCross for the duplicate payment.

### Use of accredited facilities for advanced radiology imaging services

Effective April 1, 2012, services for advanced radiology imaging services must be performed at an accredited facility. If a request for prior approval is submitted to MedSolutions and the service is to be performed at a non-accredited facility, you will receive a message that a non-accredited facility has been chosen. Use of a non-accredited facility may result in the service(s) being denied as non-covered with no member liability. For help in choosing an accredited facility contact MedSolutions at 1-888-693-3211.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Reminder: Changes to prior authorization requirements for select procedures

New authorization requirements were implemented Jan. 1, 2012, 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 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

A grace period has been allowed and no denials have been issued due to lack of authorization. **Beginning April 1, 2012 if no authorization is obtained, denials will begin to be issued and benefits will not be eligible.**

**Note:** Prior authorization is not required for outpatient procedures for TRH members.

### New options coming for electronic claims submission

Currently, BlueCross BlueShield of Tennessee transmits claims electronically through ECGateway using dial-up modem. BlueCross will soon offer several options using the Internet including a secure website, Secure File Transfer Protocol (SFTP) and File Transfer Protocol (FTP) over SSL. Watch for information on start dates and times in upcoming BlueAlerts.

### Reminder: Diabetic mail order modifier required

Diabetic Mail Order companies are reminded to include the KL modifier when submitting claims. The Centers for Medicare and Medicaid Services (CMS) added the KL modifier for use on claims for diabetic supplies that are delivered via mail with dates of service July 1, 2007, and after.

Per CMS, "The KL modifier shall be used with diabetic supplies identified by the codes (A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259) that are ordered remotely and delivered to the beneficiary's residence by common carriers (e.g., US postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier store fronts."

BlueCross BlueShield of Tennessee follows CMS guidelines for pricing and modifier usage. Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule are required for correct claim adjudication. Providers can view this document on the CGS website, http://www.cgsmedicare.com.

### OB Delivery Admissions

Effective immediately, facilities will no longer be required to notify BlueCross BlueShield of Tennessee of maternity **delivery** admissions for commercial lines of business. **All** NICU admissions will continue to require authorization.

# BlueCare/TennCare*Select*

## CLINICAL

### Spirometry testing

For the assessment and diagnosis of Chronic Obstructive Pulmonary Disease (COPD), the most common pulmonary function test is the spirometry test. It can be performed with a hand-held device and can

easily be used by your patients with the help of an experienced technician. This noninvasive procedure could be a big help in diagnosing a respiratory problem. **BlueCare/TennCare*Select*** members 40 years of age and older will be receiving information about COPD and the use of spirometry testing in March.

### Low back pain diagnosis and treatment

Low back pain ranks as the fifth highest reason that patients go see a physician. Roughly 25% of U.S. adults have reported having low back pain that lasted for at least one whole day in the past 3 months. The corresponding costs for care and missed work add up quickly. Most patients who seek medical care usually improve rapidly in the first month. There are large variations in diagnostic tests and treatments, but the outcomes are similar despite significant differences in the costs of care. Guidelines published by the American College of Physicians (ACP) have offered new recommendations on the treatment of Low Back Pain (LBP) based on their research in partnership with the American Pain Society (APS).

Prior to ordering imaging studies, providers are recommended to do a focused history and physical examination. Providers should give patients evidence-based information on low back pain with their course of action and effective self-care options, as well as encouraging them to remain active.

Providers should consider the use of medications that have proven benefit results when used with back care information and patient self-care. For most patients, the first-line medication options would be acetaminophen or nonsteroidal anti-inflammatory medication.

For patients who do not improve with self-care options, providers may consider adding nonpharmacologic therapy that has proven benefits such as or intensive interdisciplinary rehabilitation, exercise therapy, cognitive-behavioral therapy or progressive relaxation for patients with chronic or subacute low back pain.

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## CLINICAL (Cont'd)

### Low back pain diagnosis and treatment (Cont'd)

If there are severe or progressive neurologic deficits present, or serious underlying conditions are suspected based on the results of the history and physical examinations, diagnostic imaging and testing are recommended along with the inclusion of the other conditions on the claim for easy reference. Patients with persistent low back pain and symptoms or signs of radiculopathy or spinal stenosis should be evaluated with magnetic resonance imaging (MRI) or computed tomography only if they are potential surgery candidates or will be treated with an epidural steroid injection (for suspected radiculopathy).

Quality of care for the patient is top priority. Part of that is not having patients go through unnecessary tests or treatment. Progressive treatment levels for low back pain are strongly encouraged.

Resource: *Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society.* Roger Chou, MD; Amir Qaseem, MD, PhD, MHA; Vincenza Snow, MD; Donald Casey, MD, MPH, MBA; J. Thomas Cross Jr., MD, MPH; Paul Shekelle, MD, PhD; and Douglas K. Owens, MD, MS, for the Clinical Efficacy Assessment Subcommittee of the American College of Physicians and the American College of Physicians/ American Pain Society Low Back Pain Guidelines Panel.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE

### Reminder: NICU utilization management reviews

Effective Feb. 1, 2012, **all** NICU admissions require authorization regardless of network status. **All NICU** requests are to be submitted by fax only. This will ensure a timely response to your NICU requests.

Submit all initial NICU requests to fax line 423-535-1861**,** as well as DRG threshold updates and concurrent review requests if the baby is not being managed by Alere Case Management.

**Please continue to send all updates to Alere if the baby is being followed by Alere Case Management, at fax number 201-512-7126.**

VSHP has up to fourteen (14) days to complete their review and respond to non-urgent requests. For questions contact us at:

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

### March quality initiative - Quitting Tobacco

Any day is a good day to quit smoking or using other tobacco products. In March, Volunteer State Health Plan would like to encourage providers to counsel smokers and tobacco users to quit and provide them with resources to help them.

Tennessee Tobacco QuitLine is available at **1-800-QUIT-NOW** (1-800-784-8669). There are also resources available for providers and members online at http://health.state.tn.us/tobaccoquitline.htm.

Let's not wait until the Great American Smoke Out to make this a healthy goal for our members.

**March is National Colorectal Cancer Awareness Month. This is a good time to remind your patients age 50 to 75 years old to have this important screening.**

# BlueAdvantage

## ADMINISTRATIVE

### 2011 Medicare Health Outcome Survey Results Are In

Every year, The Centers of Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to participate in the annual Medicare Health Outcomes Survey (HOS). This survey allows CMS to measure and trend certain aspects of quality among Medicare Advantage health plans, like BlueAdvantage. This measurement, in turn, allows Medicare beneficiaries to compare the quality ratings of their health plan with those of other prospective plans.

The treatment you provide to Medicare Advantage subscribers is critical to the success of a Medicare Advantage health plan. Measures such as improving or maintaining physical health, improving or maintaining mental health, monitoring physical activity, improving bladder control, and reducing the risk of falling are all measures that impact the quality outcomes of a Medicare Advantage health plan.

Quality scores for most of these measures are lower than anticipated for the BlueAdvantage plan. The following measures have been identified as needing to be addressed with your Medicare Advantage patients at the appropriate interval:

- Discuss and advise physical activity, at least every 12 months
- Discuss and treat urinary incontinence, at least every 6 months
- Discuss and manage fall risk, at least every 12 months

# BlueAdvantage

## ADMINISTRATIVE (Cont'd)

### Correct coding of bevacizumab (Avastin®) for intravitreal injection

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

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

Billing guidelines for compound drugs can be reviewed in the billing and reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual* found online at www.bcbst.com.

# Cover Tennessee

## ADMINISTRATIVE

### New explanation code created for corrected bills *

Effective April 1, 2012, for 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 April 1, 2012, these claims have been returned to the provider on the front-end with no EX code. Corrected claim billing guidelines may be found in the *Blue Cross Blue Shield of Tennessee Provider Administration Manual* available on the company web site at <BlueCross BlueShield of Tennessee Provider Administration Manual>

**Note:** Applies to CoverTN, AccessTN, CoverKids and HealthyTN Babies

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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## †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

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

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

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

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

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

***BlueCare/TennCareSelect Medical Management Hours***
Monday-Friday, 8 a.m. to 6 p.m. (ET)

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

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

***eBusiness Technical Support***
Phone: Select Option 2 at **423-535-5717**
e-mail: ecom_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

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*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAlert

provider news flash

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**April 2012**

## 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 05/06/12**

- Magnetic Resonance Imaging (MRI) of the Breast

**Effective 05/12/2012**

- Bioimpedance Devices for Detection of Lymphedema
- Bone Turnover Markers for the Diagnosis and Management of Osteoporosis
- Computed Tomography Angiography for Coronary Artery Evaluation
- Hyperbaric Oxygen Pressurization Therapy (HBO2)
- Pegloticase

**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:

**Guidelines for the Diagnosis and Management of Asthma (EPR-3) 2007**
<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 American Academy of Neurology**
<http://www.neurology.org/cgi/reprint/55/6/754.pdf>

**Global Initiative for Chronic Obstructive Lung Disease. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease (Revised 2011)**
http://www.goldcopd.org/

**AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update**
<http://circ.ahajournals.org/content/124/22/2458>

**CSI: Health Care Guideline: Routine Prenatal Care (14th edition. 2010, July)**
<http://www.icsi.org/prenatal_care_4/prenatal_care__routine__full_version__2.html>

**ACOG: Guidelines for Perinatal Care, 6 Edition (2007)**
Available for purchase at:
<http://www.acog.org/bookstore/Guidelines_for_Perinatal_Care__P262.cfm>

**Standards of Medical Care in Diabetes - 2012**
<http://care.diabetesjournals.org/content/35/Supplement_1/S11.full.pdf+html>

**Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III Final Report) (2002)**
<http://www.nhlbi.nih.gov/guidelines/cholesterol/profmats.htm>

**Implications of Recent Clinical Trials for the National Cholesterol Education Program**
**Adult Treatment Panel III Guidelines (2004)**
<http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04.pdf>

Hyperlinks to these guidelines are also available within the B*lueCross 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 – Importance of keeping Provider Data Verification Form current

A Data Verification Notice is sent to participating providers to confirm the most up-to-date demographic, patient acceptance, medical license and other important claims processing information is loaded in the claims adjudication system. If a provider's demographic information is not up-to-date, claims payments could be delayed or sent to an incorrect address.

The patient acceptance information is beneficial to determine if your practice is open or closed to commercial and/or government plan members.

Please notify BlueCross BlueShield of Tennessee Provider Network Services department when you have changes by calling 1-800-924-7141 and say "Network Contracting" or choose Option 2; or go to our website at http://www.bcbst.com/providers/forms/ and complete the Practitioner Change Form.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## CLINICAL (Cont'd)

### Quantitative sensory testing and AXON-II™ & Neural-Scan™ devices

Quantitative sensory testing (QST) systems are used as a noninvasive assessment and quantification of sensory nerve function in individuals with symptoms of, or the potential for, neurologic damage or disease. QST devices measure and quantify the amount of physical stimuli required for sensory perception to occur in the individual. QST can assess both small and/or large fiber dysfunction based on the type of device used. Some devices evaluate small myelinated and unmyelinated nerve fibers via vibration or thermal thresholds. Pressure-specified sensory devices assess large myelinated sensory nerve function by quantifying the thresholds of pressure detected with light, static and moving touch. Current perception threshold testing (i.e., sensory nerve conduction threshold testing) involves the quantification of the sensory threshold to transcutaneous electrical stimuli. In current perception threshold testing, three different frequencies are typically tested (there is some variability among products): 5 Hz, designed to assess C fibers; 250 Hz, designed to assess A-delta fibers; and 2,000 Hz, designed to assess A-beta fibers. Some devices are referred to as voltage-actuated sensory nerve conduction threshold tests, but this is another type of quantitative test of sensory function and represents a modification of current perception threshold testing.

The AXON-II™ NCSs System, Neural-Scan™ and Medi-DX 7000® are examples of marketed current perception threshold testing or voltage-actuated sensory nerve conduction threshold testing devices. Sensory testing performed using any of these devices, or a similar device, does not qualify to be billed as a nerve conduction study, but should be submitted using an appropriate quantitative sensory testing procedure code on the claim form. Billing of quantitative sensory testing using a nerve conduction study procedure code would be submitting a claim with the wrong procedure code for the service actually delivered. The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) does not endorse the use of quantitative sensory testing in the assessment of sensory nerve function. Effective April 2004, CMS concluded that the use of any type of sensory nerve conduction threshold device (e.g., current perception threshold testing, voltage-nerve conduction threshold testing or pain tolerance threshold testing) to diagnosis sensory neuropathies or radiculopathies was not reasonable and necessary. BlueCross BlueShield of Tennessee, and most other health insurers, consider all forms of quantitative sensory testing to be investigational; thus, not eligible for coverage.

## ADMINISTRATIVE

### Reminder: Allow adequate time before requesting claim status

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

Providers may also check claims status online through BlueAccess, the secure section on BlueCross' website, www.bcbst.com.

### Preparation for ICD-10 moving forward despite possible delays

The U.S. Department of Health and Human Services announced in February their intent to initiate a process to postpone the compliance date for ICD-10. With the possible delay for transitioning from ICD-9 to ICD-10, BlueCross BlueShield of Tennessee suggests you take this opportunity to continue improving processes to be ICD-10 ready in the future.

- Focusing on improving clinical documentation can make the ICD-9 to ICD-10 transition easy. This will also have a positive effect on quality of care and reporting.
- Continue making the necessary changes to get your system ready for ICD-10. This will help to avoid any further delays and allow you to get a jumpstart on being compliant by the implementation date.
- Take this time to invest in educating coders. The ICD-10 coding system is more specific and detailed than ICD-9. Becoming more familiar with anatomy and physiology can benefit coders.

BlueCross is moving forward in preparation for ICD-10, so that we can continue to best serve the needs of our customers at any future compliance date.

For additional information on ICD-10 implementation and BlueCross BlueShield of Tennessee readiness, please visit our website at http://www.bcbst.com/providers/ecomm/ and click on the link **HIPAA 5010 and ICD-10 Information**.

### eBusiness updates/changes *

To allow electronic submitters to use the latest technologies to transmit claims, BlueCross BlueShield of Tennessee will be launching the new Secure File Gateway (SFG) tool effective May 1, 2012. The SFG will offer internet-based connectivity options and will replace the current EC Gateway Bulletin Board System.

If you submit claims electronically to BlueCross you or your vendor **must** be transitioned into the new system by following instructions located on our website at <http://www.bcbst.com/providers/ecomm/technical-information.shtml>. Please do not delay in taking action or your ability to submit electronic claims may be impacted.

Also, as phase two of our *Voice of the Customer* campaign, we are pleased to announce the merger of the Provider Outreach Department with the eBusiness marketing and support teams. The outcome of the merger is one cohesive voice for our entire provider community for all of your eBusiness needs. The former phone number, (423) 535-1090 for the Provider

*These changes will be included in the appropriate 2Q 2012 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)

### eBusiness updates/changes (cont'd)

Outreach Department will be phased out soon. If you have any questions about the new BlueCross Secure File Gateway or have any other eBusiness needs, please contact us at:

**Phone:** Select Option 2 at **423-535-5717**
**e-mail:** ebusiness_support@bcbst.com
Monday through Thursday, 8 a.m. to 5:15 p.m. (ET) and Friday, 9 a.m. to 5:15 p.m. (ET)

### New genetic testing codes

Effective Jan, 1, 2012, the American Medical Association (AMA) released 101 additional molecular pathology procedure codes. Each of these new molecular pathology procedure codes represents a test that is being performed and which may be billed to BlueCross BlueShield of Tennessee. Providers presently bill these genetic tests with the existing CPT® "stacked" codes or bill in combination with each other to represent one given test.

For payment purposes, these new molecular codes have been assigned a status "B" (Bundled Service). Reimbursement for the code will be bundled to the service to which it is incident regardless of location of service. It will reimburse $0.00 when billed in combination with other codes or alone.

When performing these genetic tests, BlueCross requests providers bill both the "stacked" codes, if applicable, and the new single CPT® code that corresponds to the test represented by the "stacked codes".

### Reminder: Changes to prior authorization requirements for select procedures

Effective Jan. 1, 2012, the following procedures began requiring prior authorization for commercial lines of business, including Cover Tennessee. BlueCross BlueShield of Tennessee has allowed a grace period for providers to adjust to the new requirement and has held no request non-compliant. In the March *BlueAlert* we communicated the grace period would be ending April 1, and providers would be held noncompliant when failing to obtain authorization. The grace period has been extended to April 15, 2012, to allow additional time for providers to implement this new requirement. After April 15, denials will begin to be issued and benefits will not be eligible.

- Panniculectomies (surgical removal of abdominal fat, "tummy tuck")
- Varicose Veins
- Blepharoplasties (surgical removal of skin of the upper eyelid, "lift")
- Tonsillectomy and Adenoidectomy under age 3
- Tonsillectomy under age 3
- Bariatric Surgery (if covered by your plan)
- Breast Surgery for Augmentation and Reduction
- 72-hour Ambulatory Glucose Monitoring
- Neurobehavioral Status Exam/Neuropsychological Testing
- Destruction of Cutaneous Vascular Proliferative Lesions (pediatric birthmarks) less than 10 sq. cm (laser technique)
- Gastrointestinal Tract Imaging
- Hysterectomies
- Spinal Surgeries

**Note:** Prior authorization is not required for outpatient procedures for Tennessee Rural Health members.

# BlueCare/TennCare*Select*

## CLINICAL

### Quality focus for April: Asthma and allergy awareness

Spring has sprung and the pollen is everywhere. Most people look forward to this time of year for the beauty of nature, but for your patients with asthma and allergies, it can be rough. VSHP has special programs in place to assist in the care of your patients.

The CareSmart Asthma program is a Disease Management (DM) program designed to provide members with the tools they need to better understand and manage their asthma. CareSmart is intended to reinforce the physician's treatment plan for the member and provide clinical updates to the physician as requested. Goals of the program are to:

- increase the member's knowledge of asthma self-care through education and support;
- reduce the number of emergency room visits for asthma-related issues;
- reduce inpatient hospital admissions;
- increase enrollment in the Asthma DM Program and compliance in an asthma action plan;
- increase the use of appropriate medications for members with asthma.

All **BlueCare** and **TennCare*Select*** members with a diagnosis of asthma are eligible to participate in the program. These members are automatically enrolled; however, participation is voluntary. You can enroll **BlueCare** and **TennCare*Select*** members in the CareSmart Asthma program as soon as asthma is diagnosed. Enroll members in the program by calling 1-888-416-3025.

## ADMINISTRATIVE

### Filing ambulance claims appropriately *

Effective May 1, 2012, per electronic billing requirements related to the ANSI 5010 transition, ambulance claims filed for **BlueCare** or **TennCare*Select*** members must contain a 'CR1' segment or claims will be rejected. This segment is used to supply information related to the ambulance service and applies to electronically filed claims only.

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

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE (Cont'd)

### New forms now available to make prior authorization requests more efficient

Effective May 1, 2012, providers requesting services by fax will be required to use the appropriate forms. To increase legibility, completing the forms in the electronic format (typed) is preferred.

Please visit www.bcbst.com under the **BlueCare/TennCare*Select*** forms section to locate the correct form needed to process your request. New forms have been added. If you are unable to access the Web please contact our customer service department at 1-800-468-9736 and request fax copies of the forms.

*New*<http://www.bcbst.com/providers/forms/chiro_fax_form.pdf>
*New*<http://www.bcbst.com/providers/forms/hospice_form.pdf>
*New*<http://www.bcbst.com/providers/forms/hysterectomy_notification_form.pdf>
*New*<http://www.bcbst.com/providers/forms/pa_request_form.pdf>
*New*<http://www.bcbst.com/providers/forms/pt_fax_form.pdf>
*New*<http://www.bcbst.com/providers/forms/OB_Global_Notification-bc-tcs.pdf>
<http://www.bcbst.com/providers/HITTennCare.pdf>
<http://www.bcbst.com/providers/forms/DME_Request_Form.doc>
<http://www.bcbst.com/providers/forms/home_health_services_request.pdf>

### Adult outpatient physical therapy discharge criteria update *

Effective April 1, 2012, **BlueCare/ TennCare*Select*** will use The Centers for Medicare & Medicaid Services (CMS) discharge criteria under General Therapy Guidelines to aid authorization decision making as related to adult outpatient physical therapy discharge criteria. CMS lists local coverage determination for outpatient physical therapy which indicates medical necessity guidelines. This will serve as an adjunct to Milliman Care Guidelines and the BlueCross BlueShield of Tennessee Medical Policy Manual to better clarify discharge criteria.

Additional information is available on the CMS website at <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=30009&ContrId=214&ver=44&ContrVer=1&Date=02%2f27%2f2012&DocID=L30009&bc=iAAAAAgAAAAA&>.

### New CPT® codes to require prior authorization

Effective May 1, 2012, the following new 2012 CPT® codes will require prior authorization. Codes listed below that are billed without prior authorization will be denied after the effective date.

| | | | |
|---|---|---|---|
| 20527 | 32670 | 36253 | 95885 |
| 22633 | 32671 | 36254 | 95886 |
| 22634 | 32672 | 37191 | 95887 |
| 32096 | 32673 | 37192 | 95938 |
| 32097 | 32674 | 37193 | 95939 |
| 32098 | 33221 | 37619 | 0276T |
| 32505 | 33227 | 38232 | 0277T |
| 32506 | 33228 | 49084 | 0278T |
| 32507 | 33229 | 64633 | 0281T |
| 32607 | 33230 | 64634 | 0282T |
| 32608 | 33231 | 64635 | 0283T |
| 32609 | 33262 | 64636 | 0284T |
| 32666 | 33263 | 74174 | 0288T |
| 32667 | 33264 | 90869 | S0596 |
| 32668 | 36251 | 92558 | S8930 |
| 32669 | 36252 | 93998 | |

### Reminder: New guidelines for billing emergency room claims

In the past, providers have had to bill a separate claim for reimbursement for the triage fee (Revenue code 0451) when the facility claim was for a non-medical emergency. Effective March 1, 2012, VSHP will automatically pay the triage fee when the emergency room claim (Revenue code 0450) is billed for a non-medical emergency. Providers will no longer have to submit a separate claim with the triage Revenue code 0451.

Additionally, National Uniform Billing Committee (NUBC) guidelines limit the emergency room revenue codes that can be submitted on the same claim. For example, Revenue code 0450 should not be submitted with any of the other emergency room revenue codes. NUBC information may be found at www.nubc.org/index.html.

### Observation stay update *

Good news, effective May 1, 2012, for VSHP network providers, prior authorization for observation stays is no longer required for **BlueCare/ TennCare*Select*** members, but may be subject to retrospective review based on medical policy.

### Clarification: Low back pain diagnosis and treatment

Volunteer State Health Plan has received concerns from the chiropractic community regarding the March 2012 low back pain article. Chiropractic care is recognized nationally as a treatment for low back pain. However, TennCare does not cover chiropractic treatment for adults, therefore is not included as a treatment option for VSHP members.

### Reminder: Disclosure of Ownership and Control Interest Statements

**BlueCare/TennCare *Select*** providers are required by federal guidelines to complete a current Disclosure Form with Volunteer State Health Plan (VSHP). The Disclosure Form must be submitted at the time the provider is initially accredited or re-accredited by VSHP, at least once every three years. **As of July 1, 2012, claims payments will be suspended until such time as a current form is on file**.

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 VSHP and the State of

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE (Cont'd)

### Reminder: Disclosure of Ownership and Control Interest Statements (Cont'd)

Tennessee Bureau of TennCare, VSHP must maintain disclosure information on all its providers and tax reporting entities with billing activities.

Tax reporting entities with billing activities (groups and facilities) and each rendering practitioner under the entities tax identification number are required to complete a disclosure form in accordance with federal guidelines. For example: If a group (entity) of practitioners contains ten (10) practitioners, each practitioner should complete one (1) Disclosure Form for a Provider Person. Additionally the group as a whole (tax-reporting billing entity) should complete one (1) Disclosure Form for Provider Entities. A total of 11 Disclosure Forms would be required in this example.

If you have any questions please call BlueCross BlueShield of Tennessee's Provider Service line†, and choose the "Network Contracting" option.

The **BlueCare/TennCare*Select*** Disclosure Form and FAQ's are available on the company website at <www.bcbst.com/providers/bluecare-tenncareselect/index.shtml> under the **BlueCare/TennCare*Select*** Disclosure section.

### Reminder: Non-emergency medical transportation

Non-emergency transportation services are provided for **BlueCare** and **TennCare*Select*** members to and from their health care appointments. All non-emergency transportation should be scheduled and receive prior authorization from Southeastrans, Inc. before a service is provided. A notice of at least seventy-two (72) hours is requested prior to the member's appointment.

Volunteer State Health Plan communicates how to arrange non-emergency transportation services to members via the member handbook.

Members are not required to travel excessive distances. Examples of possible excessive distance requests include a request for transportation services to a provider that is not in the area where the member resides, or a request for Medicaid transportation services to a provider that is not in the same county, bordering county or metropolitan area in a bordering state for beneficiaries living in rural areas. The general guideline is that PCP appointments greater than 30 minutes or 30 miles or appointments for specialty services greater than 90 miles must be evaluated by the plan.

For additional transportation information see the Provider page of the company website at <http://www.bcbst.com/providers/bluecare-tenncareselect/index.shtml>.

# CHOICES

## ADMINISTRATIVE

### CHOICES: Discontinuation of services form

Volunteer State Health Plan has updated the provider form for members transitioning from all private duty services to CHOICES services, or a combination of private duty and CHOICES services. The new form is available on the company website at <http://www.bcbst.com/providers/bluecare-tenncareselect/choices/index.shtml> under FORMS.

# BlueAdvantage

## ADMINISTRATIVE

### Member engagement initiatives

BlueCross BlueShield of Tennessee's Medicare Advantage health plan has embarked on a number of initiatives to help improve the quality of care provided to BlueAdvantage members. The information below reflects examples of some of the ongoing initiatives.

- **Free Silver Sneakers Fitness Club Memberships** - This may be of interest to you when discussing physical activity levels with your BlueAdvantage patients. All members have to do is show their BlueAdvantage ID card at any Silver Sneakers participating facility. For more information, your BlueAdvantage patients may call 1-888-423-4632.

- **24/7 Nurse Advice Line** - This is a valuable resource for you should your BlueAdvantage patients have non emergency health service questions or concerns after your office hours. The number to call is 1-866-275-1660. Should a member has a serious health concern, such as chest pain, they should call 911.

- **Welcome Calls** – These calls will be made to all members in an effort to improve member engagement with the health plan.

- **Automated Care Campaigns** – Automated calls to members are being made periodically throughout the year in an effort to increase utilization of critical preventive services.

- **Live Care Campaigns** – Live calls will be attempted to engage the member and assist them in making appointments to obtain much needed preventive services such as annual wellness visits, osteoporosis screenings, breast and colorectal cancer screenings, etc.

***Note***: Your practice may get calls from someone at the health plan to assist BlueAdvantage members in your practice in setting up these appointments.

### Reminder: Appropriate billing for ambulance services during an inpatient stay

During a recent retrospective audit of BlueAdvantage claims, the following services were identified as needing billing guidelines reminders.

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAdvantage

## ADMINISTRATIVE (Cont'd)

### Reminder: Appropriate billing for ambulance services during an inpatient stay (Cont'd)

BlueAdvantage follows the Centers for Medicare & Medicaid Services' (CMS) billing guidelines for claims payment.

According to CMS' Hospital Inpatient Billing manual, section 10.4, all items and non-physician services furnished to members who are inpatient must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to prospective payment system (PPS).

Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient is covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

The hospital must include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. These charges may not be billed separately under revenue code 0540.

### BlueAdvantage to resume management of certain services for PPO members *

Effective May 1, 2012, BlueCross BlueShield of Tennessee will resume the management of complete benefit administration for all durable medical equipment (DME)/medical supply services home health, orthotic and prosthetic services prescribed for the BlueAdvantage PPO members. This will include all provider network management as well as all utilization management for these services. CareCentrix will no longer manage these services for BlueAdvantage but will continue to manage DME/medical supply services for **BlueCare/TennCare*Select***. If you have any questions, please contact your local provider network manager.

# BlueCard

## ADMINISTRATIVE

### Frequently asked questions (FAQs) for the BlueCard program

Providers can view a new list of BlueCard FAQs on the BlueCard page of our website. You can get answers to some of the most asked questions about the BlueCard program. The topics include eligibility and benefits, claims payment, coordination of benefits (COB) and much more.

Visit the BlueCard page at http://www.bcbst.com/providers/bluecard/ and click on BlueCard Provider FAQs.

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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### †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

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

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

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

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

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

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

***BlueCare/TennCareSelect Medical Management Hours***
Monday-Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**

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

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

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

***eBusiness Technical Support***
Phone: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

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*These changes will be included in the appropriate 2Q 2012 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

**May 2012**

## 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 June 9, 2012**

- Immune Cell Function Assay
- Intravenous Anesthetics for the Treatment of Chronic Pain
- Lysis of Epidural Adhesions

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

## ADMINISTRATIVE

### Billing guidelines for disposable insulin delivery system Omnipod/Personal Diabetes Manager (PDM)

Effective April 1, 2012, manufacturer's information/supplier's invoice is no longer required for HCPCS code A9274, *External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories.* To address professional provider concerns regarding reimbursement of this code, BlueCross BlueShield of Tennessee has conducted an in-depth analysis of code A9274 using data from paid claims along with invoice documents provided by professional providers to establish a reasonable allowable.

Providers are encouraged to consult Pricing, Data, Analysis and Coding (PDAC) Contractor for guidance on the proper use of the Healthcare Common Procedure Coding System (HCPCS) for products and equipment used for these services.

**Note:** This information does not apply to BlueAdvantage, BlueCross BlueShield of Tennessee's Medicare Advantage product.

### Reminder: National Uniform Billing change for filing claims exempt from Present on Admission (POA) reporting

Based on guidelines effective July 1, 2011, for all inpatient admissions to general acute care hospitals by the National Uniform Billing Committee (NUBC), BlueCross BlueShield of Tennessee made the following changes for reporting POA Indicator Option "1":

1 = Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.

**When filing electronic ANSI 837 inpatient facility claims**, providers should no longer enter Indicator Option "1" in the POA field when exempt from POA reporting. The POA field should be left blank for EDI format 5010 claims.

**When filing paper CMS-1450 (UB04) inpatient facility claims**, providers should enter a "1" in the POA field when exempt from POA reporting.

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

**Claims will reject if**:

- POA "1" is submitted on an electronic ANSI 837 inpatient claim; or
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; or
- POA is required, but not submitted.

### OCR scanning process update

Effective Aug. 1, 2012, BlueCross BlueShield of Tennessee will be updating OCR scanning processes for CMS-1500 and CMS-1450 paper claims. Following the *2012 Official UB-04 Data Specifications Manual* guidelines, this update will not require any changes related to the CMS-1500, however the following changes will be required when submitting CMS-1450 paper claims:

- **Form Locator 12 - Admit Date:** Admit date should only be populated for inpatient, home health, and hospice claims. A rejection will occur for any other claim type.
- **Form Locator 13 - Admit Hour:** Admit hour should only be populated for inpatient claims, excluding type of bill 021x. A rejection will occur for any other claim type.
- **Form Locator 15 - Admission Source:** Admission source should only be populated for inpatient claims. A rejection will occur for any other claim type.
- **Form Locator 69 - Admitting Diagnosis Code:** Admitting diagnosis code is only required for inpatient claims. A rejection will occur for any other claim type.
- **Form Locator 74 - Principal Procedure Code:** Principal procedure code should only be submitted for inpatient claims. A rejection will occur for any other claim type.
- **Form Locator 74a-e - Other Procedure Code:** Other procedure codes should only be submitted for inpatient claims. A rejection will occur for any other claim type.

If you have any questions, contact Provider Service at 1-800-924-7141.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE

### Reminder: State of TN Vision Services

Please remember that the State of TN Plan does not have routine vision benefits. The member is only eligible for one non-refractive vision screening per calendar year. The State of TN Plan has been configured so that only CPT® Codes 99173, 99174, 92002, 92004, 92012, 92014, 99172 count as the member's annual non-refractive vision screening when filed under the v20.2 diagnosis code. All other codes and routine vision diagnosis codes have been configured to deny as a non-covered service.

### Reminder: Predetermination versus prior authorization

Providers are reminded of the difference in predeterminations and prior authorizations.

Predeterminations are never required, but are performed as a courtesy for Commercial, Cover Tennessee and BlueAdvantage lines of business. Providers can request a predetermination review to check benefits/coverage, exclusions/riders, possible pre-existing conditions and to ensure services meet medical criteria/guidelines. Predetermination reviews **do not take the place of any prior authorization requirements**. Failure to obtain any necessary authorization may result in a denial or reduction in benefits. If a procedure requires prior authorization providers can **call, fax or utilize BlueAccess**. For faxed requests, use of the appropriate form is important to assure accurate and timely processing. Fax forms are available on the Provider page of the company website at http://www.bcbst.com/providers/forms/.

# BlueCare/TennCare*Select*

## CLINICAL

### Quality Initiative: Antidepressant medication management and follow up after hospitalization

Quality initiatives for May focus on adult members taking antidepressant medication as prescribed, and follow up after hospitalization for members age 6 and older who were hospitalized for treatment of mental health disorders.

The first focus is on members age 18 and older with a new episode of major depression being treated with antidepressant medication. Studies show these members are often treated in their PCP's office, and may or may not be referred for behavioral health consultation. Additionally, members do not always continue to take their medication as prescribed. They may be feeling better and quit taking the medication, or they may feel like it is not working so they stop. Members may need additional counseling on the importance of taking medication as prescribed.

Members age six (6) and older who are hospitalized for treatment of mental health disorders should be scheduled for a follow up visit at seven (7) days, and again at thirty (30) days post discharge. Again, additional counseling of the patient and their guardian(s) may be needed to encourage them to follow through with these important appointments.

Additional resources for providers working with behavioral health patients may be found at vshptn.com/providers or <http://www.bcbst.com/providers/behavioral_health/organizations.shtml>.

### Follow-up care for Attention Deficit/Hyperactivity Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) is often diagnosed in children. If the condition is not diagnosed and treated, there may be social repercussions. It is important that children with newly prescribed ADHD medication be seen for follow-up visits by a practitioner with prescribing authority. Medication is considered to be newly prescribed if the child has not received such medication in the immediately preceding four-month period, regardless of when the child was first diagnosed with ADHD.

During the first thirty (30) days after the new ADHD medication prescription (initiation phase) the child should have at least one follow-up visit. Children who remain on ADHD medication for 210 days or more (continuation and maintenance phase), should have two additional follow-up visits after the initiation phase visit, for a total of at least three (3) within the ten-month period after ADHD medication is newly prescribed.

VSHP Behavioral Health has additional information that may assist you in the diagnosis and treatment of ADHD available at <www.bcbst.com/providers/behavioral_health/organizations.shtml>.

### Osteochondral allograft authorization change

Effective June 1, 2012, VSHP will require prior authorization for osteochondral allografts using CPT® codes 27415 and 29687. Previously, only code 29687 required prior authorization.

Codes descriptions:
27415 - Osteochondral allograft, knee, open
29867 - Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)

Please contact the **BlueCare** or **TennCare*Select*** Provider Service Line† if you have any questions.

### Text4Baby program

VSHP and CoverKids/HealthyTNBabies 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 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 http://text4baby.org/.

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## CLINICAL (Cont'd)

### Reminder: 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/VSHP providers.

### 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 be 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;
- Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate;
- 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 tests, one of the above seven required screening components, should be addressed with your patient(s) as appropriate for age, risk factors and health history (ex: Hematocrit or Hemoglobin, Lead Toxicity Screening, Dyslipidemia Screening).

A 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 that information at <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>.

## ADMINISTRATIVE

### Emergency room referrals for additional treatment

Please refer patients to in-state facilities for treatment when available. For example, burn patients may be referred to an in-state burn center rather than being sent out of state. If you need assistance in finding a treatment facility that is part of the VSHP network, please contact Provider Services for BlueCare at 1-800-468-9736 or for TennCare*Select* at 1-800-276-1978, Monday through Friday from 8 a.m. to 6 p.m. (ET).

# CHOICES

## ADMINISTRATIVE

### CHOICES information

The Area Agency on Aging and Disability and Managed Care Organizations are the only two entities with the authority to accept CHOICES referrals and to complete the screening and intake processes. Home and Community Based Services providers are prohibited from recruiting and/or soliciting potential or actual **BlueCare** and **TennCare*Select*** members to choose them as their CHOICES provider.

# BlueAdvantage

## ADMINISTRATIVE

### Reminder: Appropriate billing for BlueAdvantage DME claims

#### Durable Medical Equipment (DME) during an inpatient stay

DME provided during an inpatient stay for a BlueAdvantage member must be billed in accordance with guidelines outlined in The Centers for Medicare & Medicaid Services Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) manual, section 210.

The DMEPOS benefit is meant only for items a member is using in his or her home. For a member in an inpatient stay, an institutional provider (e.g., hospital) is not defined as a member's home for DMEPOS, therefore Medicare does not make a separate payment for DMEPOS. The institution is expected to provide all medically necessary DMEPOS during a member's covered inpatient stay.

# BlueAdvantage

## ADMINISTRATIVE (Cont'd)

### Reminder: Appropriate billing for BlueAdvantage claims (Cont'd)

**EXCEPTION:** Medicare makes a separate payment for a full month for DMEPOS items, provided the member was in the home on the "from" date or anniversary date defined below.

For capped rental items of DME where the DME supplier submits a monthly bill, the date of delivery ("from" date) on the first claim must be the "from" or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated the 15th of the following months (October 15, November 15, etc.).

### Reminder: BlueAdvantage to resume management of certain services for PPO members *

Effective May 1, 2012, BlueCross BlueShield of Tennessee resumed management of the Durable Medical Equipment, Prosthetic, Orthotic, Supplies (DMEPOS) and Home Health services for the BlueAdvantage PPO members.

Providers may access billing guidelines for these services in the *BlueCross BlueShield of Tennessee Provider Administration Manual*. This information will be added to the Medicare Advantage section beginning with the second quarter provider manual. Keep in mind, member coverage and contractual limitations will apply.

For dates of service starting May 1, 2012, providers can submit requests to BlueAdvantage Utilization Management by telephone (1-800-924-7141) or fax (1-888-535-5243).

# BlueCard

## ADMINISTRATIVE

### Reminder: BlueCross automates 2BC secondary claims processing

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

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

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

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

**BlueCross is no longer auto-processing 2BC claims when both member IDs belong to another Blues Plan.** Since we do not complete final adjudication of these claims it causes duplicate work between the auto-process and provider submissions. Please submit claims under the secondary billing guidelines when your patient has two (2) out-of-state BlueCross policies.

For more information, please call the eBusiness Service Center†.

### Reminder: Claim submission

In order to avoid any processing delays, the subscriber identification number should be submitted as it appears on the identification card, including using upper case for all alpha characters.

# Cover Tennessee

## ADMINISTRATIVE

### Reminder: Second opinion for CoverKids members

CoverKids members may obtain a second opinion prior to undergoing an elective medical service. The claim for the second opinion will be covered as long as they see a Blue Network S provider. If one of your CoverKids patients would like to get a second opinion, please refer him or her to a doctor who participates in Blue Network S.

If a Blue Network S provider is not available, ask the patient to call Member Services at 1-888-325-8386 and BlueCross will find a qualified provider at no additional cost to the member.

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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### †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

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

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

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

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

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

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

***BlueCare/TennCareSelect Medical Management Hours***
Monday-Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**

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

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

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

***eBusiness Technical Support***
Phone: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

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# BlueAlert

provider news flash

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

Please Route to all Providers & Office Staff

**June 2012**

## 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 June 1, 2012**

- Interferential Current Stimulation for the treatment of Pain

**Effective July 14, 2012**

- Hematopoietic Stem Cell Transplantation for Central Nervous System Embryonal and Ependymoma Tumors
- Automated Percutaneous and Endoscopic Discectomy
- Chromosomal Microarray (CMA) Analysis for the Genetic Evaluation of Individuals with Developmental Delays/Intellectual Delays or Autism Spectrum Disorder
- Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis
- Microwave Tumor Ablation
- Ophthalmologic Techniques for the Evaluation of Glaucoma
- Serologic Diagnosis of Celiac Disease
- Trigger Point Injections

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

### Reminder – Accessing Physician Quality and Cost Reporting Program

Updates to the Physician Quality and Cost Information are currently available for private physician[1] review on our secure BlueAccess Web portal.

To access your quality and cost information physicians should have a *BlueAccess* user ID and password. 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.

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: Appropriate billing for lidocaine

HCPCS code J2001 (*Injection, lidocaine HCL for intravenous infusion, 10 mg*) is limited by code description to IV infusion only. It is inappropriate to append modifier 59 to this code or to submit this code for local anesthetic use.

Modifier 59 should only be used with procedure codes to indicate a distinct procedural service. Lidocaine used as a local anesthetic has no distinct HCPCS code and should be billed using J3490 (*Unclassified drugs*).

CMS/AMA guidelines consider the use of lidocaine, marcaine, procaine, xylocaine or any "-caines" as part of the surgical service and not separately reimbursed when used as a local anesthetic.

## ADMINISTRATIVE

### Blue Physician Recognition (BPR) program begins in July

Effective July, 1, 2012, BlueCross BlueShield of Tennessee will launch the Blue Physician Recognition (BPR) program. BPR recognizes physicians across multiple disciplines and care settings who are participating in quality initiatives as determined by BlueCross BlueShield of Tennessee.

The names of physicians who participate in BlueCross BlueShield of Tennessee's Pay for Performance programs, Patient Centered Medical Home program, bundled payment initiative, or one of the Association's quality-based recognition programs have been submitted for display on the Blue National Doctor & Hospital Finder with the BPR icon.

For more information about this program, please visit our website, www.bcbst.com, and click on the link **Blue Physician Recognition** on the provider page.

### Coming soon, a new and improved BlueAccess eServices application

Later this year, changes will be made to the BlueAccess eServices application making the tool even more simple to use than the current version, especially regarding web authorizations. BlueCross BlueShield of Tennessee looks forward to giving you more details about this enhancement at the upcoming All Blue Workshops and in future *BlueAlert* newsletters.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Reminder: Are you submitting paper claims to the correct address?

To avoid delays in claims payment providers are reminded to submit paper claims for all BlueCross BlueShield of Tennessee lines of business to our current address:

**BlueCross BlueShield of TN**
**Claims Service Center**
**1 Cameron Hill Circle, Ste 0002**
**Chattanooga, TN 37402-0002**

### Electronic Funds Transfer (EFT) is the answer to faster payments

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

EFT provides a method of transferring payments automatically from us to your bank. EFT is available for all lines of business including Commercial, BlueCare, TennCare*Select*, BlueCard, Federal Employee Program (FEP), Medicare Advantage, and Preferred Dental.

Sign up today! Complete the mail-in enrollment form found online at <http://www.bcbst.com/providers/forms/EFT_Enrollment.pdf> , or for more information call eBusiness Provider Solutions at 423-535-5717 (Option 2) or e-mail, ebusiness_support@bcbst.com.

### Getting the best impression

The first person your patients usually see is the Medical Receptionist. The journal *Social Science and Medicine* recently published a study on their work. The study found receptionists are not just the "gatekeepers" or "person behind the desk." Their responsibilities often extend way beyond their administrative duties. They are a vital part of patient care.

Medical receptionists deal directly with everyone coming into the office from patients to pharmaceutical representatives, mail men, lab couriers, etc. In addition to their administrative function, they may confirm prescriptions with an angry patient, congratulate a new mother, console a patient whose spouse just died or help a mentally ill patient make an appointment. A significant portion of their work involves managing the emotions and care of patients and families.

Medical receptionists are a key part of the relationship between patients and doctors and patients' feelings about the receptionist may be reflected in their opinions of their doctor.

# BlueCare/TennCare*Select*

## CLINICAL

### Quest Diagnostics to perform lab tests*

BlueCross BlueShield of Tennessee is partnering with Quest Diagnostics® to provide lab testing services for members covered by Volunteer State Health Plan.

Quest Diagnostics is a leading provider of diagnostic testing, information and services, offering enhanced efficiency through:

- Access to more than 3,400 diagnostic tests
- Results within 24 hours for more than 97% of the most commonly ordered tests
- Trained IT Specialists who are available to provide support 24-hours-a-day, 7-days-a-week, 365-days-a-year.

All lab testing will be referred to Quest Diagnostics with the following limited exceptions:

(1) Lab testing included on the approved Exclusion List performed by participating providers. The Exclusion List will be posted on the provider section of our website at www.vshptn.com/providers

(2) Proprietary lab tests not available through Quest Diagnostics

(3) Outpatient dialysis clinics

Additional details and information will be forthcoming.

## ADMINISTRATIVE

### Reminder: Abortion, sterilization, hysterectomy requirements

OB-GYNs are reminded that VSHP covers abortions, sterilizations and hysterectomies pursuant to applicable federal and state laws and regulations. For providers to receive payment, all requirements must be met, and the corresponding paperwork (forms, medical records, etc.) must be completed in their entirety and submitted to VSHP.

**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 and the date of sterilization procedure.

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

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE (Cont'd)

### Reminder: Abortion, sterilization, hysterectomy requirements (Cont'd)

Please refer to the federal ASH guidelines which are outlined in the *VSHP Provider Administration Manual* which is located on company websites www.bcbst.com and www.vshptn.com for the complete rules and regulations regarding billing for these services, and for the required documentation. Additionally, checklists for each procedure are available on the company website at bcbst.com/providers/bluecare-tenncareselect. **Failure to provide completed forms and documentation will result in claim denial.**

### Reminder: Disclosure of Ownership and Control Interest Statement requirement

BlueCare/TennCare *Select* providers are required by federal guidelines to complete a current Disclosure Form with Volunteer State Health Plan (VSHP). The Disclosure Form must be submitted at the time the provider is initially accredited or re-accredited by VSHP at least once every three years. **Effective July 1, 2012 claims payments will be suspended until such time as a current form is on file**. The original effective date was April 1, 2012.

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 VSHP and the State of Tennessee Bureau of TennCare, VSHP must maintain disclosure information on all its providers and tax reporting entities with billing activities.

Tax reporting entities with billing activities (groups and facilities) and each rendering practitioner under the entities tax identification number are required to complete a disclosure form in accordance with federal guidelines. For example:
If a group (entity) of practitioners contains ten (10) practitioners, each practitioner should complete one (1) Disclosure Form for a Provider Person. Additionally the group as a whole (tax-reporting billing entity) should complete one (1) Disclosure Form for Provider Entities. A total of 11 Disclosure Forms would be required in this example.

If you have any questions please call BlueCross BlueShield of Tennessee's Provider Service line, 1-800-924-7141, Monday through Friday, 8 a.m. to 5:15 p.m. (ET) and choose the "Network Contracting" option.

The BlueCare/TennCare*Select* Disclosure Form and FAQs are available on the company website at <www.bcbst.com/providers/bluecare-tenncareselect/index.shtml> under the BlueCare/TennCare*Select* Disclosure section.

### Reminder: Identification numbers for newborns

TennCare requires each individual have a unique identification (ID) number. Facilities are required to contact their local Department of Human Resources to request an ID number for newborns. Claims can be filed under the mother's unique ID number for thirty (30) calendar days after the birth of the baby.

If the baby has been issued an ID number, claims must be filed using the baby's unique ID. **After the initial thirty (30) days, if newborn charges are filed using the mother's ID number the claim will be denied.**

# BlueAdvantage

## CLINICAL

### Medication adherence quality improvement efforts

BlueAdvantage is committed to working with network providers to ensure quality service to members.

Over the next few months, BlueAdvantage will be delivering a number of care campaign calls to its membership in an effort to improve medication adherence for the following conditions:

- Hypertension
- Osteoporosis
- Rheumatoid Arthritis
- Hyperlipidemia
- Diabetes

Members taking high-risk medications will also receive outreach directing them to discuss their medications with their physician.

*What can you do?*

- Review and reconcile medications at every visit
- Discuss the importance of adherence
- Address medication fill barriers

### Musculoskeletal management prior authorization requirement changes*

Effective immediately BlueAdvantage no longer requires prior authorization for the following therapy evaluation codes:

| | |
|---|---|
| **97001** | Physical therapy evaluation |
| **97002** | Physical therapy re-evaluation |
| **97003** | Occupational therapy evaluation |
| **97004** | Occupational therapy re-evaluation |

For questions contact BlueAdvantage Provider Service†.

## ADMINISTRATIVE

### Reminder: Appropriate billing for BlueAdvantage preadmission services

Preadmission services must be billed in accordance to guidelines outlined in the *Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Billing Manual*, section 40.3B. **Diagnostic services** (including clinical diagnostic laboratory tests) provided to a member by an admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAdvantage

## ADMINISTRATIVE (Cont'd)

### Reminder: Appropriate billing for BlueAdvantage preadmission services (Cont'd)

three (3) days prior to and including the date of the member's admission are deemed to be inpatient services and will be included in the inpatient payment. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday or Wednesday are included in the inpatient payment.

This provision does not apply to ambulance services and maintenance renal dialysis services. Additionally, Part A services furnished by a skilled nursing facility, home health agency, and hospice are excluded from the payment window provisions.

For hospitals and units excluded from the Inpatient Prospective Payment System (IPPS), this provision applies only to services furnished within one day prior to and including the date of the member's admission.

Critical access hospitals (CAHs) are not subject to the three-day (nor one-day) DRG payment window.

For this provision, diagnostic services are defined by the revenue and/or CPT® codes on the bill, which are listed on the CMS website at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf>.

**Non-diagnostic outpatient services** related to a member's hospital admission that are provided by the hospital during the three (3) days immediately preceding and including the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment. Non-diagnostic preadmission services are defined as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay. Therefore, when Part A covers an admission, the hospital may bill non-diagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission.

### Facilitating accurate pharmacy claims records

Capturing and accurately reporting pharmacy claims data presents challenges for many health insurance plans. Members often choose to use discounted generic prescription programs rather than their medical/pharmacy insurance plan. For this reason, quality improvement campaigns may not be as accurate as possible.

To further improve the quality of our clinical outreach programs, we encourage you to prescribe generic medications for conditions in accordance with our BlueAdvantage formulary. Doing so will place the least amount of financial burden on your patient and allow us to capture the pharmacy claim for quality improvement efforts.

# BlueCard

## ADMINISTRATIVE

### New remittance format for BlueCard claims complete

The remittance format for BlueCard claims has completed its transition. As previously noted in the January 2010 *BlueAlert*, the format is now similar to the commercial line of business. BlueCard is now in the process of phasing out the legacy payment system. Adjustments for claims processed under the legacy system will be handled as "net" transactions on the new system:

- If the result of an adjustment is an add-pay, the remittance advice will reflect only the additional dollars owed to you.
- If an adjustment results in a recovery, the remittance advice will reflect a recovery for the specific amount owed BlueCross. These will be reflected in the Adjustment Summary section of the remittance advice.

If you have any questions, please contact the BlueCare Provider Service line†.

*These changes will be included in the appropriate 3Q 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***
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**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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
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# BlueAlert

provider news flash

of Tennessee
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Please Route to all Providers & Office Staff

**July 2012**

## 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 Aug. 11, 2012**

- Alemtuzumab
- Filgrastim/Pegfilgrastim
- JAK2 and MPL Mutation Analysis in Myeloproliferative Neoplasms
- Bioengineered Skin and Soft Tissue Substitutes
-

**Effective Aug. 15, 2012**

- Bortezomib
- Ofatumumab

**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 Aug. 15, 2012**

**Revised or recently developed BlueCross Modifications**

***The following as relates to Home Care:***

- *Hyperemesis Gravidarum*

***The following as relates to Inpatient and Surgical Care:***

- *Psychiatric Observation in the Medical Setting: Observation Care*
- *Repair of Enterocele, Abdominal Approach*

**BlueCross modifications will be archived in favor of the Milliman Care Guideline**

***The following as relates to Ambulatory Care***

- *Loop Electrosurgical Excision Procedures (LEEP, LLETZ), Cervix*
- *Sling Procedures, Male*
- *Uvulopalatopharyngoplasty (UPPP)*

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

### New drugs added to commercial specialty pharmacy listing

Effective July 1, 2012, 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:***
Elelyso (PA)
Omontys (PA)
Eylea will no longer require prior authorization.

***Self-administered via pharmacy benefit:***
Gamunex C (PA)
Korlym (PA)

To obtain prior authorization for provider-administered specialty drugs, call the BlueCross BlueShield of Tennessee Provider Service line†.

For prior authorization of self-administered specialty drugs, call Caremark at 1-877-916-2271.

### Reminder: Correct coding for pneumococcal conjugate vaccine (PCV)

Providers are reminded production of product matching CPT® code 90669 (7-valent – Prevnar®) was suspended by the manufacturer Dec. 22, 2010 and is no longer available.

Prevnar 13®, the pneumococcal 13-valent conjugate vaccine (90670), received U.S. Food and Drug Administration approval February 24, 2010.

Providers should verify the CPT® code billed matches the description of the vaccine administered.

### New legislation passed for interventional pain management

The Tennessee Legislature recently passed the Interventional Pain Management Bill (SB1935/HB1896). This legislation has new restrictions and requirements specific to nurse practitioners and physician assistants who work in the area of pain management. For your reference this bill is available on the State of Tennessee website at http://state.tn.us/sos/acts/107/pub/pc0961.pdf.

## ADMINISTRATIVE

### Changes in coding for well-woman exams

Effective Aug. 1, 2012, BlueCross BlueShield of Tennessee will no longer consider the following procedure code/ diagnosis code combinations valid for well-woman exams: 99201 – 99205 and 99211 – 99215 when filed with V723, V7231 or V7232.

Commercial claims filed with these code combinations will be denied as "procedure/diagnosis code conflict".

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Changes in coding for well-woman exams (Cont'd)

Correct codes for well-woman exams are:
S0610, S0612
99385 – 99387
99395 – 99397
G0438, G0439

### Pharmacy medication review request fax form

To provide more efficient and accurate management of commercial and Cover Tennessee pharmacy medication reviews, the **Pharmacy Medication Review Request Fax Cover Form** must accompany these requests. The form is available on the provider page of the company website at <http://www.bcbst.com/pharmacy/provider/forms/> and http://www.bcbst.com/providers/forms/.

This fax form is a cover sheet only and is to be used for appeal requests for authorization denials or review requests for coverage of an excluded pharmacy product. Pertinent medical information that supports the pharmacy-related request is still required to be submitted with the fax cover form.

### Change in Reimbursement for FluMist® and Fluzone® Influenza Vaccine

BlueCross BlueShield of Tennessee is changing reimbursement standards for FluMist® and intradermal Fluzone® thanks to recent collaborations with the Tennessee Pediatric Council and the Tennessee Chapter of the American Academy of Pediatrics.

Beginning **Aug. 1, 2012**, BlueCross will implement changes for FluMist® and Fluzone® influenza vaccine. Except for Medicare Advantage, all lines of BlueCross commercial business will reimburse FluMist® and Fluzone® influenza vaccine at 100 percent AWP. There is no change to traditional reimbursement standards for lines of business such as BlueCare, TennCare*Select* and CoverKids. When billing for these services, please use the appropriate published CPT® code for billing these products.

Future communications will specifically describe BlueCross's influenza vaccine standards in more detail, but we wanted to alert network providers to this change in reimbursement policy in advance of the Aug. 1, 2012, implementation. Again, our many thanks to the Tennessee Pediatric Council and the Tennessee Chapter of American Academy of Pediatrics for collaborating with BlueCross on the influenza vaccine program and we look forward to implementing this change in reimbursement soon.

# State of Tennessee

## ADMINISTRATIVE

### Prior authorization requirement removed for certain procedures

Effective July 1, 2012, the State of Tennessee Public Sector Plan (#80860) no longer requires prior authorization for sigmoidoscopy, proctosigmoidoscopy and colonoscopy. This change covers all procedure codes in the range of 45300 through 45392.

# BlueCare/TennCare*Select*

## CLINICAL

### Reminder: Quest Diagnostics now providing lab testing services

Effective July 1, 2012, BlueCross BlueShield of Tennessee has partnered with Quest Diagnostics® to provide lab testing services for members covered by Volunteer State Health Plan.

All lab testing are to be referred to Quest Diagnostics with the following limited exceptions:

(1) Lab testing on the approved Exclusion List. The Exclusion List is available on the company websites www.vshptn.com and www.bcbst.com.

(2) Proprietary lab tests not available through Quest Diagnostics

### Reminder: Follow-up care for Attention Deficit/Hyperactivity Disorder

It is important that children with newly prescribed Attention Deficit/Hyperactivity Disorder (ADHD) medication be seen for follow-up visits by a practitioner with prescribing authority. Medication is considered to be newly prescribed if the child has not received such medication in the immediately preceding four-month period, regardless of when the child was first diagnosed with ADHD.

During the first thirty (30) days after the new ADHD medication prescription (initiation phase) the child should have at least one follow-up visit. Children who remain on ADHD medication for 210 days or more (continuation and maintenance phase), should have two (2) additional follow-up visits after the initiation phase visit, for a total of at least three (3) visits within the ten-month period after ADHD medication is newly prescribed.

VSHP Behavioral Health has additional information that may assist you in the diagnosis and treatment of ADHD available at <www.bcbst.com/providers/behavioral_health/organizations.shtml>.

### Breast cancer screening initiative

Volunteer State Health Plan (VSHP) is working to improve Breast Cancer Screening gaps in care and is requesting to partner with you to ensure your **BlueCare** and **TennCare*Select*** patients receive appropriate preventive screenings.

Please review the medical histories of your **BlueCare** and **TennCare*Select*** members to determine if a mammogram screening is appropriate to ensure they receive comprehensive wellness care. The *Adult Preventive Health Flow Sheet*, a useful tool for documentation of these services, is available under the **Adult Preventive Services** heading on our company websites, www.vshptn.com and www.bcbst.com.

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE

### Reminder: Disclosure of Ownership and Control Interest Statement requirement

**BlueCare/TennCare *Select*** providers are required by federal guidelines to complete a current Disclosure Form with Volunteer State Health Plan (VSHP). The Disclosure Form must be submitted at the time the provider is initially accredited or re-accredited by VSHP at least once every three years. **Effective July 1, 2012 claims payments is being suspended until such time as a current form is on file**. The original effective date was April 1, 2012.

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 VSHP and the State of Tennessee Bureau of TennCare, VSHP must maintain disclosure information on all its providers and tax reporting entities with billing activities.

Tax reporting entities with billing activities (groups and facilities) and each rendering practitioner under the entities tax identification number are required to complete a disclosure form in accordance with federal guidelines. For example:
If a group (entity) of practitioners contains ten (10) practitioners, each specific practitioner should complete one (1) *Disclosure Form for a Provider Person*. Additionally the group as a whole (tax-reporting billing entity) should complete one (1) Disclosure Form for Provider Entities. A total of 11 Disclosure Forms would be required in this example.

If you have any questions call BlueCross BlueShield of Tennessee's Provider Service line† and choose the "Network Contracting" option.

The **BlueCare/TennCare*Select*** Disclosure Form and FAQs are available on the company website at <www.bcbst.com/providers/bluecare-tenncareselect/index.shtml> under the **BlueCare/TennCare*Select*** Disclosure section.

### Cuts restored from January 2012 rate reduction

The Appropriations Legislation to restore 1.75% to the January 2012 rate reductions has been signed by the Governor. Claims were previously paid based on the additional 4.25% rate reduction that was effective Jan. 1, 2012, with a total rate reduction of 8.50%.

Claims that are affected will be adjusted accordingly. Fortunately, most of the adjustments can be made with the automated adjustment process and should be done in three (3) weeks. For those adjustments requiring additional review, we anticipate it may take up to 14 weeks. Thank you for your patience as this change is implemented. We will notify you via the BlueAlert and on the company websites once all adjustments have been completed.

Claims affected include those listed below:

- All pathology, lab, and radiological services which includes all professional, inpatient and outpatient services.
- All emergency and non-emergency transportation, defined as HCPCS Codes A0000 – A0999.
- All home health services except respite, hospice, and home and community based services.

### Patient billing reminder

There are times when it may or may not be appropriate to bill your patients directly. Please refer to the *Volunteer State Health Plan Provider Administrative Manual* for complete information regarding medical billing.

- Providers may bill Class 77 (uninsured/disabled with Medicare) for the Medicare coinsurance and deductibles.
- Class 17 (Medicare/Medicaid dual eligible) members may **not** be billed for coinsurance and deductibles.
- Providers may **not** bill a member for services that were denied based on late claims submission.
- If a denial is based on a referral, or determination was made that there was no referral on file, the Provider may **not** bill the member or plan.
- Members may **not** be billed for services that VSHP does not consider medically necessary.
- Providers may **not** bill the member for charges that exceed the member's liability.
- Providers may **not** bill the member for the transfer of medical records from one provider to another provider.
- For non-emergent care, providers may only bill patients for normal TennCare co-payments and deductible amounts.
- Providers may **not** bill members for missing a scheduled appointment.
- Providers **may** seek payment from a person whose TennCare eligibility is pending at the time services are rendered if the provider informs the person that TennCare assignment will
- not be accepted, whether or not eligibility is established retroactively.
- Providers **may** seek payment from a person whose TennCare eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility is established.

### New ASH explanation code for anesthesia claims

Effective, Aug, 1, 2012, anesthesiologists will no longer receive a letter requesting medical records and/or forms related to abortion, sterilization, or hysterectomy (ASH) services. Claims will be denied "W1T" to advise we are waiting on medical records. Claims will be automatically re-adjudicated once the information is received and a determination has been made related to the ASH service - no need for providers to submit a corrected bill.

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAdvantage

## CLINICAL

### Osteoporosis management

BlueCross BlueShield of Tennessee is working to improve osteoporosis management in women who have a fracture. We would like to partner with you to ensure your Blue Advantage patients receive appropriate preventive screenings and treatment.

BlueCross will be calling members who have a gap in care for this measure and will be encouraging them to seek their physician's advice in determining appropriate treatment options. If you are treating BlueAdvantage members over the age of 65 for a fracture, please screen them for osteoporosis and treat positive findings by prescribing appropriate medications.

### Preventive care campaign

Over the next few months, representatives from the BlueAdvantage health plan will be contacting members to engage them in their own health care and assist them in making appointments to obtain much needed preventive services such as screenings for osteoporosis, glaucoma, breast cancer, colorectal cancer and diabetes.

We expect an increase in member demand for these services and as a result, your practice may get calls from BlueAdvantage members to schedule an appointment or from someone representing BlueAdvantage to assist members in setting up these appointments. Please support these quality improvement efforts by scheduling and/or coordinating these preventive services as quickly as possible.

# BlueCard

## ADMINISTRATIVE

### Where do labs, DME and specialty pharmacy providers file Blues claims?

By Oct. 14, 2012, Blue Cross Blue Shield Association is requiring all Blue Plans to implement new ancillary provider claim filing rules. The new rules state that for independent clinical laboratory services, the local plan is the plan in whose service area the specimen is obtained. For durable medical equipment and supplies, the local plan is the plan in whose service area the equipment was shipped to or purchased at a retail store. For specialty pharmacy, the local plan is the plan in whose state the ordering physician is located.

If you contract with more than one plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either plan. Please note the referring physician must be on the claim or it will be rejected.

For more information please visit our website, www.bcbst.com, and look for New Claim Filing Procedures for Ancillary Providers in the News section of the provider page.

### New remittance format for BlueCard claims complete

The remittance format for BlueCard claims has completed its transition. As previously communicated in the January 2010 BlueAlert, the format is now similar to the commercial line of business. BlueCard are now in the process of phasing out the legacy payment system.

Adjustments for claims processed under the legacy system will be handled as "net" transactions on the new system.

- If the result of an adjustment is an add-pay, the remittance advice will reflect only the additional dollars owed to you.
- If an adjustment results in a recovery, the remittance advice will reflect a recovery for the specific amount owed BlueCross. These will be reflected in the Adjustment Summary section of the remittance advice.

If you have any questions, please contact the BlueCard 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)

***eBusiness Technical Support***
Phone: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueCross BlueShield of Tennessee offices will be closed Wednesday, July 4, 2012, in observance of the Fourth of July Holiday**

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueAlert
provider news flash

of Tennessee
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August 2012

# 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. 9, 2012**

- Minimally Invasive Procedures for Weight Loss
- Optical Coherence Tomography for Imaging of Coronary Arteries
- Photodynamic Therapy for Choroidal Neovascularization
- Vertebral Fracture Assessment with Densitometry

**Effective Sept. 12, 2012**

- Treatment of Congenital Port Wine Stains and Hemangiomas
- Bendamustine
- Panitumumab
- Rituximab

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

## ADMINISTRATIVE

### 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, e.g., 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 BlueCross as well as payment to the DME supplier.

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

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### 2012-2013 Reimbursement for FluMist® and Fluzone® Intradermal Influenza Vaccine

Flu season can begin as early as October and as late as May. However, in Tennessee, flu activity is typically worse in February and March. Providers are reminded not all Blues health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

Each year the formulation of the "seasonal flu vaccine" is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control (CDC). This vaccine contains different "strains" of flu expected to be active for that year. In order to allow providers to prepare for the upcoming 2012-2013 flu season, the following influenza immunization guidelines for BlueCross BlueShield of Tennessee apply with dates of service of beginning Aug. 01, 2012:

**Commercial**

- ***Vaccine and administration***
  Covered if offered under the member's health care plan
- ***FluMist® nasal spray (recommended for healthy individuals ages 2-49)***
  Covered if offered under the member's health care plan
- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  Covered if offered under the member's health care plan

**BlueCare or TennCare*Select***

- ***Vaccine and administration***
  Covered
- ***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
- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  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.**

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### Correct coding of compound drugs

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

An example of a compounded medication is **bevacizumab (Avastin®) for intravitreal injection.** Bevacizumab is supplied from

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Correct coding of compound drugs (Cont'd)

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

Effective Aug. 1, 2012, for each date of service compound drugs are administered, instilled, inserted, or implanted, a reasonable compounding fee will be reimbursed for commercial and BlueAdvantage claims if the pharmacy compounding fee is submitted on a separate line item billed with the appropriate HCPCS code for Pharmacy compounding and dispensing services.

Billing guidelines for compound drugs can be reviewed in the billing and reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual* found online at www.bcbst.com.

### Where do labs, DME and specialty pharmacy providers file Blues claims?

By Oct. 14, 2012, Blue Cross Blue Shield Association is requiring all Blue Plans to implement new ancillary provider claim filing rules. The new rules state that for independent clinical laboratory services, the local plan is the plan in whose service area the specimen is obtained. For durable medical equipment and supplies, the local plan is the plan in whose service area the equipment was shipped to or purchased at a retail store. For specialty pharmacy, the local plan is the plan in whose state the ordering physician is located.

If you contract with more than one plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either plan. Please note the referring physician must be on the claim or it will be rejected.

For more information please visit our website, www.bcbst.com, and look for New Claim Filing Procedures for Ancillary Providers in the News section of the provider page.

### Reminder: Continue to prepare for ICD-10

Since the U.S. Department of Health and Human Services announced their intent to initiate a process to postpone the compliance date for ICD-10, it is easy to delay or even forget about preparing for implementation. However, this is an opportunity for refining new processes and training staff. Continue to prepare for ICD-10 so that when the new implementation date is announced, you will not lose ground in moving forward to being ICD-10 compliant. The ICD-10 conversion will impact nearly all provider systems and many processes, with the largest impacts likely to be in clinical and financial documentation (billing and coding). It is critical not to delay planning and preparation.

- **Review** business and technical processes to evaluate the impacts of ICD-10 to your processes and plan accordingly.
  - Research the changes needed to your existing work flow and business process and update accordingly.
- **Focus** on improving clinical documentation; this can make the transition from ICD-9 to ICD-10 easier and will also have a positive effect on quality of care and reporting.
  - Educate coders with the additional time, the ICD-10 coding system is more specific and detailed than ICD-9.
  - Refresh knowledge of anatomy and medical terminology
  - Train staff to handle ICD-10 codes and adapt to coding, authorization, and billing changes.
- **Work** with vendors and Practice Management Systems to ensure they will be ready by the compliance date.
- **Test** with vendors and payers to ensure claims files will be accepted and transmitted correctly after the compliance date.

BlueCross BlueShield of Tennessee will keep you informed as to the progress that we are making toward becoming ICD-10 compliant.

For more information regarding ICD-10 implementation, please visit the provider page on our website at www.bcbst.com.

### Changes to commercial business peer-to-peer review process *

Based on feedback from the provider community, BlueCross BlueShield of Tennessee has implemented changes in our commercial peer-to-peer process by streamlining the scheduling of these reviews and eliminating the need to talk to multiple people. By calling the Provider Service line† you can reach the dedicated voicemail system for requests which now allows providers to leave necessary information, prompting a return phone call. All messages left *before* 3 p.m. (ET) will be returned the same day. Messages left *after* 3 p.m. (ET) will be returned the next business day. The new voicemail system requires two (2) specific dates and times to schedule the peer-to-peer review as well as other member demographics as indicated by voicemail prompts.

BlueCross values your input as we strive to provide, not only the best medical coverage for our members, but also the best experience for our providers.

### Reminder: Are you submitting paper claims to the correct address?

When submitting paper claims for all BlueCross BlueShield of Tennessee lines of business, providers are reminded to use the current address:

BlueCross BlueShield of TN
Claims Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37402-0002

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## CLINICAL

### Quest Diagnostics now providing lab services

Volunteer State Health Plan (VSHP) recently introduced its plans to consolidate lab services to Quest Diagnostics in an effort to rein in rapidly escalating lab expenditures within its TennCare business. Based on discussions with the provider community, several changes have been made to the original program design, including a decision to exclude the following:

- Inpatient lab services (already excluded from the original program)
- Outpatient dialysis (already excluded from the original program)
- Emergency room-based lab services
- Outpatient observation services
- Certain pathology services (List of specific codes to be published)
- Certain Obstetric services (List of specific codes to be published)

A revised Exclusion List will also be available on the VSHP provider website in August. Visit www.VSHPTN.com/providers for more information.

### Reminder: Behavioral health consultation line available

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

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

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

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

### Reminder: Access and availability requirements

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

***For primary care provider or physician extender:***

- Distance/time between the practitioner and member in urban area: 20 miles or 30 minutes;
- Distance/time between the practitioner and member in rural area: 30 miles or 30 minutes;
- Patient load: 2,500 or less for physician; 1,250 or less for physician extender;
- Appointment/waiting times: Usual and customary practice should not exceed three (3) weeks from the date of the member's request for regular appointments and 48-hours for urgent care; and
- Office waiting times should not exceed 45 minutes

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

### Pending Medicaid Number?

Providers waiting to receive a Medicaid Number should go ahead and file claims to meet timely filing requirements. Claims will deny for no Medicaid Number, but they will be on file. Once you receive the Medicaid Number and update your information, claims can be paid.

# BlueAdvantage

## CLINICAL

### Reminder: Medicare annual wellness visit - not the same as a member's yearly physical

Effective for dates of service on or after Jan. 1, 2011, BlueAdvantage provides coverage for two annual wellness visits (AWV), an initial preventive physical exam (IPPE) or first AWV and a subsequent AWV with personalized prevention plan services (PPPS).
BlueAdvantage pays for only one IPPE per member per lifetime. However, a member may receive subsequent AWVs annually thereafter.

**Note:** The AWV is a preventive wellness visit and is not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner.

Elements of the First AWV

- Health risk assessment
- Establishment of patient's medical/family history
- Review of patient's risk factors for depression
- Review of patient's functional ability and level of safety
- Physical assessment
- Establishment of current providers and suppliers
- Detection of cognitive impairment
- Establishment of a written screening schedule
- Establishment of a list of risk factors for primary, secondary and tertiary interventions are recommended
- Provision of personalized health advice to the patient and a referral to health education or preventive counseling services as appropriate

Elements of the Subsequent AWV

- Update of health risk assessment
- Update of patient's medical/family history
- Physical assessment
- Update of current providers and suppliers
- Detection of cognitive impairment
- Update of written screening schedule
- Update of list of risk factors for primary, secondary and tertiary interventions
- Provision of personalized health advice to the patient and a referral to health education or preventive counseling services as appropriate

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAdvantage

## CLINICAL (Cont'd)

### Reminder: Medicare annual wellness visit - not the same as a member's yearly physical (Cont'd)

For more information about the AWV with PPPS visit <http://www4a.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf >.

### BlueCross 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 BlueAdvantage members. As part of the clinical improvement process, BlueCross conducts member education and other activities to promote prevention and help 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, telephone reminder messages and Care Management education. However, despite such efforts by BlueCross and our network providers to increase screenings, several rates continue to fall below the CMS established four-star threshold*. The following HEDIS 2012 results show more emphasis is needed to improve colorectal cancer screening rates.

| 2012 Rate | | |
|---|---|---|
| Colorectal Cancer Screening | PFFS** | PPO** |
| | 38.84% | 55.00% |

The Medicare Advantage CMS Quality Rating Management Department at BlueCross continually plans new initiatives to specifically promote these screenings. It is hoped these interventions will improve screening rates.

Preventive screenings are a covered benefit of Medicare Advantage health plans. Health 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.

*CMS four-star threshold for colorectal cancer screening is 58%.

** Private Fee For Service (PFFS)
Preferred Provider Organization (PPO)

# BlueCard

## ADMINISTRATIVE

### National Consumer Cost Tool available to members

Effective Sept. 6, 2012, BlueCross BlueShield of Tennessee members will be able to view cost data for network facilities, surgeons and radiologists within the National Consumer Cost Tool (NCCT). This is part of our ongoing effort to support transparency and empower members in their health care decision-making process.

Additionally, specific facilities and physicians have the opportunity to review the data prior to it being published within the NCCT. A recent update of the claims data was mailed for review in July. If you did not receive cost data, there was not enough claims data available for your facility or office to be included in the tool at this time. In the future, your cost data may be included in the National Consumer Cost Tool as the claims data will be updated every six months.

Using the NCCT, members of Blue plans across the country are able to choose a treatment category, select a zip code and see estimated, average cost ranges for facilities, surgeons and radiologists in their area. The tool is available for a variety of common, elective treatment options and conditions. Currently, there are a total of 168 treatment categories.

If you have any questions, please email us at NCCTquestions@bcbst.com.

*These changes will be included in the appropriate 3Q 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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

# BlueAlert

provider news flash

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

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September **2012**

## 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. 13, 2012**

- Chromoendoscopy as an Adjunct to Colonoscopy
- Cognitive Rehabilitation
- Diagnosis and Treatment of Sacroiliac Joint Pain
- Temporary Prostatic Stent

**Effective Nov. 21, 2012**

- Cetuximab
- Temozolomide

**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>

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

**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/content/early/2010/10/21/STR.0b013e3181f7d043.full.pdf>

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

**Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents — Third Edition (2008)**
<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>

**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>

**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>

**Seventh Report of the Joint National Committee (JNC) on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure**
<http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf>
Use in correlation with:
JNC 7 Express
<http://www.surhta.com/PDF/JNC%207/JNC7Express.pdf>

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

Hyperlinks to these guidelines are 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.

## ADMINISTRATIVE

### Correction: Changes in coding for well-woman exams

In the July issue we advised the correct codes for well-woman exams were:

S0610, S0612
99385 – 99387
99395 – 99397
G0438, G0439

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Correction: Changes in coding for well-woman exams (Cont'd)

The "S" codes, S0610 & S0612 are considered "information only" codes and do not have a fee associated with them and may be filed with one of the other listed codes. We apologize for any inconvenience this may have caused.

### Reminder: 2012-2013 Reimbursement for FluMist® and Fluzone® Intradermal Influenza Vaccine

Flu season can begin as early as October and as late as May. However, in Tennessee, flu activity is typically worse in February and March. Providers are reminded not all Blues health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

Each year the formulation of the "seasonal flu vaccine" is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control (CDC). This vaccine contains different "strains" of flu expected to be active for that year. In order to allow providers to prepare for the upcoming 2012-2013 flu season, the following influenza immunization guidelines for BlueCross BlueShield of Tennessee apply with dates of service of beginning August 01, 2012:

**Commercial**

- ***Vaccine and administration***
  Covered if offered under the member's health care plan

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

- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  Covered if offered under the member's health care plan

**BlueCare or TennCare*Select***

- ***Vaccine and administration***
  Covered

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

  **Note:** In the August 2012 BlueAlert *FluMist®* was noted as being available under the Vaccines for Children (VFC) Program for children ages 5 through 18 years. The correct age range of children that may receive *FluMist®* through the VFC Program is 2 through 18 years. We apologize for any confusion this may have caused.

- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  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.**

### Reminder: New claim filing procedures for independent clinical laboratory (Lab), DME, and specialty pharmacy providers

Effective Oct. 14, 2012, all Blue Plans will implement new claim filing procedures for ancillary providers. **Due to these changes, it is very important that ALL providers understand the impact of this change**.

File the claim accordingly for the ancillary provider as follows:

- Independent Clinical Laboratory (Lab) - The Plan in whose state♦ the specimen was drawn.

- Durable/Home Medical Equipment and Supplies (DME) - The Plan in whose state♦ the equipment was shipped to or purchased at a retail store.

- Specialty Pharmacy - The Plan in whose state♦ the ordering physician is located.

♦ If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

***Providers that utilize vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting your Provider Network Manager.***

Claims must include the referring physician or will be rejected. For more information visit our website at www.bcbst.com/providers/news/ or contact us at 1-800-705-0391.

### Pharmacy medication review request fax form

To provide more efficient and accurate management of commercial and Cover Tennessee pharmacy medication reviews, the **Pharmacy Medication Review Request Fax Cover Form** must accompany these requests. The form is available on the provider page of our company website at <http://www.bcbst.com/pharmacy/provider/forms/> and http://www.bcbst.com/providers/forms/.

This fax form is a cover sheet only and is to be used for appeal requests for authorization denials or review requests for coverage of an excluded pharmacy product. Pertinent medical information that supports the pharmacy-related request is still required to be submitted with the fax cover form.

*These changes will be included in the appropriate 4Q 2012 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)

### Reminder: Provider Contracting/Credentialing requirements

Providers are reminded that participation in BlueCross BlueShield of Tennessee/Volunteer State Health Plan (BCBST/VSHP) Provider Networks requires satisfaction of applicable network participation and credentialing requirements. Credentialing of providers is performed by BlueCross BlueShield of Tennessee, Inc. Credentialing Department.

Providers interested in participating in one or more BCBST/VSHP networks should contact their local Provider Network Manager or call the BlueCross BlueShield of Tennessee Provider Service line†.

# BlueCare/TennCare*Select*

## CLINICAL

### Smoking cessation support for pregnant women

TennCare and the 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 us 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) or visit their website at http://health.state.tn.us/tobaccoquitline.htm.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE

### Cultural disparities information

BlueCross BlueShield of Tennessee conducted an analysis of top conditions by race/ethnicity using episode treatment groupings for commercial and TennCare members who had claims in 2011. Additional, BlueCross examined compliance with evidence-based guideline measures to determine if compliance varied by race. The results are in and there are some significant differences in the health of some racial/ethnic groups. Please look at these results and keep them in mind as you treat your patients.

**Asians**

- Asian commercial members had lower prevalence for every top condition when compared to all other racial/ethnic groups.
- The prevalence of gynecological cancers for Asian TennCare members almost doubles that of other racial/ethnic groups.

**African Americans**

- African American commercial members had significantly higher rates of hypertension and diabetes compared to other racial/ethnic groups.
- African American TennCare members had significantly higher rates of STDs compared to other racial/ethnic groups.

**Hispanics**

- Hispanic commercial members had low compliance with most preventive measures in every gap measure group.
- Hispanic commercial members had higher rates of obesity compared to the other racial/ethnic groups.

**American Indian/Alaskan Native**

- AI/AN TennCare members had significantly higher prevalence of diabetes and gynecological cancers compared to the other racial/ethnic groups.

**White**

- White TennCare members had a significantly higher prevalence of hypertension and endocrine gland diseases compared to other racial/ethnic groups.

### Home health services request change *

Effective Oct. 1, 2012, **all** home health services requests must be submitted via fax to **1-865-588-4663.** All other previously listed fax lines utilized for home health requests will be terminated at that time. Requests for services includes physical therapy, occupational therapy, skilled and non-skilled home health, private duty nursing care and missed shifts as well as procedures and services with HCPCS codes S, G and T.

### Notification requirement change for outpatient physical therapy *

Effective Sept. 1, 2012, **BlueCare** and **TennCare*Select*** will require notification for only the initial six (6) outpatient physical therapy visits for members age 21 and older. Notification must include demographic and clinical information, and indicate who will be performing the services. This information is necessary for accurate claims processing and payment.

*These changes will be included in the appropriate 4Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE (Cont'd)

### Notification requirement change for outpatient physical therapy * (Cont'd)

All notification services 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 may be subject to retrospective review based on medical policy and medical necessity. **All** services provided by **out-of-network** providers require prior authorization.

Notify us of the initial six outpatient physical therapy visits by faxing the required information to:

East Region: 1-800-292-5311
West Region: 1-800-919-9213
SelectCommunity: 1-888-255-9175

### Reminder: Individualized Education Plan (IEP)

The Individuals with Disabilities Education Act (IDEA) requires public schools to develop an Individualized Education Plan (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 (MC0), such as Volunteer State Health Plan (VSHP). 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.

*****These changes will be included in the appropriate 4Q 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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

*These changes will be included in the appropriate 4Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAlert

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**October 2012**

## 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. 10, 2012**

- Corneal Collagen Cross-Linking
- Plasma Exchange
- Complementary and Alternative Medicine
- Treatment of Tinnitus

**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 Nov. 21, 2012**

***The following as relates to Inpatient and Surgical Care:***

- Bone Excision
- Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander

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

### New drugs added to commercial specialty pharmacy listing

Effective Nov. 1, 2012 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:***
Kyprolis (PA)
Marqibo (PA)
Perjeta (PA)
Zaltrap (PA)

***Self-administered via medical benefit:***
Bosulif (PA)
Xtandi (PA)

Providers can obtain PA for:

- Provider-administered drugs having a valid HCPCS code by logging onto BlueAccess, the secure area of bcbst.com, select Service Center from the main menu, followed by Authorization/Advance Determination Submission. If you are not registered with BlueAccess or need assistance using bcbst.com call eBusiness Solutions†.
- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.
- Self-administered Specialty Drugs by calling Caremark at 1-877-916-2271.

**Note:** BlueCross BlueShield of Tennessee updates the web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

### October quality focus: Women's health month

Nationwide, October is known as Breast Cancer Awareness Month. BlueCross BlueShield of Tennessee, VSHP, and Cover Tennessee would like to extend that focus to all women's health, especially breast cancer screening, cervical cancer screening, and Chlamydia screening. Prenatal or postpartum visits may also provide a good opportunity for PAP and Chlamydia screenings.

Several activities have been conducted focusing on increased member awareness:

- Automated telephone calls to members with directed reminders and education on the importance of cervical cancer screenings, breast cancer and Chlamydia screenings, as well as other preventive testing;
- Health cards are mailed to women during their birthday month with information on Pap tests and mammography encouraging them to discuss with their health care provider whether they should be tested; and
- Newsletter articles with education on the importance of all preventive tests supporting clinical practice guidelines, for improved member quality of life.

**Prevention messages are more effective when they come from the member's health care provider.** Please encourage your female patients to schedule these important screenings as appropriate.

## ADMINISTRATIVE

### Electronic funds transfer *

If you are not already participating in the Electronic Funds Transfer (EFT) process to receive your payments from BlueCross BlueShield of Tennessee, now is a good time to start.

Effective Nov. 1, 2012, Network Participation Criteria will require all new contracting providers to enroll in the EFT program. This applies only to newly contracted providers; current providers are not affected by this change at this time.

Key advantages to enrolling in EFT are:

- Earlier payments
- More secure payment process
- Reduced administrative costs
- Less paper storage

To enroll in EFT complete the *Electronic Funds Transfer Enrollment* form available on the company website at <http://www.bcbst.com/providers/forms/EFT_Enrollment.pdf>.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Electronic Funds Transfer (Cont'd)

Fax the completed form and a void check to (423) 535-3066 or (423) 535-7523 or mail to:

BlueCross BlueShield of Tennessee
ATTN: Provider Information Dept. 2.4CH
One Cameron Hill Circle
Chattanooga, TN 37402

If you have any questions or need assistance, please contact eBusiness Technical Support†.

### BlueAccess improved user experience

You spoke, and we listened! Coming soon is a new and improved user interface for our online web tools found in the current Service Center application. You will still access patient inquiry for your benefit and eligibility verification, claim center for claim status and Authorization/Advance Determination for your prior authorization requests. Quick reference guides will also be available to you online. Please contact your eBusiness Marketing Team if you are interested in personal training or if you have any questions. You may also contact our eBusiness Service center for any technical questions†.

**e-Business Solutions Staff**

**Debbie Angner - West TN**
Debbie_Angner@bcbst.com 901-544-2285

**Faye Mangold - Middle TN**
Faye_Mangold@bcbst.com 423-535-2750

**Faith Daniel - East TN**
Faith_Daniel@bcbst.com 423-535-6796

### Inpatient web authorizations

The inpatient web authorization form includes a discharge date field. This field should only be used if the date of discharge is known. If you would like training on how to submit authorizations online, please contact the eBusiness Marketing Consultant in your region.

**Note:** *Consultant contact information is included in the previous article.*

### Reminder for durable medical equipment (DME) and supplies with place of service (POS) 11

Providers are reminded that certain DME items and medical supplies allow $0.00 reimbursement when billed with the place of service 11. These items such as syringes, gauze, tape, etc. are not separately reimbursed if incident to a physician's service.

Additional information is available on the CMS website, https://www.cms.gov/.

### New compliance date confirmed for ICD-10 implementation

Effective Oct. 1, 2014, all entities under the Health Insurance Portability and Accountability Act (HIPAA) must be ICD-10 compliant. The Department of Health and Human Services set the new compliance date in their final ruling published in August.

While providers continue preparing for ICD-10, it is not exclusively the coding and billing staffs that need education. Clinicians should also be encouraged to learn about the additional details in documentation required to support ICD-10.

For example, enhanced charting allows for more accurate coding and reimbursement, as well as tracking disease states and outcomes. Without more detailed documentation in medical records, queries may be required in order to assign the appropriate ICD-10 codes; the query process negatively impacts productivity in the revenue cycle.

BlueCross BlueShield of Tennessee continues to move forward with the remediation project and plans to continue processing claims based on date of service or inpatient discharge. We will keep you informed of the progress being made toward becoming ICD-10 compliant.
FAQs regarding ICD-10 implementation are available on the Provider page of our company website at <http://www.bcbst.com/providers/ecomm/ICD10%20Frequently%20Asked%20Questions.pdf>.

### Reminder: New claim filing procedures for independent clinical laboratory (Lab), DME, and specialty pharmacy providers

Effective Oct. 14, 2012, all Blue Plans will implement new claim filing procedures for ancillary providers. **It is very important ALL providers understand the impact of this change**.

File the claim accordingly for the ancillary provider as follows:

- Independent Clinical Laboratory (Lab)
  - The Plan in whose state♦ the specimen was drawn, *which will be determined by which state the referring provider is located.*
- Durable/Home Medical Equipment and Supplies (DME)
  - The Plan in whose state♦ the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy
  - The Plan in whose state♦the ordering physician is located.

♦If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.
♦For contiguous county providers, please file claims according to these guidelines regardless of network status.

***Providers that utilize outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting your Provider Network Manager.***

Claims must include the name of the referring physician or the claim will be rejected. For more information please visit our website at www.bcbst.com/providers/news/ or contact us at1-800-705-0391.

*These changes will be included in the appropriate 4Q 2012 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)

### Reminder: 2012-2013 Reimbursement for FluMist® and Fluzone® Intradermal Influenza Vaccine

Flu season can begin as early as October and as late as May. However, in Tennessee, flu activity is typically worse in February and March. Providers are reminded not all Blues health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

Each year the formulation of the "seasonal flu vaccine" is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control (CDC). This vaccine contains different "strains" of flu expected to be active for that year. In order to allow providers to prepare for the upcoming 2012-2013 flu season, the following influenza immunization guidelines for BlueCross BlueShield of Tennessee apply with dates of service beginning Aug. 1, 2012:

**Commercial**

- ***Vaccine and administration***
  Covered if offered under the member's health care plan
- ***FluMist® nasal spray (recommended for healthy individuals ages 2-49)***
  Covered if offered under the member's health care plan
- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  Covered if offered under the member's health care plan

**BlueCare or TennCare*Select***

- ***Vaccine and administration***
  Covered
- ***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 2 through 18 years
- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  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.**

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### Reminder: Prior authorization requirement

Claims for treatment or services requiring prior authorization will be **denied** if there was no request made before the treatment or service. Physicians who delegate responsibility to the facilities to obtain prior authorization for treatment will also be held as non-compliant if the facility did not obtain authorization prior to the treatment or service. **The ultimate responsibility for prior authorization belongs to the physician to ensure claims are paid.**

# BlueCare/TennCare*Select*

## CLINICAL

### Reminder: Notification requirement change for outpatient physical therapy

**BlueCare** and T**ennCare*Select*** allow network providers to submit six (6) initial outpatient physical therapy (PT) visits for patients ages 21 years and older as notification for claims payment. Subsequent visits require full medical necessity review. Submit these notifications via fax to 1-800-292-5311.

Requests for notification for claims payment must include: member name, member ID number, number of visits requested, dates of service, provider ID number, ordering physician's name, modalities being used and the physician's order for service.

Requests beyond six (6) outpatient PT visits for the same or similar diagnosis or limb will require all pertinent clinical information to support the medical need for the service or ongoing service.

All non-covered or aquatic services will continue to be reviewed for coverage or medical necessity. Providers are reminded notifications may be subject to retrospective claims review based on Medical Policy.

## ADMINISTRATIVE

### CareCentrix update

For the past 20 months, CareCentrix® (CCX) has provided claims administration, utilization management and provider network management services to **BlueCare** and **TennCare*Select*** members for durable medical equipment (DME) and medical supplies. As of Nov. 1, 2012, provider network management and claims administration will return to VSHP. We are working to finalize an agreement that will allow CareCentrix to continue performing utilization management for these services.

As part of the utilization management services, it will be important for you to continue to obtain authorizations from CareCentrix. To obtain authorizations quickly and efficiently, please use the provider portal at www.carecentrixportal.com. Check the provider directory on the company websites, www.bcbst.com and www.vshptn.com for a listing of participating DME providers.

Until Nov. 1, 2012, continue to work with CCX as you always have. For rentals, if the rental month starts before Nov. 1, 2012, CCX will process the claim. For supplies and enterals, claims must be split based on date of service (DOS). For purchases Oct. 31, 2012 or prior, CCX will process the claim, and if purchased Nov. 1, 2012, and after, VSHP will process the claim and route any claims questions to the corresponding company.

In addition, the following updates have been made to VSHP DME and orthotics and prosthetics (O&P) authorizations:

- CCX will manage all DME and O&P authorizations
- All DME and O&P requests from DME and O&P providers will require authorization

# BlueCare/TennCare*Select*

## ADMINISTRATIVE (Cont'd)

### CareCentrix update (Cont'd)

- Non-DME providers with DME requests over $500 require authorization
- Non-O&P providers with O&P requests over $200 require authorization
- All TENS and CPAPs require authorization

Additional information will be sent out prior to November 1 by VSHP and CCX. Please be aware of this important change.

### Reminder: Behavioral Health Adverse Incidents

Volunteer State Health Plan would like to remind providers of their contractual obligation to report all adverse incidents in a timely manner. Please make certain you and your staff are familiar with this process.

More information regarding adverse incident reporting is available at <http://www.valueoptions.com/providers/Network/TennCare/Sentinel_Event_Adverse_Incident_and_Adverse_Occurrence_Reporting_Presentation.pdf>. Any questions should be directed to your regional network manager.

### Correction: Home health services request change *

The following is a correction to information published in the September 2012 *BlueAlert*. Submit requests for home health services including HCPCS G codes, physical therapy, occupational therapy, skilled and non-skilled services via the following:

**Fax: 1-865-588-4663 or**
**Phone: 1-888-423-0131 for BlueCare and 1-800-711-4104 for TennCare*Select***

Requests for HCPCS S and T codes should be submitted via fax to:
**Fax: 1-865-588-4663**

Missed Shifts for Home Health continue to be sent to:
**Fax: 1-800-292-5311 or**
**Phone: 1-800-215-3851**

SelectCommunity requests continue to be sent to:
**Fax: 1-888-255-9175 or**
**Phone: 1-800-292-8196**

# BlueCard

## ADMINISTRATIVE

### New claim filing procedures for independent clinical laboratory (Lab), DME, and specialty pharmacy providers

BlueCard lab, pharmacy and DME claims follow the same guidelines as commercial. Refer to the full article on page 2 under **Commercial Administrative** updates.

# Cover Tennessee

## ADMINISTRATIVE

### CoverKids Payment Error Rate Measurement (PERM) Program

The Centers for Medicare & Medicaid Services (CMS) will be performing an audit of Blue Network S providers' medical records as part of the Payment Error Rate Measurement (PERM) program. The PERM program measures improper payments made under the Children's Health Insurance Program (CHIP), called CoverKids.

CMS will review a random sample of payments with original dates of payment from Oct. 1, 2012, through Sept. 30, 2013. Medical record requests for the PERM review will begin in first quarter, 2013.

For more information about PERM, visit the CMS PERM website at http://www.cms.gov/PERM.

*These changes will be included in the appropriate 4Q 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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

*These changes will be included in the appropriate 4Q 2012 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

**November 2012**

## 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 Dec. 8, 2012

- Aqueous Shunts for Glaucoma
- Beta Amyloid Imaging with Positron Emission Tomography (PET) for Alzheimer's Disease
- Genetic Testing for Lipoprotein(a) Variant(s) as a Decision Aid for Aspirin Treatment
- Genotyping for 9p21 Single Nucleotide Polymorphisms to Predict Risk of Cardiovascular Disease or Aneurysm
- Sleep Disorder Studies

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

## ADMINISTRATIVE

### BlueAccess improved user experience

You spoke, and we listened! Coming soon is a new and improved user interface for our online web tools found in the current Service Center application. You will still access patient inquiry for your benefit and eligibility verification, claim center for claim status and Authorization/Advance Determination for your prior authorization requests. Quick reference guides will also be available to you online & will be located underneath the Service Center section of BlueAccess. Please contact your eBusiness Marketing Team if you are interested in personal training or if you have any questions. You may also contact our eBusiness Service center for any technical questions†.

**e-Business Solutions Staff**

**Debbie Angner - West TN**
Debbie_Angner@bcbst.com 901-544-2285

**Faye Mangold - Middle TN**
Faye_Mangold@bcbst.com 423-535-2750

**Faith Daniel - East TN**
Faith_Daniel@bcbst.com 423-535-6796

### Magellan Behavioral Health® available to assist medical practitioners

BlueCross BlueShield of Tennessee, AccessTN and CoverKids all partner with Magellan Behavioral Health to address mental health and substance abuse disorders. For your patients with behavioral health needs, Magellan can assist in providing care with:

- important resources, including the locations, practice and specialty information about practitioners and facilities;
- total network resources available to patients, including resources often outside the awareness of the patient or practitioner ;
- providing medical practitioners information about crisis intervention and alternatives to inpatient levels of care ;
- medical directors are available to discuss treatment, medications or alternative resources; and
- communication with primary medical practitioners.

To help ensure our members receive the most appropriate care, Magellan is committed to successful communication between behavioral health providers and primary care practitioners. This communication and coordination provides the best plan of care for your patients.

Additional information regarding behavioral health is available on our company website at <http://www.bcbst.com/providers/behavioral_health/>.

Contact Magellan by calling the toll-free number on the patient's member ID card. Practitioner information and tools are also available on Magellan's website, www.magellanprovider.com.

### BlueCross focuses on improving preventive care

BlueCross BlueShield of Tennessee's Preventive Screening Programs focus on improving the quality of preventive clinical care received by its members. As part of this initiative, BlueCross conducts member education and other activities to promote prevention and help ensure continued health and wellness within our member populations and to improve the preventive screening rates as determined by the Healthcare Effectiveness Data Information Set (HEDIS®).

Preventive screening reminders are disseminated through various avenues including, but not limited to postcards, telephone reminder messages and Care Management education. However, despite such efforts by BlueCross and our network providers to increase screenings, several rates continue to fall below the benchmarks set by the National Committee for Quality Assurance (NCQA) for the highest level of quality. The HEDIS® 2012 results show more emphasis is needed to improve rates for cervical cancer screening, breast cancer screening and colorectal cancer screening.

Preventive screenings are a covered benefit for most BlueCross plans and some have little or no out-of-pocket costs to members. Health 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.

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### BlueCross focuses on improving preventive care (Cont'd)

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.

### NCCI edits for commercial lines of business

Since 1996 the Medicare National Correct Coding Initiative (NCCI) procedure to procedure edits have been assigned to either the Column One/Column Two Correct Coding edit file or the Mutually Exclusive edit file based on the criterion for each edit. As of April 1, 2012, in order to simplify the use of NCCI edit files, The Centers for Medicare & Medicaid Services (CMS) will no longer publish a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services. All active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file.

The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. The Mutually Exclusive edits were denied as redundant. With this move all Column One/Column Two Edits are considered as redundant and the charges will be denied with a denial explanation.

### Pharmacy program enhancements beginning Jan. 1, 2013

BlueCross is making a transition to Express Scripts® as our new pharmacy benefit manager for all commercial, Cover Tennessee and BlueAdvantage pharmacy members. While many processes will remain the same, there are a number that will change. The transition should be smooth for both you and your patients.

Some key points to this transition are:

- **Formulary** – will remain as the standard BlueCross BlueShield of Tennessee formulary. The process for communicating changes – typically effective Jan. 1 – will be the same.
- **Network** – more than 62,000 pharmacies are included in the national network – comparable to the existing network. There should be little, if any, disruption to members. We will let members know how to select an in-network pharmacy if their current pharmacy is out of network.
- **Open refills** – BlueCross will work with Express Scripts to transfer mail order prescriptions.
- **Prior Authorizations** – will be transferred to Express Scripts and require no action from members or providers. The prior authorization phone number will remain the same.
- **Claims History** – two years of pharmacy claims will be provided to Express Scripts for seamless utilization review.

Our Provider Service and Customer Service phone numbers will remain the same.

### Postpartum depression screening

New mothers are often so focused on their newborn they don't pay attention to themselves. When newborns come in for their first pediatric visit, please consider giving the mother the Edinburgh Postnatal Depression Scale. Positive results may be referred to their provider for follow up and treatment.

The Edinburgh Postnatal Depression Scale screening tool, scoring instructions, a sample signature page for new mothers and a sample letter to the patient's doctor(s) regarding screening results may be found at <http://www.tnaap.org/DevBehScreening/screeningtools.htm>.

### Reminder: Use of bevacizumab (Avastin) for treatment of eye disorders

Providers are reminded that prior authorization for bevacizumab (Avastin) is not required for use in treatment of eye disorders; however, prior authorization ***is*** required for bevacizumab (Avastin) in the treatment of neoplastic conditions/diseases.

For additional information, please refer to the *BlueCross BlueShield of Tennessee Medical Policy Manual* available on the company website at <http://www.bcbst.com/mpmanual/Bevacizumab.htm>.

### Need CME, CEU, or CCM credits?

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

There is **no cost** to BCBST/VSHP providers. There are a limited number of licenses available for theses courses, so please register quickly to take advantage of this valuable learning opportunity. The registration deadline is Dec. 31, 2012.

To register, go to the Provider page on the company website, www.bcbst.com and click on the *Quality Interactions® Cross Cultural Training* link which will give you instructions for registering for the training. The BlueCross organizational code is 88700.

This is a great way to get valuable professional credits, for no cost, and gain useful knowledge to work with the culturally diverse population of Tennessee.

*These changes will be included in the appropriate 4Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueCare/TennCare*Select*

## ADMINISTRATIVE

### Behavioral health updates

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. The referral line is a Tennessee-based resource staffed by people who are familiar with local resources, and who can arrange for care that will save you or your office staff valuable time.
- Telephone consultation services provided by Behavioral Health Peer Advisors who are Board Certified Psychiatrists are available to discuss all aspects of mental health and substance abuse treatment including medications by calling 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 a behavioral health diagnosis should reflect efforts that support coordination of medical and behavioral health, which may include written correspondence to and/or from behavioral health providers, or inquiries regarding such services, and referrals if appropriate.

### 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 parties involved in the member's healing process.

Members enrolled in a case management program are assigned a Volunteer State Health Plan (VSHP) Case Manager (registered nurse) to coordinate their complex needs.

Disease management services are available to members with diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease, pregnancy, coronary artery disease, obesity, bipolar disease, major depression and schizophrenia. Members enrolled in a disease management program are assigned a Volunteer State Health Plan Disease Manager who supports and coaches members in adopting and maintaining healthy habits. When these nurses recognize changes or lifestyle issues that may affect the member's health, they work with the member and provider to address the issues and coordinate appropriate treatment, services and medications.

Members may self refer to either program by calling the Customer Service number listed on their 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 |

### Reminder: Individualized Education Plan (IEP)

The Individuals with Disabilities Education Act (IDEA) requires public schools to develop an Individualized Education Plan (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 (VSHP). 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: Mammogram information

Patients who seek mammograms may do so without a physician's order. However, many facilities require primary care provider information so screening results may be sent for patient follow up as needed, and placement in the patient's medical records. If a referral is requested, please respond promptly to avoid hindering the patient from receiving a mammogram screening.

Some members may be assigned to a primary care office, but have not yet seen the provider. Please compare any "new" patient information you may receive from a facility by checking your most recent **BlueCare/TennCare*Select*** Member Listing available on BlueAccess.

### Volunteer State Health Plan Payment Error Rate Measurement (PERM) Program

The Centers for Medicare & Medicaid Services (CMS) will be performing an audit of VSHP providers' medical records as part of the Payment Error Rate Measurement (PERM) program. The PERM program measures improper payments made by Medicaid and the Children's Health Insurance Program (CHIP).

CMS will review a random sample of payments with original dates of payment from Oct. 1, 2012 through Sept. 30, 2013. Medical record requests for the PERM review will begin in first quarter, 2013.

For more information about PERM, please visit the CMS PERM website at http://www.cms.gov/PERM.

# BlueCare/TennCare*Select*
## ADMINISTRATIVE (Cont'd)

### Name change for TennCare Pharmacy Benefit Manager *

The State of Tennessee, Bureau of TennCare's Pharmacy Benefit Manager (PBM) has changed its name from SXC Health Solutions to **Catamaran Corporation**.

Address and contact information remain the same at:

2441 Warrenville Road, Suite 610
Lisle, IL 60532

Phone: 1-866-434-5524
Fax: 1-866-434-5523

### Well child care checkups

There are no limits or timeframe guidelines for well child care checkups for Medicaid eligible children under the age of 21. If parents, teachers or other caregivers believe there is a problem, children may also receive screenings between regular checkups. Medically necessary screenings, interperiodic screenings, diagnostic and follow-up treatment services are all in accordance with federal and state requirements.

When children come in for illness, acute care or sports/camp physicals, please check their medical history to determine if TENNderCare services should be provided and documented in their medical records. Under TENNderCare benefits, children under the age of 21 years should have vision, hearing and dental screenings at intervals that meet the reasonable standards of medical and dental practice.

TENNderCare billing guidelines can be found in the *VSHP Provider Administration Manual* located on the Provider page on the company websites www.vshptn.com and www.bcbst.com. You may also use your patient listing available on BlueAccess to know when children are due for services.

### Durable Medical Equipment (DME) update *

Effective Nov. 1, 2012, VSHP will assume claims administration and utilization management (UM) for its DME Provider network. Providers writing orders for DME products may go directly to participating DME providers and the DME providers will submit authorization requests directly to VSHP UM using the steps below. A list of participating providers may be found in the *BlueCross BlueShield of Tennessee Referral Directory* located on the *BlueSource Provider Information CD*.

DME and Orthotics and Prosthetics (O&P) requests for authorization should be faxed to VSHP UM at **1-800-292-5311** using the *DME Request Form* located on the company website, www.vshptn.com.

- All DME and O&P requests from DME and O&P providers require authorization.
- Non-DME providers with DME requests over $500 require authorization.
- Non-O&P providers with O&P requests over $200 require authorization.
- All TENS and CPAPs require authorization.

During the transition, VSHP will honor existing CareCentrix® (CCX) prior authorizations as of Oct. 31, 2012. Until Nov. 1, 2012, please continue to work with CCX as you always have. For rentals, if the rental month starts before Nov. 1, 2012, CCX will process the claim. For supplies and enterals, claims must be split based on date of service. For purchases prior to Nov 1, CCX will process the claim. If purchased on or after Nov. 1, VSHP will process the claim. Please route claims questions to the corresponding company.

VSHP claims may be filed using the normal claims procedures found in the Billing and Reimbursement Section of the *VSHP Provider Administration Manual* which is available on the Provider pages on the company websites, www.vshptn.com and www.bcbst.com.

*****These changes will be included in the appropriate 4Q 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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueCross BlueShield of Tennessee offices will be closed Nov. 22 & 23, 2012, in observance of the Thanksgiving Holiday.**

# BlueAlert

provider news flash

of Tennessee
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Please Route to all Providers & Office Staff

**December 2012**

## 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 Jan. 12, 2013**

- Intervertebral Disc Decompression using Radiofrequency Coblation (Nucleoplasty) or Laser Energy (Laser Discectomy)
- Occlusion of Uterine Arteries Using Transcatheter Embolization

**Effective February 13, 2013**

- Pralatrexate
- Varicose Vein Treatment of Lower Extremities

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

## ADMINISTRATIVE

### Physician Quality and Cost Information will soon be updated

The Physician Quality and Cost information will soon be updated and available for private physician viewing beginning the week of Dec. 10, 2012. Physicians will once again have a 45-day review period to make any updates to your data before it is released to our customers no earlier than Feb. 11, 2013. As in the past, this data will also be made available to members on the BlueCross BlueShield Association Provider Directory.

Along with the updated information, the following three new measures have been added bringing the total to 13 individual measures:

- Use of Appropriate Medication for People with Asthma
- Immunization for Adolescents: Meningococcal vaccine, Tetanus, Diphtheria
- Use of Imaging Studies for Low Back Pain

If you have not previously accessed the Physician Quality and Cost information on our website, please go to www.bcbst.com to create your user ID and password. Step-by-step registration instructions are available at www.bcbst.com/secure/providers/. For more information on BlueAccess registration, contact eBusiness Solutions at (423) 535-5717 Option 2 or by email at ecomm_techsupport@bcbst.com.

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

### Physician's Guide to Patient Ratings *

A *Physician's Guide to Patient Ratings* brochure is now available on the Provider page on our company website. This brochure contains more information about the upcoming launch of a new online capability that allows Blue Members to view and post reviews based on their patient experiences. *Patient Review of Physicians* is an online review system that Blue Members nationwide can use as part of their decision-making when they are selecting a physician or other professional provider. BlueCross BlueShield of Tennessee delivers information about members' actual experiences with their providers through an easy-to-use, nationally consistent, online survey and aggregated results display.

Providers can soon logon to *BlueAccess* and navigate to the "Transparency Review" section and choose "Provider Ratings Review" to access a summary of all provider reviews and perform a number of provider-specific actions, such as:

- sign up for e-mail or fax alerts when new reviews are received;
- hide up to two (2) reviews; and
- post a response to a review.

Not only is patient review a valuable tool for providing insights into your patients' experiences, it can also attract new patients. While patient reviews are just one of many factors to consider when patients choose a health care provider, research shows that online patient reviews are one of the most sought after pieces of information for consumers. Approximately 85-90 percent of patient reviews are positive, and some Physicians use them as a means to promote their practice. To assure your overall score is positive, encourage your patients to contribute to your reviews.

### Electronic funds transfer (EFT) *

In an effort to help keep premiums affordable for our members and make it easier for health care providers to do business with BlueCross, we will soon be launching efforts to increase the use of electronic transaction tools.

The first initiative focuses on increasing participation in the EFT process. By participating in EFT, a provider's payment will be deposited directly into the provider's bank account rather than receiving a paper check.

To enroll in EFT, simply complete the EFT enrollment form which is located in the Provider Section of our website at <http://www.bcbst.com/providers/forms/EFT_Enrollment.pdf >. Fax the completed form and a void check to (423) 535-3066 or (423) 535-7523 or mail to:

BlueCross BlueShield of Tennessee
ATTN: Provider Information Department
2.4CH
1 Cameron Hill Circle
Chattanooga, TN. 37402

# BlueCross BlueShield of Tennessee, Inc. (BCBST)

**(Applies to all lines of business unless stated otherwise)**

## ADMINISTRATIVE (Cont'd)

### Electronic funds transfer (EFT) (Cont'd) *

More information on EFT is available at http://www.bcbst.com/providers/ecomm/ or by contacting eBusiness Technical Support †.

### Dental coding changes

Per the current guidelines set by the American Dental Association (ADA), the following CDT® codes will be deleted as of Jan. 1, 2013: D0360,D0362, D1203, D1204, D4271, D6254, D6795, D6970, D6972, D6973, D6976 and D6977.

The following CDT® codes will be added as of Jan. 1, 2013, and will be covered under the standard DentalBlue contract: D1208, D2990, D2981, D2982, D2983, D4212, D4277, D4278, D6101, D6102, D6103 and D6104.

If a deleted code is filed beginning with date of service Jan. 1, 2013 or after, that line item will not be processed and you will be advised to file the most current ADA code. For questions contact Dental Customer Service at 1-800-523-1478, Monday through Friday, from 8 a.m. to 5:15 p.m. (ET).

### Major changes to CPT® codes for behavioral health services in 2013*

Effective Jan. 1, 2013, significant changes will be made to CPT® codes for psychiatry and psychotherapy services. Changes to CPT® code sets are made by the American Medical Association (AMA) on an annual basis, but revisions to the 2013 Psychiatry CPT® code set have a much higher-than-usual impact on psychiatry and psychotherapy services.

Switching to the new codes is based on the date of service, not the date the claim is submitted. Providers must bill with new CPT® codes on January 1 for dates of service on or after Jan. 1, 2013, or the claim will deny.

To avoid delays in claims payment, providers should file with the correct codes before and after the January 1 effective date. If you are a Psychiatrist or Advanced Practice Nurse with both a medical and behavioral health provider number, BlueCross BlueShield of Tennessee recommends you include your Taxonomy number on the claim.

For more information and a list of commonly used psychiatric CPT® codes that will be changing on Jan. 1, 2013, see *The National Council* brochure available on the Provider page of the company website at www.bcbst.com

### Closing gaps in care for your patients with diabetes

According to 2011 estimates from the Centers for Disease Control (CDC), 8.3 percent of the U.S. population has diabetes. Tennessee is above the national average by more than 10 percent in many counties. As a result, BlueCross BlueShield of Tennessee continues to focus its efforts on standards of care that improve health and outcomes for all diabetic members. BlueCross has adopted the American Diabetes Association's "Standards of Medical Care in Diabetes - 2012" as the official clinical practice guideline for the treatment of diabetes. The following measures are important indicators of quality care for diabetic members and should be documented on an annual basis:

- Hemoglobin A1c (HbA1C) testing
- Retinal eye exam performed by an eye care professional
- LDL-C testing – goal control level is < 100 mg/dL
- Blood pressure control (goal is < 140/80 mm HG)
- Medical attention for nephropathy – either screening such as urine for microalbumin or evidence of treatment for nephropathy such as a visit to a nephrologist or member prescribed an ACE inhibitor or ARB therapy.

Closing gaps in care is crucial to achieving the best health outcomes and quality of life for our members with diabetes. BlueCross may be able to assist your diabetic patients in getting to their optimal control with one of our Case Management or Disease Management programs. Encourage your patients to call our "Member Service" number on the back of their member ID card or go online to www.bcbst.com for education and assistance. For more information see the Clinical Practice Guideline for Diabetes on the company website at <http://www.bcbst.com/providers/hcpr/Standards_in_Diabetes.pdf>.

### Reminder: Follow-up care for Attention Deficit/Hyperactivity Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) is often diagnosed in children, but if the condition is not diagnosed and treated, there may be social repercussions.

It is important that children with newly prescribed ADHD medication be seen for follow-up visits by a practitioner with prescribing authority. Medication is considered to be newly prescribed if the child has not received such medication in the immediately preceding four (4) month period, regardless of when the child was first diagnosed with ADHD.

During the first thirty (30) days after the new ADHD medication prescription (initiation phase) the child should have at least one follow-up visit. Children who remain on ADHD medication for 210 days or more (continuation and maintenance phase), should have two (2) additional follow-up visits after the initiation phase visit, for a total of at least three (3) within the ten (10) month period after ADHD medication is newly prescribed. It may be beneficial to have the follow up appointment set before the patient leaves the office.

Additional information that may assist you in the diagnosis and treatment of ADHD is available on the company website at <www.bcbst.com/providers/behavioral_health/organizations.shtml>. Your assistance is needed to help increase the number of your VSHP and CoverKids patients receiving the appropriate ADHD follow-up care.

*These changes will be included in the appropriate 4Q 2012 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)

### Childhood and adolescents immunizations: Shots BEFORE age 2 and 13 years

Childhood and immunization guidelines recommend children have immunizations BEFORE their second birthday and adolescents BEFORE their thirteenth birthday. There seems to be some confusion on the part of some parents. Many are not bringing their children for immunizations until AFTER their second and thirteenth birthdays.

Your help is needed to schedule your patients for immunizations PRIOR to age two and thirteen years. Immunization schedules are available on the American Academy of Pediatrics website at <http://www2.aap.org/immunization/IZSchedule.html>.

Our **BlueCare/TennCare*Select*** and CoverKids staff is providing education information to members on the importance of immunizing their children at the appropriate ages, as well as making phone calls to help schedule immunizations and childhood screenings.

### New Inter-Plan Medical Policy and Precertification link

An Inter-Plan Medical Policy and Precertification link is now available on the Provider page of the company website at http://www.bcbst.com/providers/ to help providers determine specific information about their patients' health care plans regarding medical policy and/or prior authorization requirements for commercial and Cover Tennessee lines of business.

**Note:** If you are registered for the BlueAccess, BlueCross BlueShield of Tennessee's secure are of the company website, you will also be able to view the Inter-Plan Medical Policy and Precertification link from the secure site.

### Pharmacy program enhancements beginning Jan. 1, 2013

BlueCross is making the transition to Express Scripts® as our new pharmacy benefit manager for all commercial, Cover Tennessee and BlueAdvantage pharmacy members. While many processes will remain the same, there are a few that will change. The transition will be smooth for you and your patients.

Here are some key points of the transition:

- **Formulary** – will remain as the standard BlueCross BlueShield of Tennessee formulary. The process for communicating changes – typically effective January 1 – will be the same.
- **Network** – more than 62,000 pharmacies are included in the national network – comparable to the existing network. There should be little, if any, disruption to members. We will let members know how to select an in-network pharmacy if their current pharmacy is out of network.
- **Open refills** – BlueCross will work with Express Scripts to transfer mail order prescriptions.
- **Prior Authorizations** – will be transferred to Express Scripts and require no action from members or providers. The prior authorization phone number will remain the same.
- **Claims History** – two years of pharmacy claims will be provided to Express Scripts for seamless utilization review.

Our Provider Service and Customer Service phone numbers will remain the same.

### Postpartum depression screening by pediatrician

In the November edition of *BlueAlert*, pediatricians were provided information regarding postpartum depression screenings for mothers of newborns. These screenings can be billed separately using the preferred code 99420 and should be billed under the baby's member ID. Diagnosis codes V20.2 (or V20.31, V20.32 depending on the baby's age) and V61.49 may also be used.

Pediatricians can assess the baby's risk of serious health implications if the mother is suffering from postpartum depression. The Edinburgh Postnatal Depression Scale screening tool, scoring instructions, a sample signature page for new mothers and a sample letter to the patient's doctor(s) regarding screening results may be found at <http://www.tnaap.org/DevBehScreening/screeningtools.htm>.

### BCBST focuses on improved quality care and service

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, BlueCare, TennCare*Select*, Cover Tennessee, 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 and our network providers to increase screenings, several rates continue to be below the national benchmark. The following HEDIS® 2012 results show more emphasis is needed to increase rates for the measures below:

| Product | HEDIS Measure | | |
|---|---|---|---|
| | Retinal Eye | Mammogram | PAP Test |
| BlueCare - East | 44.08% | 46.75% | 69.00% |
| BlueCare - West | 43.32% | 43.92% | 70.76% |
| TennCare*Select* | 58.58% | 35.77% | 45.96% |
| Commercial | 48.54% | 65.32% | 71.79% |
| CoverTN | 23.55% | 56.17% | 64.04% |
| AccessTN | 41.35% | 68.06% | 60.50% |
| Medicare Advantage - LPPO | 68.37% | 73.92% | 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

*These changes will be included in the appropriate 4Q 2012 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)

### BCBST focuses on improved quality care and service (Cont'd)

**BlueCare** and **TennCare*Select*** members by participating in VSHP-sponsored community health events featuring onsite screening clinics. Providers who conduct screenings at these events are eligible for reimbursement at their contracted rates. Providers can also host an outreach event for their **BlueCare and TennCare*Select*** patients at their practice location.

The Preventive Services section on the Provider page of the company website, www.bcbst.com, offers links to resources that 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: Are you submitting paper claims to the correct address?

When submitting paper claims for all BlueCross BlueShield of Tennessee lines of business, providers are reminded of the importance of using the current address:

BlueCross BlueShield of TN
Claims Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37402-0002

### Winter illness reminder

It is the time of year when your office will be filled with patients sniffling and coughing. Is it a cold or an infection? Studies have shown most patients expect to leave their doctor's office with a prescription, especially for antibiotics.

Children between 2 and 18 diagnosed with pharyngitis should receive a group A streptococcus (strep) test, and antibiotics if appropriate. To avoid antibiotic resistance, treat only proven group A strep.

Parents of children with an upper respiratory infection and adults with acute bronchitis may also request an antibiotic. Having helpful handouts for your patients with information about why antibiotics will not be effective for these illnesses may be found at <http://kidshealth.org/parent/h1n1_center/h1n1_center_treatment/antibiotic_overuse.html> and <http://www.cdc.gov/getsmart/antibiotic-use/>.

### Electronic Secondary Claims

Did you know BlueCross accepts electronic secondary claims? Save time and money by avoiding the mailing of paper claims and explanation of benefit statements. Contact your software vendor or clearinghouse with the information at the following link to get started: <http://www.bcbst.com/providers/ecomm/bcbst_5010/5010_EDI_Secondary_Claims_Professional-Institutional.pdf>.

If you have further questions, please contact eBusiness Solutions†.

### Tobacco cessation support

As a health care provider you are in a good position to ask your patients if they use tobacco and if they would like to quit. BlueCross BlueShield of Tennessee offers resources to support our members who are trying to stop using tobacco. Our members can access the BlueCross Health Information Library by calling 1-800-656-8123. Additionally, members can contact BlueCross Member Service at the phone number listed on their member ID card to learn if they are eligible for a tobacco cessation coaching program.

You can also refer patients to the Tennessee Tobacco Quit Line toll free at 1-800-QUITNOW (1-800-784-8669) or Tennessee residents may join the program online at www.tnquitline.com. The hearing impaired may call 1-877-559-3816. For more information, access the Surgeon General's website or view the 2012 report on treating tobacco use among youth and young adults at <http://www.cdc.gov/tobacco/data_statistics/sgr/2012/consumer_booklet/pdfs/consumer.pdf>.

### Personal Health Assessment (PHA)

BlueCross offers a free PHA to all adult members 18 and older. Our PHA sets the stage for members to understand their health risk factors. It also identifies coaching and outreach opportunities by capturing vital information about the health and lifestyle of each participant. Members are encouraged to discuss health concerns with their physician. Members can access the PHA by logging onto their secure BlueAccess account.

### Preconception counseling

When preconception counseling is appropriate, 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/preconception/index.html.

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

# Federal Employee Program (FEP)

### Reminder: Prescription drug prior authorization requests for FEP members

Providers are reminded that certain prescription drugs require prior authorization for FEP members. A list of these drugs is available in the pharmacy section of the FEP website at www.fepblue.org. To obtain prior approval, physicians may call CVS Caremark toll free at 1-877-727-3784. The website also has a form specific to each drug that can be printed, completed and faxed to Caremark at 1-877-378-4727.

*These changes will be included in the appropriate 4Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# Federal Employee Program (FEP) (Cont'd)

## Reminder: Prescription drug prior authorization requests for FEP members (Cont'd)

NOTE: Prior approval requests are not conducted by the Pharmacy Management Department at BlueCross BlueShield of Tennessee for FEP members.

# BlueCare/TennCare*Select*

## CLINICAL

### Medical policy reminder for specialty pharmacy

When requesting prior authorization for Erythropoiesis-Stimulating Agents (ESAs), prior authorization review requires all of the following information be submitted: Hematocrit, hemoglobin, transferring, ferritin, and other anemia sources ruled out.

The full text of the policies can be accessed at http://www.bcbst.com/providers/mpm.shtml.

### Focus group feedback regarding Providers

Communication is an important part of health care, and an easy way to increase your overall patient approval ratings. According to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey conducted annually by the Centers for Medicare & Medicaid Services (CMS), and a recent VSHP member focus group, most patients do not think their doctor takes enough time to listen to them, resulting in a lower satisfaction rating of their physician.

Although you may be able to quickly determine the problem from the visible symptoms, most patients want the opportunity to tell you about everything. Additionally, patients say they often do not understand what their doctor says, or only understand part of it. For example, if they have rhinitis or sinusitis, they'd rather be told they have a sinus infection. Talking with your patients in terms they understand can affect their satisfaction.

Not only will patients have more positive feelings about their provider, but it may also help the patient have more positive feelings about themselves and a team approach in managing their health.

## ADMINISTRATIVE

### Claims filing guidelines *

Effective with claims for dates of service Jan. 1, 2013, contracted and non-contracted providers will be required to submit all medical service claims within 120 days of the date of service, or for facilities, within 120 days from the date of discharge, **or** within 60 days from the date of the VSHP rejection notice, whichever is later.

For claims submitted by physicians and other suppliers that include span dates of **service (i.e., a "From" and "Through" date on the claim), the "From" date will be used for determining timely filing.**

Corrected bills will also be required to be resubmitted **within 120 days of the date of the remittance.** For more information on filing Corrected Bills, see *VSHP Provider Administration Manual* located on the company websites, www.vshptn.com and www.bcbst.com.

If BlueCare or TennCare*Select* is secondary to a commercial insurer or Medicare, claims must be submitted within 120 days from the date the primary insurer's remittance was produced.

Exceptions to the 120-day timely filing period will be made for recovery of overpayments as required under Section 6402 of the Affordable Care Act and TennCare policy; and retrospective adjustments of a nursing facility's per diem rates.

### Reminder: Name change for TennCare Pharmacy Benefit Manager

The State of Tennessee, Bureau of TennCare's Pharmacy Benefit Manager (PBM) has changed its name from SXC Health Solutions to **Catamaran Corporation**.

Address and contact information remain the same at:

2441 Warrenville Road, Suite 610
Lisle, IL 60532

Phone: 1-866-434-5524
Fax: 1-866-434-5523

### Reminder: Prior authorization for specialty pharmacy medications

Medications on the specialty pharmacy list need to be submitted for prior authorization for **BlueCare** and **TennCare*Select*** members. Medications not on the specialty pharmacy list are not required to be submitted to VSHP for prior authorization. The list may be found on company websites at http://www.vshptn.com/providers and <http://www.bcbst.com/providers/bluecare-tenncareselect/index.shtml>.

### Hospice rate change

Effective Jan. 1, 2013, claims submitted for hospice services provided to patients residing in a nursing facility will be reimbursed at 95 percent of the nursing facility's per diem as established by the Comptroller's Office for the Bureau of TennCare. This change is in accordance to policy BEN 07-001 of the TennCare Policy Manual.

# BlueCard

## ADMINISTRATIVE

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

Not sure how to verify eligibility and benefits for out of area Blue members? First, look for the three-character alpha prefix that precedes the identification number on the member ID card, then call BlueCard *Eligibility* at 1.800.676.BLUE. Provide the member's alpha prefix and, depending on the member's Blue plan, you might also be asked for the plan code also located on the member ID card. You will then be routed to the appropriate Blue Plan to verify eligibility and coverage.

If you are interested in facilitating quicker payments, take the easy route and submit an electronic eligibility inquiry to BlueCross BlueShield of Tennessee.

For further information, please visit our website at www.bcbst.com or call 1-800-705-0391.

*These changes will be included in the appropriate 4Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

# BlueAdvantage
## ADMINISTRATIVE

### Stress management/depression screening

Providers are reminded the holidays for your senior patients can be filled with busy schedules, shopping, and laughter, but there can also be feelings of tension, stress and loss. For many people, the holidays mean spending time with family and friends but for others, this can be a frustrating and anxiety-provoking time.

Seniors may worry they do not have the resources to buy the food and gifts they wish for their families. They may also acutely feel losses and changes in their lives. It is important to be aware of the issues your seniors face in order to ensure they are getting needed referrals for support.

### BlueAdvantage PPO changes to prior authorization reviews

Effective Dec. 1, 2012, BlueAdvantage PPO requests for home health, physical and occupational therapy prior authorizations will be reviewed by Triad HealthCare. Requests can be faxed to Triad at 1-800-520-8045 or you may access Triad Musculoskeletal Program via BlueAccess, BlueCross BlueShield of Tennessee's secure area on its website, www.bcbst.com.

BlueAdvantage Utilization Management will continue to authorize all other home health services performed in a home setting. These BlueAdvantage PPO requests are accepted by calling 1-800-924-7141, by fax to 1-888-535-5243, or via www.bcbst.com web authorization through BlueAccess.

### Medication adherence for cholesterol management

BlueAdvantage, BlueCross BlueShield of Tennessee's Medicare Advantage plan is showing a decrease in compliance to lipid-lowering medication for members with hypercholesterolemia. To assist with quality improvement efforts, BlueAdvantage requests you consider counseling patients on the importance of adhering to the prescribed drug regimen if you haven't already done so. If barriers to adherence are identified, find ways to help resolve those barriers and encourage the member take medication as directed.

### Reminder: Fall prevention

Each year, one in every three adults age 65 and older falls. When treating patients in this age group, your help is requested to aid in reducing fall risk. According to the *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*, patients taking a tricyclic antidepressant, anti-psychotic or sleep agent can pose a higher fall risk for their age group. If you have patients taking these medications and it has not already been done, please consider a safer alternative if clinically appropriate.

### Reminder: Mammography Screening

The American Cancer Society recommends a yearly mammogram for patients aged 40 to 69 which it has been shown to reduce mortality. To assist with quality improvement efforts, consider ordering a mammogram for any of your patients in this age group who have not had a current screening.

*****These changes will be included in the appropriate 4Q 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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueCross BlueShield of Tennessee offices will be closed December 24 – 25, 2012, in observance of the Christmas Holiday.**