

April 2008

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy update/changes

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

Effective May 10, 2008

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

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

ADMINISTRATIVE

Real-time claim estimation/adjudication online application enhanced

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

The application tutorial (available just below the Real-Time Claim Estimation/Adjudication link on BlueAccess,) details the enhanced functionality. Additional enhancements are

forthcoming and will be communicated to you as they become available.

Reminder: Allow adequate time before requesting claim status

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

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

Reminder: Billing Workers' Compensation claims

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

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

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

Changes to CMS-1450 billing guidelines*

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

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

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

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

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

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

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

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

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

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

BlueCross BlueShield of Tennessee, Inc. (BCBST)

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ADMINISTRATIVE (cont'd)

Reminder: Reporting anesthesia services appropriately

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

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

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

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

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

Reminder: Acknowledgement of financial responsibility

If a BCBST Network provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the provider must obtain a written statement from the member prior to the service(s) being rendered, acknowledging that the member understands he/she may be responsible for the cost of the specific service(s) and any related services. The Waiver form may also be utilized in the

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

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

1. The name of the specific service/procedure the Provider will perform;
2. The reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
3. The approximate cost of the service/procedure and associated costs;
4. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
5. A statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
6. A statement indicating the form is only valid for one (1) service/procedure; and
7. A specific expiration date.

Providers should keep the signed statement

April 2008

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

BlueCard[®]

ADMINISTRATIVE

BlueCross and BlueShield Association (BCBSA) provider satisfaction initiative

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

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

Reminder: Blues move to automatic crossover for all Medicare claims

All claims automatically submitted to the secondary payer

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

Providers can learn more about the Medicare crossover process by visiting the company Web site at

<http://www.bcbst.com/providers/news/>.

BlueCard®

ADMINISTRATIVE (cont'd)

Get faster, easier information electronically for Blue members

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

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

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

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

BlueCare/TennCareSelect

ADMINISTRATIVE

NOTICE: BlueCare and TennCareSelect migration to BCBST claims processing system delayed

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

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

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

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

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

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

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

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

1. Refills of written prescriptions presented at a pharmacy before April 1, 2008;

April 2008

2. Prescription sent to the pharmacy electronically (either by e-prescribe or by fax);
3. Prescription communicated to the pharmacy by telephone; or
4. Drugs administered in nursing facilities and intermediate care facility for the mentally retarded.

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

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

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

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

Completing claims form information appropriately helps expedite claims payment

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

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

**BlueCare/TennCareSelect
ADMINISTRATIVE**

**TennCare pharmacy preferred
drug list (PDL)**

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

**Reminder: Erythropoietin
stimulating agents require prior
authorization**

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

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

**Correction: National Provider
Identifier (NPI) Reporting
requirement letter**

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

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

We apologize for any inconvenience this error may have caused.

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

ADMINISTRATIVE

Risk adjustment data validation

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

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

Note: All requested records for data validation purposes should be provided promptly. Effective **July 1, 2008**, any claim payment associated with records not

received will be recouped from the provider, since the claim cannot be substantiated by the medical record.

**CoverTN
ADMINISTRATIVE**

**Filing diagnosis codes
appropriately on rehabilitation
therapy claims**

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

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

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† Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

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

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

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

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

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

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*These changes will be included in the appropriate 2Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals. BlueCross BlueShield of Tennessee, Inc., is an Independent Licensee of the BlueCross BlueShield Association. ®Registered marks of the BlueCross BlueShield Association of Independent BlueCross BlueShield Plans CPT® is a registered trademark of the American Medical Association