

October 2008

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

CLINICAL

Medical policy update/changes

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

Enhanced and Expanded Disease Management Support for Members

Introducing Healthy Focus Health Coaching

Since 2001, BlueCross BlueShield of Tennessee has provided disease management services to members with chronic conditions. Now, that service is enhanced to include 24/7/365 availability for inbound health questions and outreach for certain other conditions such as back pain, women’s health, men’s health and more.

Our new Healthy Focus Health Coaching helps improve patient health with integrated, personalized coaching services that support a broad spectrum of medical conditions and physician treatment plans. Health coaches do not provide medical advice or clinical care. They do provide evidence-based, unbiased information and support, including tools and resources to help patients make the most of each office visit. Our aim is to help patients become more engaged in their health care and work more effectively with their physicians.

Every Day, Round-the-Clock Support Health Coaches give members and their families 24/7/365 access to specially trained health care professionals such as nurses, dietitians and respiratory therapists. Coaches provide evidence-based information and support to help patients

work with their physicians to address a wide range of issues, such as managing their chronic conditions, evaluating different treatment options, finding the best way to care for an injury and understanding symptoms. This information does not replace physician care. Rather, it prepares patients to make health care decisions in partnership with their physician.

Health Coaches provide whole-person support that helps your patients:

- understand their diagnoses
- become motivated to actively manage their health
- learn important self-care skills
- increase their compliance with physician treatment plans

Health Coaches also provide additional health education support through award-winning videos, materials, tools and resources. Health Coaching supports total population health management, ensuring that members receive the right support at the right time.

Consider Health Coaching for your patients who:

- have chronic conditions
- are at high risk for ER and hospital visits
- are non-adherent with care plans or medication
- need decision support

To refer a patient for Health Coaching, call 1-800-225-8698.

ADMINISTRATIVE

Reminder: You can submit corrected claims electronically

Providers are reminded that medical and dental corrected claims can be submitted electronically. Please see guidelines for submitting corrected claims on the company Web site at www.bcbst.com/providers/ecommm/ElectronicCorrectedClaims.pdf.

Reminder: Reporting Modifier 50

Historically, BlueCross BlueShield of Tennessee required claims for bilateral procedures be submitted on two separate lines for both facility claims (CMS-1450) and professional claims (CMS-1500). As a reminder, bilateral procedures billed by facility and professional providers should be filed as a **single** line item using the appropriate procedure code with Modifier 50 and **one** unit. This guideline applies to all BlueCross and BlueShield of Tennessee products and is necessary to comply with mandates of the Health Insurance Portability and Accountability Act (HIPAA).

At times, it is appropriate to bill a bilateral procedure with:

- a single line with no modifier and 1 unit
- a single line with modifier 50 and 1 unit
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples include, but are not limited to:

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

For more information, please refer to Billing Guidelines published in the provider administration manuals located at www.bcbst.com/providers/manuals.

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

ADMINISTRATIVE

Reminder: Reporting preventive medicine services

Preventive medicine services are routinely performed to promote wellness and for disease prevention. Depending on the age of the patient, these visits usually include services such as vaccinations, screening laboratory services, counseling and even management of medical problems. Often, during the course of a preventive medicine visit, a significant and/or separate problem may need to be addressed. When this occurs, it is important for providers to report the additional services appropriately, since benefits for preventive medicine services can vary between individuals. Examples:

1. When a preventive medicine service is reported in Block 24d of the CMS 1500 claim form, a routine exam diagnosis code should be reported in Block 24e.
2. When a non-preventive medicine service is reported in Block 24d of the CMS 1500 claim form, a non-routine exam diagnosis code should be reported in Block 24e.

Effective Dec. 1, 2008, when a non-preventive medicine service is reported in Block 24d on the CMS 1500 claim form with a routine exam diagnosis code (V70.0 or V20.2) in Block 24e, the line item will be returned to the provider for a more appropriate diagnosis code.

Reminder: Correct usage of code E1028

Code E1028 is appropriately submitted for swing-away, removable or retractable hardware only (e.g. joystick, headrest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g. hardware for seat, back or tray). A separate claim line is required for each item billed with E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.

Consult the Pricing, Data Analysis and

Coding Contractor (PDAC) located on the Noridian Administrative Services, LLC (NAS) Web site: www.dmepdac.com for specific products billable with code E1028.

Reminder: Claims filed without POA codes will be returned

As previously communicated, effective Jan. 1, 2008, BlueCross BlueShield of Tennessee began accepting present on admission (POA) indicator codes on inpatient hospital claims.

The Centers for Medicare & Medicaid Services (CMS) will begin rejecting claims filed without the POA codes Oct. 1, 2008. BCBST will begin rejecting these claims for discharge date Nov. 1, 2008, and after.

BlueCare/TennCareSelect Clinical

Reminder: Case management and disease management programs available

Case management services are available to members having complex chronic conditions, a major trauma, or complicated care needs in which extensive interaction is necessary to connect with all the parties involved in the member's healing process. Members enrolled in a case management program are assigned a Volunteer State Health Plan 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, coronary artery disease and pregnancy.

Members enrolled in a disease management program are assigned a Clinical Health Coach (registered nurse) who supports and coaches members in adopting and maintaining healthy habits. When these nurses recognize changes or lifestyle issues that may affect the member's health, they work with the member and provider to address the issues and coordinate appropriate treatment, services and medications.

Members may self refer to either program

by calling the Customer Service number listed on their ID card and providers may refer patients to either program by calling one of the following numbers:

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

ADMINISTRATIVE

Prior authorization required for select radiology procedures*

Beginning Nov. 1, 2008, for members in the West Grand Region and Jan. 1, 2009, for members in the East Grand Region, Volunteer State Health Plan will require prior authorization for select high tech imaging procedures performed in an outpatient setting. These services will not require an authorization if they are performed when a patient is receiving treatment in an emergency room or in an inpatient setting.

Procedures requiring prior authorization include, but are not limited to: CT, CTA, MRI, MRA, MR Spectroscopy, PET Scans, and Nuclear Cardiology.

At this time, TennCareSelect members and individuals who qualify as dually eligible for Medicare and Medicaid will be exempt from the prior authorization requirement. More information will be available in future *BlueAlert* newsletters, on our Web sites, www.bcbst.com, and www.vshptn.com, and other communications.

Prior authorization information on member ID card

As reported above, effective Nov. 1, 2008, prior authorization will be required for select high tech imaging services for BlueCare Members in the West Grand Region. Because a BlueCare member from the West Grand Region may seek services in the East Grand Region on or after November 1, providers should verify if prior authorization is required for their patients. If the words "Medical/Behavioral" appear on the front of the member ID card, please check the back of the card for information regarding prior authorization. The number to call for prior authorization is located on the back right (Advanced Radiological Imaging Auth. 1-888-693-3211).

BlueCare/TennCareSelect **ADMINISTRATIVE**

Reminder: Volunteer State Health Plan (VSHP) announces new transportation contract with Southeastrans, Inc.*

Providers are reminded that beginning Sept. 1, 2008, Southeastrans, Inc., began managing all non-emergency transportation services across the state of Tennessee for TennCare members enrolled in BlueCare and TennCareSelect.

Effective Sept. 1, 2008, BlueCare and TennCareSelect Members should contact Southeastrans, Inc. at **1-423-893-8282** to request non-emergency transportation for **medical** services only.

Effective Nov. 1, 2008, for BlueCare Members in the West Grand Region and **Jan. 1, 2009**, for BlueCare Members in the East Grand Region, non-emergency transportation to and from their **behavioral health care** appointments will be provided by Southeastrans. (Prior to this date these members should continue to use their existing BHO to arrange this service.)

Non-emergency transportation for TennCareSelect Members to and from their **behavioral health care** appointments will continue to be arranged through Premier Behavioral Health Systems or Tennessee Behavioral Health, Inc.

Changes to benefit limits for home health and private duty nursing services*

Effective Sept. 8, 2008, TennCare began applying benefit limits to adults age 21 and over for both Home Health and Private Duty Nursing services. This is a positive change to help to curtail over-utilization and gain control of very costly services. TennCare's private duty nursing and home health costs have grown from \$54 million to \$243 million in a four year period. The annual growth rate of 53 percent is unsustainable in a taxpayer funded program. This change will assist us in keeping the TennCare program stable as we move back into an at-risk arrangement with the Bureau. The Bureau of TennCare mailed letters August 8 to members and providers announcing this change and also held a provider training forum in Nashville on August 13, which was well attended.

Important claims information pertaining to these changes follows:

- Providers will bill for a benefit week – which is defined as Monday – Sunday.
- Billing must occur on one claim per defined benefit week per patient.
- If second claim is billed for same week, claim will be denied.
- Providers must bill each day and service as a single line item on the claim.
- Fee schedule amounts for services did not increase or decrease with these limit changes – although the billing units for revenue codes 551/G0154, 571/G)156 and 589/T1000 are to be reported in 15 minute increments.
- Billing guidelines are the same for both adult and pediatric claims. All claims must be billed using HCPCS and revenue codes beginning Sep. 8, 2008. Both the revenue and the HCPCS code are required – if not included, the claim will be denied for the provider to refile using the correct billing guidelines.

For a detailed listing of the benefit changes, please visit our Web site at <http://www.bcbst.com/providers/news/HH%20PDN%20PDF%20Prov%20Notice.pdf>.

Reminder: The Federal Deficit Reduction Act of 2005

The Federal Deficit Reduction Act of 2005 (DRA) sets forth new requirements and penalties designed to reduce and control Medicaid costs through the reduction of fraudulent and erroneous claims. The False Claims Act (Title 31, Section 3729) includes provisions for liability for certain acts for any person who knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Claims may include, but are not limited to overcharges, or charging for a product or service delivered to someone other than the covered party.

Organizations receiving Medicaid payments for fraudulent or erroneous claims will:

- have to repay those funds;
- be subject to numerous penalties; and
- be excluded from Medicare reimbursements and from participation in federal health care programs.

BlueCross BlueShield of Tennessee cooperates with all state and federal agencies in the investigation of fraud and abuse.

October 2008

Reportable fraud and abuse includes fraud and abuse in the administration of the TennCare program, in addition to provider and member fraud and abuse. Providers and subcontractors acknowledge that as a condition of receiving any amount of TennCare payment, they must comply with the applicable Fraud and Abuse section of the TennCare Contractor Risk Agreement, the DRA, the False Claim Act and all other federal and state regulations. Also, providers are required to educate staff on the DRA and the False Claims Act including the requirement to report potential fraud and abuse.

Complete fraud and abuse information can be found in the *BlueCross BlueShield of Tennessee* and *BlueCare* provider administration manuals, available on the company Web sites, www.bcbst.com and www.vshptn.com, or if you have questions regarding fraud and abuse please call the appropriate provider service line. Additionally, a Web based fraud and abuse training tutorial will be available on the *BlueSource* Provider Information CD during the fourth quarter.

Behavioral health referral services available around the clock*

Effective Nov. 1, 2008, behavioral health care services are available 24-hours-a-day, 7-days-a-week for BlueCare members in the West Grand Region. Members, behavioral health providers and primary care practitioners can call BlueCare at 1-888-423-0131 to find out about available behavioral health resources in their areas.

In a crisis situation they may also call the State of Tennessee crisis hotline at 1-800-809-9957 for direction to their local crisis team for assistance. For urgent situations, members will be referred to providers in their community that can see them within 48 hours.

TennCareSelect members and providers statewide should continue to call Premier Behavioral Health Systems of Tennessee at 1-800-325-7864 for all their behavioral health care needs.

BlueCare/TennCareSelect

ADMINISTRATIVE (cont'd)

TennCare Pharmacy preferred drug list (PDL)*

Beginning Oct. 1, 2008, SXC[®] Health Solutions, the new TennCare Pharmacy Benefits Manager, will assume pharmacy management responsibilities. Additionally, on this date new PDL changes will be implemented including the addition of diabetic supplies (blood glucose meters and test strips) with some products preferred and some non-preferred. Providers are encouraged to review the revised PDL at one of the following online locations:

- Provider page of the company Web site, www.bcbst.com or www.vshptn.com
- SXC[®] Health Solutions, Inc. via the Bureau of TennCare's Web site, www.tennessee.gov/tenncare/pro-pharmacy.html.

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

ADMINISTRATIVE

Risk Adjustment: Medical record documentation reminder

For purposes of risk adjustment data submission and validation, Medicare Advantage Organizations, such as BlueCross BlueShield of Tennessee are required by the Centers of Medicare & Medicaid Services (CMS) to ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider.

All dates of service that are identified for review on the record must be **signed** (with credentials) and **dated** by the physician or an appropriate physician extender (e.g.,

nurse practitioner). The physician must authenticate each note for which services were provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signature. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note.

ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

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

UNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

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

Reminder: Editing of hospital Part B inpatient services

It is important to remember that only certain services (ancillary and physician charges) will be reimbursed when submitting an inpatient facility claim with a Bill Type 121. The complete guideline can be viewed online in the Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual (Section 240.1) located at <http://www.cms.hhs.gov/manuals/downloads/clm105c04.pdf>.

BlueCard[®]

ADMINISTRATIVE

BlueCross BlueShield of Tennessee discontinues Blue Network C*

Effective Jan. 1, 2009, BlueCross BlueShield of Tennessee will discontinue marketing benefit packages through Blue Network C (BlueClassicSM). As a result of this action, BlueCard Traditional and BlueCard PPO members will begin utilizing Blue Network P as their BlueCard provider network. The discontinuation of Blue Network C will not affect any other network agreements under which a provider may be contracted.

We appreciate your participation in the BlueCross BlueShield of Tennessee provider networks and your continued support in providing its members with the best of care. If you have any questions, please contact your provider network manager.

.....

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

BlueCare 1-800-468-9736
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).

.....

*These changes will be included in the appropriate 3Q or 4Q 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