

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Reminder: Health reimbursement arrangement (HRA) and flexible spending account (FSA) programs

Effective Jan. 1, 2009, BCBST introduced its internally administered HRA and FSA programs, previously administered by a third party. Due to significant interest in these programs you may see more patients with these types of arrangements. A few things to remember:

- **Checking eligibility and real time.** When checking member eligibility online, you will be able to see whether the member has an HRA or FSA account with his/her health plan. If a member has an HRA account, it will be indicated on the front of the member's ID card. With our Real Time Claims Estimation/Adjudication system, (a free Web-based tool available through *BlueAccess*, BCBST's secure area of our Web site, www.bcbst.com) you can see the actual patient liability as well as what payments will be made directly to you from the HRA. You can also call BCBST's provider service line to check eligibility and find out if HRA funds are available for that member.
- **Collecting patient liability vs billed charges.** With or without these types of financial arrangements, it is important to only collect patient liability – **not** billed charges at the point-of-service. Members having an HRA or FSA are only allowed to use those monies for qualified medical expenses. If members pay billed charges, any dollars paid above the allowed amounts are considered non-qualified and must by law be returned to the financial arrangement account.

If you collect the full amount from the member at the point-of-service, you will be responsible for refunding those overpayments. It may be more appropriate to wait until you receive the benefit reimbursement before billing the member in order to avoid an overpayment.

The below sample ID card represents a BCBST member having an HRA plan:

The image shows a sample BCBST ID card for Chris B Hall. The card includes the following information: Subscriber Name: CHRIS B HALL; Subscriber ID: ZEB123456789; Group No.: T23456; Subgroup: 0001; RXBIN: 610415; RXGRP: T138359U; BLUE NETWORK: P; RX04. It also lists copayments: OV 25, SPEC 25, ER 75, INH 150, RX \$100/\$500 V 30. An arrow points to the 'HRA Plan' field, which contains a PPO icon.

Reminder: Are you responsible for providing interpretation services?

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to limited English proficiency (LEP) is to be provided by the entity at the level at which the request for service is received. Anyone who does not speak English as his/her primary language and/or has reading, writing or English-speaking limitations is considered limited English proficient.

It is the responsibility of any entity that receives federal financial assistance, e.g., Medicare, BlueCare and TennCareSelect, to provide interpretation services for medical treatment. Providing interpretation services is vital to ensuring patient welfare. When deciding to use interpreters, the following may offer some cost-effective language assistance:

- train bilingual staff;
- utilize telephone and video conference services;
- use qualified translators and interpreters; and
- use qualified volunteers.

The National Health Law Program and Access Project 2003 is an organization that assists providers having patients with language issues by providing a Language Services Action Kit. The kit can be purchased by e-mailing info@accessproject.org.

Additional information can be found on the Provider page of the company Web site, www.bcbst.com in both the BCBST and VSHP provider administration manuals.

April 2009

Changes in pharmacy benefits for AccessTN members

Effective April 1, 2009, AccessTN members will move to BlueCross BlueShield of Tennessee's Limited Formulary. In addition to the formulary change, members receiving self-administered specialty medications will be required to use one of BCBST's three preferred specialty pharmacy vendors.

AccessTN members have received notification of these changes. Information on BCBST formularies and its Specialty Pharmacy Program can be found at <http://www.bcbst.com/providers/pharmacy/>.

Oncotype DX™ test for breast cancer

Oncotype DX™ is a diagnostic test that quantifies the likelihood of breast cancer and assesses the benefits of chemotherapy. Currently, BCBST medical policy considers the Oncotype DX™ test Medically Necessary if the appropriate criteria are met. Test samples are sent to a California lab, Genomic Health, for the performance of this service, but the member is not always being made aware that the service is subject to Medical Appropriateness review. Since Genomic Health does not participate in any of BCBST's provider networks, this leaves the member liable for the full charge for the service if deemed not Medically Necessary. Additionally, not all benefit plans cover genetic testing, which would also leave the member liable for the full charge of this service.

If you plan to send a specimen from a patient with BCBST coverage to Genomic Health, please submit a predetermination request for review of benefits and Medical Necessity prior to services being received. If you do not submit a predetermination for this service, medical records will be requested upon receipt of the claim. We appreciate your cooperation in helping ensure your patients and our members are fully informed about the potential cost of their care.

Please note this policy does not apply for BlueCare or TennCareSelect.

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Reminder: Changes to BCBST commercial durable medical equipment and medical supply networks

Effective April 6, 2009, BCBST will implement new quality standards for participation in its Commercial DME and Medical Supply networks resulting in changes within those networks. Facilities and providers are reminded of the requirement to verify suppliers are contracted with BCBST prior to referring members to those suppliers. We encourage you to review the provider referral directory located on the Provider page of our company Web site, www.bcbst.com.

If you have questions, please call the Provider Service line[†].

BlueCare/TennCareSelect

ADMINISTRATIVE

Reminder: Home health/Private duty nursing billing guidelines

Billing of home health (HH) intermittent visits must be billed in 15 minute increments rounded to the nearest hour and filed with the appropriate procedure code GO154 and GO156.

Extended visit codes S9122, S9123, and S9124 should be filed for services two (2) hours or more per day when the member does not qualify for private duty nursing. Private duty nursing (PDN) services are for members who require continuous skilled nursing care (eight (8) or more hours during a 24-hour period) provided by a registered or licensed practical nurse under the direction of the recipient's practitioner.

HH/PDN coding for members under the age of 21 years:

For purposes of billing, home health agencies have been instructed to use private duty nursing codes (T1000) for patients

who meet the adult criteria for PDN care (i.e. vent/trach patients), all other nursing care that is not provided as a visit, would be coded using the skilled nursing/hour codes (S Codes). According to TennCare Rule 1200-13-14-01 (88), children under the age of 21 may receive Medically Necessary PDN services that are dependent upon technology-based medical equipment requiring constant nursing supervision. The Medical Necessity review process includes reviewing the need for nursing supervision, visual assessment, and monitoring of the child as well as the equipment used in association with the services requested. For children up to age 21, the T1000 code may be billed for PDN Medically Necessary services for the eight (8) or more hours of continuous skilled nursing care during a 24-hour period.

As a reminder, children are eligible to have aides and nurses accompany them outside the home under certain circumstances as defined by rule. The coding decision described above does not in any way determine whether a nurse may accompany a child outside the home.

We encourage you to review the billing guidelines in the *VSHP Provider Administration Manual* located on the Provider page of our company Web sites, www.vshptn.com and www.bcbst.com or on *BlueSource*, our provider information CD mailed quarterly to all BCBST contracted providers.

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

Reminder: Hospice billing guidelines

Effective with claims filed on or after Dec. 1, 2008, BlueCare and TennCareSelect inpatient hospice claims filed with Revenue Codes 0655, 0656, or 0658 should not be filed with outpatient Type of Bill 81X.

Claims filed with an "inpatient" Revenue Code and an "outpatient" Type of Bill will be returned to the provider.

April 2009

Reminder: Verifying member eligibility via BlueAccess

When verifying eligibility through BlueAccess for BlueCare and TennCareSelect members, it is important to remember to enter the date you wish to verify eligibility. Some members may have multiple eligibility records in our processing system, which means the member's coverage may not have ended on the term date being displayed.

If you have questions about member eligibility, please call the appropriate BlueCare or TennCareSelect Provider Service line[†].

Reminder: BlueCare and TennCareSelect prior authorization information

Requesting prior authorization for 23-hour observation

Neither BlueCare nor TennCareSelect requires prior authorization for a 23 hr observation stay unless any of the following apply:

- the physician or hospital is out of network;
- the request is for a hysterectomy or a bariatric surgery; or
- the request is for a potentially cosmetic/investigational/non-covered procedure, an arthroscopy, an upper or lower endoscopy, laparoscopic cholecystectomy, or transplant.

Clarification to prior authorizations for Colonoscopy and Endoscopy

BlueCare and/or TennCareSelect requires prior authorization for all **upper** endoscopies. **Lower** endoscopies (colonoscopies, flexible sigmoidoscopies, etc) do **not** require prior authorization.

Colonoscopies do not require prior authorization unless the physician or facility is out of network or unless the procedure is to be performed as a 23 hour observation or as an inpatient procedure.

BlueCare/TennCareSelect

ADMINISTRATIVE

Reminder: BlueCare and TennCareSelect prior authorization information (cont'd)

The BlueCare and TennCareSelect prior authorization list is available in the *VSHP Provider Administration Manual*, located on the company Web sites, www.VSHPTN.com and www.bcbst.com.

If you have questions about the prior authorization list, please call the appropriate BlueCare or TennCareSelect Provider Service line[†].

Change to prior authorization requirements for home health therapy*

Effective March 1, 2009, Volunteer State Health Plan (VSHP) no longer requires prior authorization for home health therapy for BlueCare and TennCareSelect members under the age of 21 years.

BlueCard[®]

ADMINISTRATIVE

Get information faster, easier services electronically

Want a faster and easier service that reduces the time your office 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 to:

- **verify eligibility and benefits** for members of other Blue Plans;
- **check claims status** electronically for Blue members; and
- **get faster responses to inquiries** for local members and members from other Blue Plans.

BlueCross BlueShield of Tennessee is your single point of contact for submitting claims electronically. Reduce your time completing

claims forms and get faster, more accurate claims processing.

For more information on electronic services, call eBusiness Solutions Marketing Department at 423-535-3057, Monday - Friday, 8 a.m. to 4:30 pm (ET) or e-mail inquiries to ecomm_marketing@bcbst.com.

Reminder: Blues move to automatic crossover for all Medicare claims

Effective Jan. 1, 2008, all Blue Plans began crossing over Medicare claims for services covered under Medigap and Medicare Supplemental products. This resulted in automatic claims submission of Medicare claims to the Blue secondary payer, reducing or eliminating the need for the provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims crossover in the same manner nationwide.

Some key steps to remember when submitting Medicare primary/Blue Plan secondary claims:

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to the Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential to enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member ID card for additional verification.
- Be sure to include the alpha prefix as part of the member identification number. The member ID will reflect the alpha prefix in the first three (3) positions in the ID number. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payment.

The claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been

processed by Medicare. This process may take up to fourteen (14) business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time the provider receives the Medicare Summary Notice. As a result, it may take an additional 14-30 business days for the provider to receive payment from the Blue Plan.

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[†]Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Lines; CoverTN; CoverKids; AccessTN 1-800-924-7141 (Monday– Friday, 8 a.m. to 5:15 p.m. ET)
Note: If you moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

BlueCare 1-800-468-9736
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 2009 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