

June 2009

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 July 11, 2009

- Osteochondral Allografting
- Saliva Testing for Hormone Levels
- Bariatric Surgery for Morbid Obesity

Note: Effective dates also apply to BlueCare and TennCareSelect pending state approval.

BCBST continues to monitor H1N1 influenza outbreak

For some time, BlueCross BlueShield of Tennessee has had a pandemic response plan in place to ensure it is prepared in serving our members' needs while working in concert with our network physicians and other providers.

With the recent outbreak of the H1N1 influenza virus, we are continuing to cover flu tests and treatments as we normally do. Prescription medications such as Tamiflu® and Relenza® are covered by many of our lines of business; however, we encourage you to verify benefits and prior authorization requirements prior to prescribing these medications to your BCBST patients.

We will continue to monitor the H1N1 influenza and will work to ensure that you have access to the appropriate resources to provide necessary treatment to our members.

Reminder: Prescribing for oneself and one's family

The Tennessee Board of Medical Examiners adopts the following guidelines as policy for self-prescribing, and for one's immediate family:

Self-prescribing

1. A physician cannot have a bona fide doctor/patient relationship with himself or herself.
2. Only in an emergency should a physician prescribe for himself or herself schedule IV drugs.
3. Prescribing, providing, or administering of schedule II and III drugs to himself or herself is prohibited.

Immediate Family

1. Treatment of immediate family members should be reserved only for minor illnesses or emergency situations.
2. Appropriate consultation should be obtained for the management of major or extended periods of illnesses.
3. No schedule II, III, or IV controlled substances should be dispensed or prescribed except in emergency situations.
4. Records should be maintained of all written prescriptions or administration of any drugs.

ADMINISTRATIVE

All Blue 2009 provider workshops Coming Soon to a City Near You!

The annual state-wide *All Blue* provider workshops, designed for office staff of specific providers as determined by BlueCross BlueShield of Tennessee, have been scheduled and are coming soon to a city near you. The workshops will feature Ancillary, Facility and Professional breakout sessions.

At our workshops, you will have access to dedicated BlueCross BlueShield of Tennessee professionals who will share important information on current issues and answer your questions.

Watch for your invitation announcing upcoming dates, times and locations.

Reminder: Billing guidelines for glucose monitoring systems

Effective April 6, 2009, BlueCross BlueShield of Tennessee no longer requires a manufacturer's information/supplier's invoice when billing the following codes:

- **A9276** - Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply;
- **A9277** - Transmitter; external for use with interstitial continuous glucose monitoring system; and
- **A9278** - Receiver (monitor); external, for use with interstitial continuous glucose monitoring system.

Consult Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the proper use of the Healthcare Common Procedure Coding System (HCPCS) for products. Providers are also encouraged to review the description of the codes to file claims appropriately, e.g., A9276 1 unit = 1 day supply.

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ADMINISTRATIVE

Reminder: Supplies and equipment included in procedure reimbursement

Under the Resource Based Relative Value Scale (RBRVS) reimbursement methodology, the relative value unit for the practice expense portion of the procedure code includes an allowance for supplies that are necessary to assist or perform the procedure.

Providers can review supplies and equipment included in the reimbursement for a particular procedure code on the CMS Clinical Practice Expert Panel files at <http://www.cms.hhs.gov>.

Reminder: Appropriate claims filing for providers practicing in contiguous counties

Is your practice located in a bordering county of one of the eight (8) states Tennessee touches? If so, there is a good chance you hold contracts with **both** your home state's Blue Plan and BlueCross BlueShield of Tennessee.

In those instances, you should file all claims for **BlueCross BlueShield of Tennessee members** with BlueCross BlueShield of Tennessee, **not** with your home Blue plan.

This will help ensure claims for BlueCross BlueShield of Tennessee members are adjudicated in accordance with your contract with the Tennessee plan.

Please visit the *News* section on the Provider page on our company Web site, www.bcbst.com for more information and responses to frequently asked questions.

If you have additional questions, please call us at 1-800-705-0391.

Reminder: Negative pressure wound therapy services

Benefits are provided for Negative Pressure Wound Therapy for our commercial members when provided by a BlueCross BlueShield of Tennessee participating provider.

When arranging these services for our Blue Network P and Blue Network S members, please refer to the *BlueCross BlueShield of Tennessee Provider Directory* located on the BlueSource Provider Information CD or visit our company Web site, www.bcbst.com

Reminder: Correct reporting of infusion and drug administration services

According to Current Procedural Terminology (CPT®), physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff. CPT® codes 96360-96549 include evaluation and management services.

If a significant, separately identifiable evaluation and management service is performed on the same day, the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549. This billing guideline is also in accordance with Evaluation and Management Guidelines located in the Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual, Chapter 12, Section 30.6.7D.

BlueCross BlueShield of Tennessee billing guidelines state that all services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission. Providers are reminded to follow these guidelines to help ensure prompt adjudication of claims.

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BlueAccess receives new feature

With the focus on "going green" and in response to provider community feedback, another change has been implemented to *BlueAccess*, the secure area on the company Web site, www.bcbst.com.

Effective immediately, providers can make demographic changes online. *BlueAccess* enables registered providers to view information in a secure online environment, just as it appears **right now** in our customer service computer system.

If you have not yet registered, visit www.bcbst.com ; click on "Register now" and follow the prompts.

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ADMINISTRATIVE (cont'd)

Reminder: Coding claims appropriately

The National Uniform Billing Committee (NUBC) and National Uniform Claim Committee (NUCC) periodically make and publish revisions to their manuals, which are available online at www.nubc.org/ and www.nucc.org/.

Providers are reminded of their responsibility to ensure codes filed are valid for the dates of service when submitting claims for BCBST and VSHP members. To avoid delays in receiving payments, unnecessary overpayments, and to help ensure the most appropriate member benefit is applied, it is important that all codes submitted are valid for the date of service on the claim. Please check your claims to ensure all codes, including but not limited to the following are reflected accurately:

- ICD-9-CM Procedure codes
- ICD-9-CM Diagnosis codes
- HCPCS/CPT® codes
- Revenue codes
- Type of Bill codes
- Place of Service codes
- Admission Source codes
- Occurrence codes
- Value codes
- Modifier codes

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

ADMINISTRATIVE

Reminder: CMS auditing tool required for all BlueAdvantage ED/EM claims

The BCBST Provider Audit Team may include BlueAdvantage Private Fee-for-Service (PFFS) and Preferred Provider Organization (PPO) claims during audits. For BlueAdvantage Acute Care Hospital Emergency Department claims the ED Evaluation and Management visit level tool mandated by the Local Centers for Medicare & Medicaid Services (CMS) Fiscal Intermediary will be used. This tool can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506P_Draft_AHA_AHIMA_Guidelines.pdf.

CMS does not require providers to utilize the *Draft Visit Guidelines*; each facility is free to develop its own guidelines. However, the use of this tool is required for the medical review of all BlueAdvantage ED E/M claims. Please note this tool differs from the sample tool reflected in the BCBST and VSHP provider administration manuals, which is used to audit non-BlueAdvantage ED claims.

BlueCard[®]

ADMINISTRATIVE

Improved BlueCard/FEP provider online experience

In mid-May, you may have noticed some additional enhancements made to the Remittance Advice (RA) information for BlueCard/FEP section on *BlueAccess*, the secure area on the company Web site, www.bcbst.com. These new enhancements give providers the ability to:

- View remittance number on the claim status response page if the remittance is available.
- Click a hyperlink on the remittance number to access the actual RA

The payment information is more clear and

user-friendly by the addition of these new features:

- The check number will show "N/A" when the claim has been denied or allowed payment is zero.
- View the remit information when payment is paid through Electronic Fund Transfer.

We are confident these enhancements will allow for an easier online remittance and payment inquiry experience. For more information or suggestions, please call eBusiness Service Center at 423-535-5717.

BlueCare/TennCareSelect

ADMINISTRATIVE

Avoid claims processing delays on 276/277 transactions

Beginning July 1, 2009, providers using the standard 276/277 Claim Status and Response Time format must use the identification number exactly as it appears on the member's ID card. Following the three-character alpha prefix, the member ID should not include any spaces or special characters for a maximum of 17 characters.

Standard 276/277 transactions that do not reflect this requirement will be returned to the provider for correction.

Changes to CMS-1450 (UB04) inpatient and outpatient billing guidelines*

Effective with claims filed on or after July 1, 2009, the following changes will apply to BlueCare and TennCareSelect institutional inpatient and outpatient hospital claims filed on a CMS-1450 (UB04) Health Insurance Claim form or submitted electronically in the ANSI-837 version 4010A1 format:

- An Admitting Diagnosis Code is required for claims filed with type of bills **11x**, **12x**, **18x**, and **21x**.
- A Patient's Reason for Visit Diagnosis Code is required for type of bills **13x**

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and **85x**, when filed with Type of Admission codes 1, 2, or 5 and revenue codes 045x, 0516, 0526, or 0762.

Claims filed without an "Admitting or Patient Reason for Visit" diagnosis code as specified above will be returned to the provider.

Reminder: Hospice and patient liability billing changes

Some TennCare enrollees receiving TennCare-reimbursed Nursing Home Facility care may elect to receive hospice benefits.

Claims for these members should be filed on a CMS-1450 claim form reflecting one of the following appropriate Value codes along with the patient liability amount in Form Locators 39-41:

- 23 (recurring monthly income);
- 24 (Medicaid rate code);
- 31 (patient liability amount); or
- C3 (estimated responsibility payer c).

We encourage you to review the Hospice billing guidelines available in the *VSHP Provider Administration Manual* located on the Provider page of the company Web sites, www.vshptn.com or www.bcbst.com, and on *BlueSource*, BCBST's provider information quarterly CD.

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



†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).

