

September 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 Oct. 10, 2009

- Extracorporeal Photochemotherapy/Photopheresis
- Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress

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

### ADMINISTRATIVE

#### Genzyme Corporation implements Cerezyme supply management plan

On Aug.3, 2009, Genzyme Corporation communicated that the projected inventory levels of Cerezyme (imiglucerase for injection) may not be sufficient to protect the most vulnerable patients through the month of August.

As a result of this situation, Genzyme implemented a Cerezyme supply management plan for all pharmacies, to include CVS Caremark Specialty Pharmacy, one of BlueCross BlueShield of Tennessee's specialty pharmacy vendors.

Per the supply management plan, CVS Caremark will only be able to ship to patients meeting the following criteria:

- Children age 18 years of age or younger;
- Patients with Type 2 or 3 Gaucher Disease; or
- Adult patients facing life-threatening clinical situations.

Additionally, they will:

- limit shipments to a one (1) dose supply;
- notify prescribers and patients of the revised management plan;
- direct prescribers and patients to information on the Cerezyme Emergency Access Program (CEAP) and product availability.

**Note:** Fabrazyme (agalsidase beta) supply will continue to be monitored, but is not included in this supply management plan at this time.

For more information on the Cerezyme Emergency Access Program, call Genzyme's Medical Information line, 1-800-745-4447, Option #2 or visit the product shortage Page on Genzyme's Web site at [www.genzymesupplyupdate.typepad.com](http://www.genzymesupplyupdate.typepad.com).

#### New feature being implemented to BCBST provider service line

Effective 4th quarter 2009, providers will be able to check claims status via the Provider Service line, 1-800-924-7141, 24-hours-a-day, 7-days-a-week. Member claims status will be available for all lines of business, including BlueCard® out-of-state member claims.

This new feature should help reduce the time you spend on the phone checking claims status by 50 percent. Many of the questions you have regarding claims status can be answered utilizing this automated function, to include, paid amount, patient liability, check number and check date.

In order to obtain information you will need your BCBST provider ID number, NPI number or tax ID number. Additional information you should have available at the time of the call is:

- member ID number, *including the alpha characters (early September 2009)*;
- member date of birth;
- date of service; and
- total charge.

#### BCBST to replace mailed explanations of benefits (EOBs) with monthly claims statements

Starting Oct.1, 2009, BCBST members currently receiving EOBs by mail will begin receiving a monthly Claims Statement reflecting claims paid to providers on their behalf.

Members can still see their detailed EOBs online at [www.bcbst.com](http://www.bcbst.com) on the secure BlueAccess pages and print them from there if copies are needed. Members who do not have access to a computer or printer can call the Customer Service number listed on their BCBST ID card to request a copy.

There will be no change for members who opted for online EOB notices. These members will continue to receive e-mails when their EOB is posted on BlueAccess. Members can also access their Personal Health Statement which contains same information the monthly statement includes only more comprehensive and up to date.

Members who currently receive their information by mail can choose to receive EOBs electronically by logging on to BlueAccess and following the registration steps.

## BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

### ADMINISTRATIVE

#### Clarification: Billing guidelines for bilateral procedures

In the August 2009 issue of BlueAlert, we reported per HIPAA guidelines, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported.

We included examples in the article, and noted sometimes 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, and/or if procedure is “other” than surgical such as radiology CPT® codes, then bill as:
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

The article failed to indicate the above guidelines are for facility claims only (CMS-1450/UB-04/ANSI-837I format).

We apologize for any inconvenience this may have caused.

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#### Reminder: Electronic funds transfer (EFT)

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

EFT provides a method of transferring payments automatically from BCBST’s account to your bank by electronic means without any paper money changing hands. EFT is available for all lines of business including Commercial, BlueCare East and West, TennCareSelect, BlueCard, Federal Employee Program (FEP), Medicare Advantage and Preferred Dental.

Sign up today and enjoy benefits such as:

- Increased efficiency

- More secure payment process – less chance for check misplacement
- Earlier receipt of payments than when mailed
- Reduced administrative costs
- Simplified bookkeeping – less paper

To participate in the EFT process, providers must complete the EFT Enrollment Form and return it along with a voided check to:

BlueCross BlueShield of Tennessee  
Attn: Provider Network Mgmt – CH 2.4  
1 Cameron Hill Circle  
Chattanooga, Tennessee 37402-0001

The EFT Enrollment Form and Frequently Asked Questions (FAQs) can be found on the Provider page of the company Web site, [www.bcbst.com](http://www.bcbst.com). To access the form and FAQs, choose “Administration” and click on the “Forms” tab. **Note:** when you begin to receive EFT payments, you will no longer receive a paper remittance advice as this information is made available online for viewing and printing.

We also support and provide the remittance information in the ANSI 835 format which for many providers facilitates automated posting of claims payment information.

## BlueCare/TennCareSelect Clinical

### American Academy of Pediatrics (AAP) recommends routine developmental screenings

The AAP recommends routine developmental/behavioral surveillance at every pediatric patient preventive care visit. Developmental and behavioral screening using standardized tools are recommended during preventive care exams for children aged 9 months, 18 months and 30 months, or if risks are identified through routine surveillance. Autism screening is recommended at the 18-month and 24-month visits.

Find additional information on developmental and behavioral surveillance and screening tools at [www.tnaap.org/DevBehScreening/surveillancescreening.htm](http://www.tnaap.org/DevBehScreening/surveillancescreening.htm).

## ADMINISTRATIVE

### BlueCare transition of care unit needs your assistance

Beginning first quarter 2009, in an effort to assist our Transition of Care Unit with discharge planning for our BlueCare and TennCareSelect members, VSHP began contacting facilities requesting discharge dates for inpatient admissions.

To help with this process, VSHP developed a “Discharge Fax” form for provider use in faxing the information to us. Facilities can call the VSHP Utilization Management Department to request a form or simply report any BlueCare or TennCareSelect discharges at the time of the call. When calling or faxing, please use one of the numbers listed below:

#### BlueCare

Phone		1-888-423-0131
Fax	East	1-800-292-5311
Fax	West	1-800-919-9213

#### TennCareSelect

Phone		1-800-711-4104
Fax		1-800-292-5311

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### Change in reimbursement for assistant-at-surgery provided by a physician\*

Effective with dates of service Oct. 1, 2009, Volunteer State Health Plan (VSHP) will reimburse for eligible assistant-at-surgery services provided by a physician based on the lesser of total covered charges or 16 percent of the maximum allowable fee schedule amount for all VSHP networks.

Assistant-at-surgery services provided by a physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon), 82 (Assistant Surgeon when qualified resident surgeon is not available) to the procedure code. This reimbursement is in accordance with the Centers for Medicare & Medicaid (CMS) guidelines.

The 80, 81, or 82 modifiers should **not** be used to report assistant-at-surgery services provided by a physician assistant, nurse

## **BlueCare/TennCareSelect** **ADMINISTRATIVE**

### **Change in reimbursement for assistant-at-surgery provided by a physician\*(cont'd)**

practitioner or clinical nurse specialist. Assistant-at-surgery services provided by a physician assistant, nurse practitioner, or clinical nurse specialist should be reported by appending the Level II HCPCS modifier AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant-at-surgery). The maximum allowable for procedures reported with an AS modifier will be \$0.00.

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### **Change in reimbursement for procedures performed by two surgeons\***

Effective with dates of service Oct. 1, 2009, Volunteer State Health Plan will reimburse eligible procedures performed by two surgeons based on the lesser of covered charges or 62.5 percent of the base maximum allowable fee schedule amount for the procedure for each surgeon (or a total of 125 percent of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the providers in accordance with standard coding and billing guidelines for all BCBST/VSHP networks.

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding **modifier 62** to the procedure code(s). Each surgeon should report the co-surgery once using the same procedure code(s).

This reimbursement is in accordance with the Centers of Medicare & Medicaid Services (CMS) reimbursement guidelines.

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### **Annual eligibility re-determination process for TennCare enrollees**

The Bureau of TennCare requested BlueCare and TennCareSelect make the following important notification available to the provider community.

As you may be aware, a group of TennCare enrollees who had previously not been subject to TennCare's annual eligibility re-determination process are now going through that process. These enrollees are part of a group known as the Daniels Class.

A critical part of the eligibility re-determination process involves a requirement that the enrollee respond to a Request for Information (RFI). This information is provided on "peach pages" that are mailed to the enrollee. If these enrollees do not provide the requested information they will lose their TennCare coverage for failure to respond.

If you become aware of any patient who has lost his/her TennCare coverage and you believe it may be due to a failure to respond to the RFI you may direct them to **call the Family Assistance Service Center toll free at 1-866-311-4287. In the Nashville area they may call, 743-2000.**

It is not too late for these patients to complete the RFI and, if eligible, to regain their TennCare coverage. In some cases, coverage may even be reinstated retroactively to the date of termination.

Thank you for your assistance in helping to assure those who are eligible continue to receive TennCare coverage.

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### **Reminder: Reporting home health non-covered shifts**

Home health agencies are reminded to notify VSHP Case Management when home health/private duty shifts are not covered. A non-covered shift is defined as any scheduled home health/private duty visit or service that does not occur, including partially covered and future open shifts.

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Effective Oct. 1, 2009, non-covered shifts can be reported by calling the new VSHP Home Health Compliance line, 1-800-215-3851, Monday through Friday from 8 a.m. to 6 p.m. After regular business hours, you can call the *NurseAdvise* line, 1-800-262-2873, 24-hours-a-day, 7-days-a-week. Effective with implementation of the new compliance line, VSHP will no longer accept faxed notification.

**Note:** Home health agencies should only submit claims for services actually rendered. Any liquidated damages, penalties or fines assessed against VSHP by TennCare related to non-covered shifts by the home health agency shall be passed on to the home health agency for payment.

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### **New Volunteer State Health Plan edit requirements**

The Contractor Risk Agreement between VSHP and the Bureau of TennCare requires BlueCare and TennCareSelect to submit all data relevant to the adjudication and payment of claims according to standards and formats as defined by TennCare. In October 2009, VSHP will begin implementing a new set of edit requirements to improve the reporting capability of accurate claims data to the Bureau of TennCare.

These new edits will be listed in the BCBST EDI Front-End Edit Guides for 837 Professional and 837 Institutional claims available on the Provider page under eBusiness Technical Information of the company Web sites, [www.bcbst.com](http://www.bcbst.com) and [www.vshptn.com](http://www.vshptn.com).

If you have any questions, please contact the eBusiness Service Center at (423) 535-5717 or via e-mail at [ecommm\\_techsupport@bcbst.com](mailto:ecommm_techsupport@bcbst.com). Technical support is available Monday through Friday, from 8 a.m. to 6:30 p.m. (ET).

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

**ADMINISTRATIVE**

**Risk Adjustment Data Validation**

*Document medical records appropriately*

Annually, the Centers for Medicare & Medicaid Services (CMS) randomly select Medicare Advantage (MA) Organizations for risk adjustment data validation (RADV) audits. 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.

At the recommendation of CMS, BlueCross BlueShield of Tennessee developed its own independent Data Validation process and during a recent audit found a reoccurring error related to diagnosis code 250.02, which indicates the diabetes is uncontrolled. The code for these occurrences should have been 250.00, as there was no documentation in the medical records supporting the "uncontrolled" status of the disease.

**Tip:** Document a cause and effect of the condition.

**Examples:**

**250.40** - DM w/Renal Manifestations + CKD 585.9, Nephropathy 583.81, or Nephrosis 581.81 (*Instead of documenting "DM with Renal manifestations", which does not specify the manifestation, use "DM w/CKD" to be more concise.*)

**250.50** - DM w/Ophthalmic Manifestations + Glaucoma 365.44, Macular Edema 362.07, Retinopathy 362.01-362.07, Cataract 366.41, or Retinal Edema 362.07

**250.60** - DM w/Neurological Manifestations + Polyneuropathy 357.2, Gastroparesis 536.3, Peripheral Autonomic Neuropathy 337.1, Neurogenic Arthropathy 713.5

**250.70** - DM w/Peripheral Circulatory Disorders + PVD 443.81

**BlueCard®**

**ADMINISTRATIVE**

**Having trouble printing a legible copy of BlueCard remits?**

If you recently tried to print a legible copy of a BlueCard remittance advice and were unsuccessful, please verify you are using Adobe Acrobat version 9.

In order to print a legible copy of the remit, you must upgrade to Adobe version 9. The remits on BlueAccess are in a PDF format and will automatically adjust to a smaller font and print to fit an 8 ½ by 11 sheet size. Once upgraded, you can print to legal size paper and expand the document to extend the margins of the page. Upgrading to version 9 is free and offered online by Adobe Acrobat.

If you have any questions, please contact the eBusiness Service Center at 423- 535-5717 or via e-mail at [ecomm\\_techsupport@bcbst.com](mailto:ecomm_techsupport@bcbst.com). Technical support is also available Monday through Friday, from 8 a.m. to 6:30 p.m. (EST).

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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).

**Note:** Some providers using phone numbers other than the Provider Service Line, 1-800-924-7141 will have the opportunity to take advantage of our Provider Self Service line when dialing the other numbers.

The caller will hear a message stating that some of the options have changed and can then choose the option that best suit his/her needs. The caller will be asked to enter specific identifying information via touchtone or voice activated response to provide necessary information pertaining to the specific line of business.

We are confident these changes will better serve your calling needs, and enable you to obtain information more efficiently.

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