Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the “Upcoming Medical Policies” link.

Effective April 14, 2011

- Everolimus
- Temozolomide
- Mechanical Embolectomy for Treatment of Acute Stroke
- Continuous Passive Motion (CPM) Device in the Home Setting
- Genetic Testing for BRCA1, BRCA2 or CHEK2 for Breast or Ovarian Cancer
- Endothelial Keratoplasty
- Non-BRCA Breast Cancer Risk Assessment (OncoVue®)
- Autologous Hematopoietic Stem-Cell Transplantation for Malignant Astrocytomas and Gliomas

Note: These effective dates also apply to BlueCare®/TennCareSelect pending State approval.

Smoking cessation support

BCBST offers support for our members who are trying to stop smoking. Through our Health Information Library, members are able to listen to educational information such as second-hand smoking, hazards of smoking and smoking during pregnancy. Members can contact BCBST Customer Service at the phone number on the back of their member ID card to learn if they are eligible for behavioral management and counseling to help with smoking cessation. Tennessee residents can access the Tennessee Tobacco Quit Line toll free at 1-800-QUITNOW (1-800-784-8669). The hearing impaired may call 1-877-559-3816. Callers can receive a FREE Tobacco Quit Kit, work with a FREE Quit Coach and learn to deal with tobacco cravings and other challenges. For more information access the Surgeon General’s Guideline for treating tobacco use and dependence at <http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf>.

ADMINISTRATIVE

Reminder: Filing National Provider Identifier (NPI)

BCBST follows CMS guidelines as it pertains to requiring the submission of the Ordering/Prescribing Physician’s NPI. If the NPI is not valid BCBST will return the claim.

Reminder: Filing surgical equipment claims correctly

Providers are reminded that charges for any device or medical equipment used in conjunction with a surgical procedure must be billed by the facility. Separate claims submitted by a DME supplier for any charges related to the facility service will result in zero reimbursement, i.e., pneumatic compression devices. The member cannot be held liable in these cases, as reimbursement for DME is part of the all-inclusive global payment for inpatient and/or outpatient surgeries to contracted facilities.

Should a facility choose to partner with a DME supplier to provide equipment/supplies associated with the facility services, the facility will be responsible for submitting all charges to BCBST as well as payment of the DME supplier.

These guidelines are in accordance with the BCBST Institution Agreement. Contact your local Network Manager for any questions concerning your provider contract.

Reminder: Filing corrected bills appropriately

Claims that have been processed and paid incorrectly because of an error or omission on the claim may be filed as a “Corrected Bill”. BCBST is receiving claims filed as a corrected bill with no indicated changes. A corrected bill must include additional/changed dates of service, codes, units, and/or charges that were not filed on the original claim.

Providers are encouraged to review the Billing and Reimbursements section of the BCBST and VSHP Provider Administration Manuals, located on the company websites, www.bcbst.com and www.vshptn.com for detailed information for filing corrected paper and electronic claims.

Claims subject to retrospective review

BlueCross BlueShield of Tennessee retrospectively audits BCBST Medicare Advantage, CoverKids and CoverTN claims for improper payments. The identification of improper payments will occur for claims according to provider contractual requirements. Claims submitted by a provider to BCBST on a CMS-1450 (UB04) or CMS-1500 claim form are subject to audit.

BCBST will perform Complex Reviews, a thorough review of a medical record for coding validation and utilization review, and Automated Reviews, where no medical record is required. All complex reviews are performed with Corporate Medical Director oversight by physicians, RNs and certified coders.

For more information refer to Frequently Asked Questions (FAQs) available on the Provider page of the company website, www.bcbst.com.
**BlueCross BlueShield of Tennessee, Inc. (BCBST)**

*(Applies to all lines of business unless stated otherwise)*

**ADMINISTRATIVE (cont’d)**

**Clarification: Nurse Practitioner modifier guidelines**

Nurse Practitioners (NP), billing as an Assistant-at-Surgery, are required to file the appropriate modifier in conjunction with their contracted agreement with BlueCross BlueShield of Tennessee. Claims that do not follow this guideline will be subject to audit recovery. Refer to the Billing and Reimbursement section of the **BCBST Provider Administration Manual** found on the BlueSource Provider Information CD or on the company website, [www.bcbst.com](http://www.bcbst.com) for appropriate billing guidelines.

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**Reminder: EC Gateway password**

Your EC Gateway (ECG) communication system password expires every 45 days. The new password must be at least eight characters in length, contain at least one alpha and one numeric character, and cannot be reused. To access the ECG Bulletin Board System (BBS) each user must have his/her own user ID and password. This can be requested by completing an electronic system password request form on the BlueSource Provider Information CD or on the company website, [www.bcbst.com](http://www.bcbst.com) for appropriate billing guidelines.

For more information or ECG User ID and Password maintenance, contact eBusiness Solutions at (423) 535-5717.

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**Important Reminder: LDL-C & HbA1c Initiative: Diabetes Gaps in Care**

Volunteer State Health Plan, Inc. (VSHP) recently launched an initiative for BlueCare and TennCareSelect members. As part of this initiative, VSHP partnered with LabCorp to use Lab-In-An-Envelope, an alternative approach to closing gaps in comprehensive diabetes care. Our goal is to work with providers to improve diabetes care by increasing HbA1c and LDL-C test rates.

Lab-in-an-Envelope kits, with easy-to-follow instructions, are mailed to non-compliant diabetic members who have gaps in LDL-C and HbA1c testing upon receipt of your authorization. This is a dry spot testing kit that contains all the necessary collection supplies. The test kit is then mailed back in a pre-addressed, pre-paid envelope. Lab results will be faxed to your office to help in managing your patient’s care. Some providers may receive an on-site visit from our clinical team and receive an educational packet that includes member details you might find useful in treating your BlueCare and TennCareSelect patients who suffer from diabetes.

Please support this initiative by authorizing VSHP to send Lab-In-An-Envelope kits to your patients with diabetes that show gaps in care for HbA1c and/or LDL-C.

Providers may send individual or batch authorizations for identified members. If you have any questions, call VSHP Disease Management at 1-888-416-3025, Monday through Friday, 9 a.m. to 6 p.m. (ET). The *Lab-In-An-Envelope MD Fax Form* may be found on our website at [www.bcbst.com/providers/forms/Lab-in-an_Envelope_MD_Fax.pdf](http://www.bcbst.com/providers/forms/Lab-in-an_Envelope_MD_Fax.pdf), or you may request the authorization form from Disease Management.

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**Reminder: TENNderCare age-specific screenings.**

Two important elements of the seven required TENNderCare screenings that should be addressed with your patients are:

- Appropriate laboratory tests according to age and health history.
- Immunizations in accordance with current American Academy of Pediatrics (AAP) recommendations.

**Federal Vaccines for Children guidance on new CPT® Codes for vaccine administration**

The Centers for Medicare & Medicaid Services released new information regarding the Vaccines for Children (VFC) program and the new CPT® vaccine administration codes 90460 and 90461.

According to the Department of Health, reimbursement for the administration codes will continue to be based on a per vaccine (per unit) basis and NOT on a per antigen or per component basis.

Standard rates will be reimbursed for VFC administration code 90460 for those vaccines included in the VFC program. Reimbursement for the component administration code 90461 is $0 for the VFC program.

Fee-for-service reimbursement will apply to the administration of vaccines not included in the VFC program. Reimbursement according to components will only be applied to those vaccines not available through the VFC program.

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**BlueCare/TennCareSelect**

**CLINICAL**

**Incontinence Supplies**

Adult incontinence supplies are provided to prevent skin deterioration, ulceration, and other complications that may occur due to loss of bladder or bowel control. Requests for incontinence supplies require prior authorization. Requests will be reviewed by CareCentrix based on Medical Necessity and on the individualized needs of the member.

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**Reminder: TENNderCare screenings.**

*The importance of laboratory testing and immunization*

The Bureau of TennCare requires Medicaid-eligible individuals under twenty-one (21) years of age be provided with immunizations in accordance with current American Academy of Pediatrics (AAP) recommendations.
BlueCare/TennCareSelect

CLINICAL (cont’d)

Federal Vaccines for Children guidance on new CPT® Codes for vaccine administration (cont’d)

Claims with no vaccine to match the administration fee will be denied with explanation code WB8: The number of administration services for these injections must equal injections billed.

ADMINISTRATIVE

Reminder: Civil penalties imposed for presenting false or fraudulent claims

Under the Deficit Reduction Act (DRA) of 2005, there are civil penalties for presenting false or fraudulent claims for payment or approval by the government. Providers receiving any federal funds are required to have policies and procedures in place addressing the DRA, False Claims Act, and what employees should do if they suspect fraud, waste or abuse. Your policies and procedures should include verbiage to address whistleblower protection. You should also have training available for all your staff to include this information.

As directed by the Bureau of TennCare, Provider Network Managers will be asking to review your policies and procedures, as well as training your staff on the Provider page on our website, www.bcbst.com, or your Provider Network Manager can provide you with a copy. Please ensure your policies and procedures training and are easily accessible.

Reminder: TennCare member appeal poster must be displayed

The Bureau of TennCare requires the Member Appeal Poster be displayed in a visible location within provider offices in the event the member has a grievance with the managed care organization or the provider. The poster is available on the company websites at

<http://www.bcbst.com/providers/forms/Member_Appeal_Poster.pdf> or <http://www.vshptn.com/providers/Member_Appeal_Poster.pdf> Please be sure to display this poster in your office for BlueCare and TennCareSelect members.

Cover Tennessee

CLINICAL

Maternity/Newborn Benefits

Women covered under CoverTN are eligible for maternity benefits through CoverKids/HealthyTNBabies. This coverage also provides routine care for the newborn while the mother is confined to the hospital. Non-routine services are not covered, therefore, the parent/guardian must obtain coverage for the newborn for these services. If no coverage options are available, the parent/guardian may apply for coverage through CoverKids for the newborn.

BlueAdvantage®

ADMINISTRATIVE

Resource available for new physicians

The U.S. Department of Health & Human Services Office of Inspector General has published a roadmap for new physicians: Avoiding Medicare & Medicaid Fraud and Abuse. This resource assists physicians in understanding how to comply with federal laws by identifying red flags that could lead to potential liability in law enforcement and administrative actions. The key issues addressed in this brochure are relevant to all physicians, regardless of specialty or practice setting and can be downloaded free of charge at <www.oig.hhs.gov/fraud/PhysicianEducation>.

CAHPS survey results are in! Plan H4979, H5884 & H7917

The Centers for Medicare & Medicaid Services (CMS) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to collect information about member experiences with Medicare Advantage (MA) health plans over the previous six months. On average 70.9% of BCBST members surveyed, responded.

The 2010 CAHPS survey of MA and MA Prescription Drug (MA-PD) plans was conducted from February 2010 through June 2010. One of thirty-seven (37) Private-Fee-For-Service (PFFS) MA plans and one out of ten Preferred Provider Organization (PPO) plans in Tennessee participated in the survey. This summary highlights the results of the survey for all BlueAdvantage health plans.

BlueAdvantage scored above the national average on all measures, including:

- Health Plan Customer Service
- Getting Needed Care
- Getting Needed Prescription Drugs

Even though all BlueAdvantage health plans exceeded the national average on all measures, we believe that opportunities for improvements exist. The areas that remained the same between 2009 and 2010 include:

- Getting Care Quickly
- Doctors Who Communicate Well
- Rating of Care Received
- Rating of Personal Doctor
- Overall Rating of Prescription
- Drug Coverage

Survey results reflect not only the member’s satisfaction with our overall plan, but about services they received from you, their physician. To review the CAHPS data further, refer to the Provider page of our company website, www.bcbst.com.

Readmission guidelines for BlueAdvantage PPO* 

A readmission is defined as a preventable, unplanned admission occurring within fourteen (14) days after a hospital discharge to the same facility for a condition related to, or complication of the original hospital stay or admission resulting from a modifiable cause. Claims for patients at either a DRG or Per Diem facility that are re-admitted under these circumstances are not eligible for two payments.

March 2011
BlueAdvantage®
ADMINISTRATIVE (cont’d)

Readmission guidelines for BlueAdvantage PPO (cont’d)*

Some examples of readmissions that **MAY NOT** be authorized are:
- respiratory admissions, e.g., asthma, COPD, pneumonia;
- complications from surgical procedures; or
- abdominal pain.

Some examples of readmissions that **MAY be** authorized are:
- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain; or
- admissions for complication due to rejection of transplant/implant surgery.

These guidelines apply to BlueAdvantage PPO line of business. Members cannot be held liable for charges associated with a readmission within 14 days of a previous admission ± Effective April 1, 2011,

**Changes to prior authorization requirements for therapy services***

Effective April 1, 2011, BlueAdvantage PPO will require prior authorization for all therapy services performed in a home or outpatient setting. This includes all physical therapy, occupational therapy and speech therapy. An advanced determination is recommended for these services for BlueAdvantage PFFS members.

To process your initial request quickly, BlueAdvantage PPO therapy requests will be accepted telephonically by calling the Provider Service line, 1-800-924-7141 or via BlueAccess, BlueCross BlueShield of Tennessee’s secure area on its website, www.bcbs.com. If additional visits are needed, all concurrent review requests should be faxed to BlueAdvantage utilization management at 1-888-535-5243.

BlueCard®
ADMINISTRATIVE

Out-of-area Blue member’s medical policy and prior authorization requirements now easier to access

BCBST provides you easy access to look up medical policy applicable to your out-of-area Blue patients, along with general prior authorization requirements, and contact information for initiating prior authorization. We have now added additional access points to this information.

Three options are now available to access medical policy and prior authorization requirements from the Provider page of the company website, www.bcbs.com:

**Option 1.**
- Logon to BlueAccess
- Click the BlueCard/FEP link
- Click on Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization

**Option 2 (Direct access via Quick Links)**
- Click Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization

**Option 3 (Under BlueCard)**
- Choose More>
- Under the Additional Information tab Click Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization

With any of the three options you will be routed to the Home plan’s medical policy and/or prior authorization requirements. Once medical policy and/or prior authorization requirements are viewed, you will be reconnected to the local plan’s website. For questions or feedback, contact us at 1-800-705-0391.

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†Provider Service lines Featuring “Touchtone” or “Voice Activated” Responses

Note: If you have 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.

**Commercial Lines** 1-800-924-7141 (includes CoverTN; CoverKids & AccessTN)

**Operation Hours**
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)

**Medical Management Hours**
Monday–Friday, 9 a.m. to 6 p.m. (ET)

**BlueCare** 1-800-468-9736

**TennCare Select** 1-800-276-1978

**CHOICES** 1-888-747-8955

**SelectCommunity** 1-800-292-8196

**Monday – Friday, 8 a.m. to 6 p.m. (ET)**

**BlueCare/TennCare Select Medical Management Hours**
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 1Q 2011 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. CPT® is a registered trademark of the American Medical Association.