September 2011

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

CLINICAL
Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The 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 Sept. 29, 2011
- Electroencephalograms (EEG) by Telemedicine Transmission

Effective Oct. 8, 2011
- Bevacizumab
- Leuprolide Acetate
- Cervical Cancer Screening Technologies (Pap/HPV/Speculoscopy/Cervicography)
- Intraoperative Radiation Therapy (IORT)
- KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy
- Microarray-Based Gene Expression Testing of Cancers of Unknown Primary Malignancy
- Radiofrequency Ablation for the Treatment of Tumors
- Gene Expression Testing for Coronary Artery Disease
- Left-Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
- Orthoptic Training for the Treatment of Vision or Learning Disabilities
- Testing and Treatment for Lyme Disease

Effective Nov. 16, 2011
- Hip Resurfacing

Interferential Current Therapy (BCBST will retain the historical policy statements)

Note: These effective dates also apply to BlueCare/TennCare Select pending State approval.

Changes to the commercial specialty pharmacy listing

Effective Aug. 1, 2011, the following drugs require prior authorization.

Provider-administered via medical benefit: Provenge
Self-administered via pharmacy benefit: Incivek Infergen Introns A Pegasys Peg-Intron Ribavirin Victrelis

The prior authorization requirement of the self-administered drug, Actiummune, has been removed effective Aug. 1, 2011.

Medication Assisted Treatment (MAT) update

As announced in the July BlueAlert the Medication Assisted Treatment (MAT) program for chemical dependency began on Aug. 1, 2011. This pharmacy management program is a contract exclusion for TRH members.

Implant billing guidelines*

Effective Oct. 1, 2011, BlueCross BlueShield of Tennessee will require providers to file the most appropriate HCPCS codes in accordance with the National Uniform Billing Guidelines on CMS-1450/ANSI 8371 facility claim forms for Implant Revenue Codes 274, 275, and 278. When a claim is received without an appropriate HCPCS code, the claim line item will be denied y74 “revenue code requires HCPCS code”. The provider must then submit a corrected claim that includes the appropriate HCPCS code. This guideline is applicable to outpatient claims.

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

ADMINISTRATIVE
New Mandate Requires Hearing Aid Benefit for Children

Recent legislation mandated coverage of up to $1,000 per hearing aid, per ear every three years for children under age 18. According to the mandate, "hearing aid" includes ear molds and services to select, fit and adjust the hearing aid. That means fittings are covered and included in the $1,000 limit. Any accessories, including batteries, cords and other assistive listening devices – such as FM systems – are excluded.

This benefit is effective for fully insured and non-ERISA self-funded groups upon new sale or renewal and for members with individual products on or after Jan. 1, 2012. Benefits are subject to deductible and coinsurance.

In order to process claims, providers will need to include the RT or LT (right or left) modifiers with the hearing aid codes. Hearing aid claims filed without one of these modifiers will be returned to providers.
Preparing for ICD-10

Effective Oct. 1, 2013, ICD-10 will replace ICD-9 and require business and system changes throughout the health care industry. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

To prepare for the transition from ICD-9 to ICD-10:

- **Complete** an assessment of impacts to your current systems and work processes that use ICD-9 codes.
- **Develop** an implementation strategy to include a detailed timeline and budget.
- **Identify** your current systems, potential changes to work flow and business processes.
- **Initiate** an open dialogue with vendors, clearinghouses, billing services and BlueCross BlueShield of Tennessee to ensure a smooth transition.
- **Assess** staff training needs.
- **Budget** for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials, and training.
- **Conduct** test transactions using Version 5010/ICD-10 codes.

BlueCross BlueShield of Tennessee will keep you informed of future steps toward becoming ICD-10 compliant.

For more information regarding ICD-10 implementation, please visit <http://www.bcbs.com/providers/ecomm/ICD10%20Frequently%20Asked%20Questions.pdf>.

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**BlueCare/TennCareSelect**

**CLINICAL**

**Health literacy and cultural competency information and training available**

Health literacy occurs with mutual understanding between health care providers (or anyone communicating health information) and patients (or anyone receiving health information). Using plain language and ensuring the patient understands the information conveyed is an important part of health literacy.

Cultural competency is an important issue facing health care providers. It is important for organizations to have and utilize policies, trained and skilled employees, and resources to anticipate, recognize, and respond to various expectations (language, cultural and religious) of members and health care providers.

A Health Literacy and Cultural Competency Provider Tool Kit is available on the provider page of our company website at <http://www.bcbs.com/providers/08-538CulturealCompProvToolKit.pdf>. This tool kit provides health care professionals additional resources to better manage members with diverse backgrounds.

Providers may also register for Quality Interactions® Cross Cultural Training on the same website. This training is available at no cost to BlueCross BlueShield of Tennessee/VHSP providers.

**Pediatric asthma initiative**

Volunteer State Health Plan (VSHP) launched a new pediatric asthma initiative based on emergency department utilization, hospital admissions, and use of appropriate medications for children with asthma. The initiative was designed to provide relevant and timely member-specific clinical information to providers to help improve the health outcomes for BlueCare and TennCare Select members. These members were identified as receiving treatment in the past 12 months and diagnosed with asthma. VSHP is requesting assistance from providers in identifying and enrolling BlueCare and TennCare Select members in our CareSmart® Asthma Program.

Some providers may receive an on-site visit from our asthma team who will present the provider with chronological data on asthma related inpatient admissions, asthma related emergency department visits, and HEDIS measures for the appropriate use of controller medication for people with persistent asthma. VSHP’s goals are to work with members and providers to increase the use of appropriate medications, reduce asthma emergency department (ED) visits, reduce asthma inpatient/hospital admissions, increase enrollment in the Asthma Disease Management (DM) Program, and promote member compliance in an asthma action plan. To refer members to the CareSmart® Asthma Program, please call 1-888-416-3025.

**Text4Baby program**

VSHP and CoverKids/Healthy TNBabies have partnered with Text4Baby to increase healthy birth outcomes. Text4Baby is an educational program of National Healthy Mothers, Healthy Babies Coalition. Your patients can get FREE healthy pregnancy and healthy baby information by text each week during pregnancy, and through the baby’s first year. To get started, your
September is Infant Mortality Month

Hospice update*

Effective Oct. 1, 2011, BlueCare/TennCareSelect will no longer require prior authorization for Hospice services, but will require notification except for Medicare dual eligible members who will not require prior authorization nor notification. Notification must include demographic and clinical information, and identify who will be performing the service(s). Hospice claims require submission of an Acknowledgement of Hospice Information form, operative report, pathology report, history and physical, and office notes that include documentation of conservative measures prior to the hysterectomy. All notifications of service are screened for non-covered, out-of-network, abortion, sterilization, hysterectomy, and investigational procedures. Requests for notification are not subject to prospective medical necessity review, but are subject to retrospective review.

To notify us of hysterectomy services please fax information to: Notification fax 1-800-292-5311

Hysterectomy update*

Effective Oct. 1, 2011, BlueCare/TennCareSelect will no longer require prior authorization for hysterectomy, but will require notification for both inpatient and outpatient services. Notification must include demographic and clinical information, and identify who will be performing the service(s).

Hysterectomy claims require submission of an Acknowledgement of Hysterectomy Information form, operative report, pathology report, history and physical, and office notes that include documentation of conservative measures prior to the hysterectomy. All notifications of service are screened for non-covered, out-of-network, abortion, sterilization, hysterectomy, and investigational procedures. Requests for notification are not subject to prospective medical necessity review, but are subject to retrospective review.

To notify us of hysterectomy services please fax information to: Notification fax 1-800-292-5311

ADMINISTRATIVE

Plain language initiative

The Bureau of TennCare “Plain Language” initiative is part of a national program to encourage health care providers to promote health literacy among their patients by ensuring they understand written and oral health information. The National Adult Literacy Survey found that 66 percent of adults age 60 and over have inadequate or marginal literacy skills. Many informed consent forms and medication package inserts are written at high school level or higher, while the average patient reading level is closer to 6th grade.

In one study, out of 659 hospital patients, those with poor health literacy skills were five times more likely to misinterpret their prescriptions than those who had adequate literacy skills. Most patients will not tell you they do not understand. Using plain language allows your patients to understand their treatment plan, know how to take their prescriptions properly, and follow your instructions better.

For additional information on Health Literacy, please refer to the Department of Health and Human Services website at <http://www.hrsa.gov/publichealth/healthliteracy>.

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 website at http://www.bcbst.com/providers/forms/ and on the Bureau of TennCare website at <http://www.tn.gov/tenncare/forms/medicalappeal.pdf>. Please be sure to display this poster in your office for BlueCare and TennCareSelect members.

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 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.

If parents question the need for immunizations, you may refer them to the Centers for Disease Control and Prevention website, www.cdc.gov/vaccines. Please take advantage of all these resources, as well as the TENNderCare tool kit and other information available on our company websites, www.vshptn.com and www.bcbst.com.
BlueCare/TennCareSelect

ADMINISTRATIVE (cont’d)

Reminder: Submitting authorization requests for skilled nursing (SNF) facility, long term acute care (LTAC) and Inpatient Rehab Facility

BlueCare/TennCareSelect does not perform predetermination reviews, however all SNF/LTAC/Inpatient Rehab services require prior authorization. Authorization requests should be submitted by fax to 423-535-7790. For additional information call 423-535-5095 Monday through Friday, 8 a.m. to 6 p.m. (ET).

BlueAdvantage

ADMINISTRATIVE

Reminder: CareCentrix provides certain services for BlueAdvantage PPO members

As previously communicated, effective July 12, 2011, CareCentrix now manages complete benefit administration of all durable medical equipment (DME)/medical supply services, home health, orthotic and prosthetic services prescribed for BlueAdvantage PPO members. Contact CareCentrix for prior authorization, provider service and claims administration of the above services via one of the following methods:

Phone: 1-866-776-1123
Fax: Initial Authorization 1-866-501-4665
Fax: Reauthorization 1-866-501-4666
Web submission: www.carecentrixportal.com/ProviderPortal/

Note: To gain access to CareCentrix’ secure site for web submission, e-mail portalinfo@carecentrix.com or fax your request to 1-919-792-6823. To establish electronic claims submission, e-mail edinfo@carecentrix.com or fax your request to 1-919-792-6822.

New behavioral health program for Medicare Advantage members

Effective Oct. 1, 2011, BlueCross, in partnership with Magellan Health Services, will implement a new behavioral health program for Medicare Advantage members. Along with behavioral health services this program will provide coaching for case management and disease management.

Services requiring prior authorization include acute care, residential treatment, and electroconvulsive therapy. Effective Nov. 1, 2011, partial hospitalization and intensive outpatient treatment will also require authorization. We look forward to working with you to provide the best treatment outcomes for Medicare Advantage members.

Federal Employee Program (FEP)

ADMINISTRATIVE

Federal Employee Program (FEP) health benefit plan reminders

Observation Stays vs. Inpatient Admissions
Claims are paid based on the type of care billed. Outpatient observation care is payable at 85 percent of the plan allowance for standard option FEP members, possibly leaving the member a substantial 15 percent coinsurance. For inpatient care FEP members pay only a flat co-payment of $250. Members in an “Outpatient” status may be responsible for additional coinsurance, deductibles or certain medications in accordance with their FEP health benefit plan.

Charging Facility Co-Payments for an Office Visit
If an FEP member visits a doctor whose office is located in a facility/hospital, the member should only be charged the office visit co-payment amount. Some members are incorrectly being charged the hospital co-payment in addition to the office visit co-payment.

Generic Drugs Save Money for Members
Please explain to our members that generic drugs are FDA approved and are a safe and effective treatment for their condition. Also continue to prescribe generic drugs when available. When a generic equivalent drug is not available to substitute for a brand-name drug, there may be a generic alternative used to treat the same condition. You can help FEP members save a substantial amount of money due to the lower cost and higher benefit levels for generic drugs covered under their health benefit plan.

Dental Co-Payments
In 2011 the FEP basic option co-payment increased from $20 to $25 for covered dental care. As part of the MyBlue Wellness incentive program, FEP members can use their earned funds to pay dental charges including the co-payment amount. As long as the actual $25 co-payment is charged during the card transaction, the member will not have to provide a receipt or explanation of benefits in order to be reimbursed.

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
TennCareSelect 1-800-276-1978
CHOICES 1-888-747-8955
SelectCommunity 1-800-292-8196
Monday – Friday, 8 a.m. to 6 p.m. (ET)

Note

*These changes will be included in the appropriate 3Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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