BlueAlert
provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

February 2008

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 March 14, 2008

- PET for Oncology Applications
- Cryosurgical Ablation for the Treatment of Prostate Tumors
- Cryosurgical Ablation for the Treatment of Renal Tumors
- Temsirolimus
- Zoledronic Acid
- Alemtuzumab
- Pharmaceutical Management of Chronic Hepatitis B Virus (CHBV)

Note: Effective date(s) apply to BlueCare® and TennCare*Select* pending State approval.

Clinical Practice Guidelines adopted

BlueCross BlueShield of Tennessee adopted the following guidelines as recommended best practice references:

Guidelines for the Treatment of ADD/ADHD
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/5/1158.pdf>
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/4/1033.pdf>

Management & Prevention of Chronic Obstructive Pulmonary Disease (COPD)
http://www.goldcopd.org/index.asp?l1=1&l2=0

Hyperlinks to these guidelines are available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company Web site at http://www.bcbst.com/providers/hcpr/ Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Reminder: Encourage smokers to quit

All health care providers, especially those with direct patient contact, have an opportunity to help tobacco users quit. We encourage providers to actively counsel patients who currently smoke or those who are recent quitters (six months or less) on the dangers of smoking. Encourage smokers to:

1. Set a quit date, within 2 weeks;
2. Solicit support from family, friends, and coworkers;
3. Review past quit attempts—identify what helped, what led to relapse;
4. Anticipate challenges, including nicotine withdrawal; and
5. Identify reasons for quitting and benefits of quitting.

It is important to note that many smokers quit upon the advice of their doctor.

ADMINISTRATIVE

Reminder: Do you have your National Provider Identifier (NPI)?

*Share it with **all** insurance carriers.*

BCBST provides the following methods for reporting your NPI.

1. Print, complete and mail or fax the NPI form (located in the NPI topic on the Provider page of the company Web site, bcbst.com) to:
   BlueCross BlueShield of Tennessee
   ATTN: Provider Network Svc – 3TC
   801 Pine Street
   Chattanooga, TN 37402
   Fax: 423-535-5808
2. Call the Provider Service Line, 1-800-924-7141 and say "Contracting".
3. E-mail your Provider Name, BCBST Provider Number and NPI to PNS_GM@BCBST.com; or
4. Complete and mail the return post card included in the May, June or August 2006 issues of *BlueAlert*

Steps you should do:

1. Apply for your number from the Centers for Medicare & Medicaid Services (CMS),
2. Share your NPI with **all** insurance carriers with whom you do business.

If you do not have an NPI, learn how to apply by visiting the CMS Web site, www.cms.hhs.gov.

Reminder: Prior authorization guidelines for Positron Emission Tomography (PET) studies

All PET imaging studies must be consistent with BCBST medical policy guidelines in order to be considered for reimbursement.

MedSolutions conducts prior authorization medical necessity review for a large number of Blue Network P and Blue Network S members. For those members not requiring prior authorization for PET studies (you do not receive an approval or a denial) through MedSolutions, the scan must still meet BCBST medical policy guidelines for consideration of reimbursement.

Providers may request a predetermination for PET imaging services by calling the BCBST Provider Service line†.

Note: This does not apply to BlueCare or TennCare*Select*.

BlueCare/TennCare*Select*

ADMINISTRATIVE

LabOne no longer exclusively providing routine outpatient laboratory services*

Effective March 1, 2008, LabOne will no longer be exclusively providing routine outpatient laboratory services to BlueCare/TennCare*Select* members. Rather, providers will be able to utilize any BlueCare/TennCare*Select* participating independent lab for these services.

Lab services provided by participating labs will not require authorization; however, prior authorization will still be required when services are provided by non-participating labs.

National Drug Code (NDC) CMS-1450 claim filing requirement delayed

The Deficit Reduction Act of 2005 requires institutional claims submissions to include the NDC of the drug(s) administered, along with the correct quantity and unit for BlueCare and TennCare*Select* claims. The Centers for Medicare & Medicaid Services has announced this requirement will be delayed until Apr. 1, 2008, **for outpatient hospital claims only.**

Note: This requirement does not apply to commercial lines of business.

New provider appeal toll-free fax number now available for BlueCare and TennCare*Select* *

We recently added a new toll-free fax number, **1-888-357-1916**, solely for use in faxing a standard appeal for denied services. Provider use of this dedicated fax number will help ensure all faxed standard appeals are imaged into our system in a timely manner. This enhanced process will help expedite standard appeals and ensure the most current information is available to you when checking the status of your appeal.
When faxing a standard appeal the following documentation must be provided:

- The principle reason for upholding the non-certification determination,
- Detailed clinical rationale, and
- Pertinent medical records for the specific case you are appealing.

Reminder: Changes to billing guidelines for hospice continuous home care

In the April 2007 issue of *BlueAlert*, we advised that effective for dates of service on or after May 1, 2007, BlueCare and TennCare*Select* would change their billing guidelines for reporting Hospice Continuous Home Care (Revenue Code 0652) to 15-minute increments. Previously, the Centers for Medicare & Medicaid Services required these services be reported in 1-hour increments.

Reminder: Prenatal preventive care

Members under age 21 years who are receiving prenatal care are also eligible to receive TENNderCare services from their obstetrician. Providers may bill a preventive code, plus an Evaluation & Management code with modifier 25 when the visit includes both preventive care and prenatal services.

VSHP initiating annual accreditation and reporting projects

Volunteer State Health Plan, Inc., (VSHP) will soon begin their annual Health Plan Effectiveness Data Information Set (HEDIS) project to meet National Committee for Quality Assurance (NCQA) accreditation and the Bureau of TennCare reporting requirements for the BlueCare and TennCare*Select* programs.

Measures that require additional information from medical record documentation to report accurate results include childhood immunizations, prenatal and postpartum care, cervical cancer screening, cholesterol management and comprehensive diabetes management.

A representative from BlueCross BlueShield of Tennessee may contact your office to request documentation or schedule an onsite review of medical records for data abstraction.

Reminder: Lab procedures for TENNderCARE screening

Practitioners are reminded to perform and document all necessary lab procedures for TENNderCare screenings. Lab procedures or screenings that should be provided in accordance with the American Academy of Pediatrics' (AAP) Recommendations for Preventive Pediatric Health Care include:

- ✓ Hereditary/Metabolic Screening
- ✓ Hematocrit/Hemoglobin
- ✓ Urinalysis
- ✓ Lead Screening and Testing
- ✓ Tuberculosis Screening and Testing
- ✓ Cholesterol Screening
- ✓ Sexually Transmitted Diseases

Documentation of all lab test results must be included in the member's medical record.

Reminder: Member access-to-care is monitored

To help ensure our members have 24-hour-a-day, 7-days-a-week access to network practitioners, BlueCross BlueShield of Tennessee maintains access and availability standards in accordance with applicable regulatory and accrediting bodies.

Arrangements for 24-hour access to equally qualified practitioners participating in the same BlueCross BlueShield of Tennessee network as the member's practitioner are the responsibility of all contracted primary care practitioners who participate in our provider networks.

Our clinical audit staff monitors practitioner availability for after-office hours in coordination with the routine practice site or medical record review process for Primary Care and OB/GYN Practitioners. Routine telephone calls are made after regular office hours, using current Network Directory information available to BlueCross BlueShield of Tennessee Commercial, BlueCare and TennCare*Select* members, to assess practitioner compliance with published standards for telephone access after regular clinic/office hours.

Non-compliant results are shared with the practitioner and/or office representative, and are also reported to the Clinical Risk

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Member access-to-care is monitored (cont'd)

Management Department for continued monitoring.

These standards can be found on the Provider page of the company Web site at http://www.bcbst.com/providers/prov_man.shtm.

Note: To report any changes in demographical information, please call the BlueCross BlueShield of Tennessee Provider Service line†.

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 are 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, TennCare*Select*, 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 lepactionkit@accessproject.org.

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

Reminder: Billing process for Medicare/Medicaid dual eligible members

Claims filed electronically for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed to Medicare for primary payment. Medicare should crossover to the State of Tennessee for Medicare co-insurance amounts.

Paper claims filed for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed with Medicare for primary payment. After Medicare pays, providers should file the paper claims along with the Medicare Summary Notice to the State of Tennessee for reimbursement of Medicare coinsurance amounts. Mail paper claims for secondary payment to:

Tennessee Bureau of Medicaid
P.O. Box 460
Nashville, TN 37202-0460

Uninsured/Uninsurable members (Eligibility Class 77 with Medicare) should be billed directly for any deductible/coinsurance amounts due after Medicare pays primary. BlueCare will not pay these amounts; however, the member is liable for their Medicare deductible/coinsurance.

Claims filed for non-Medicaid members after Medicare has paid primary will show patient liability as zero (0) on the BlueCare/TennCare*Select* Remittance Advice. However, the member may be billed for any Medicare deductible/coinsurance amounts. Medicare/Medicaid dual eligibles should not be billed for any Medicare deductible/coinsurance amounts, as these should crossover to the Tennessee Bureau of Medicaid for secondary payment.

Eligibility classification may be determined by the last two digits of the group number or by reviewing the classification listing in the *BlueCare Provider Administration Manual* available on the Provider page of the company Web site, www.bcbst.com.

Update: National Drug Code (NDC) CMS-1450 claim filing requirements

In the Nov. 2007 issue of *BlueAlert*, we advised that when submitting paper claims one space should follow the NDC number and the number quantifying the number of units, grams or milliliters administered should not exceed 7 digits. The Bureau of TennCare announced effective Apr. 1, 2008, it will adopt the National Medicaid EDI HIPAA workgroup's standard of utilizing the N4 qualifier, followed by the 11-character NDC, followed by the unit measurement qualifier, followed immediately by the quantity with **NO** spaces. All data elements should be left-justified with no leading zeros on the quantity.

Example: N412345678901UN1234.567

Additionally, we announced that claims containing NDCs with less than 11 digits and the NEW data elements would be returned unprocessed. Instead, all institutional claims will be processed and only the individual line(s) containing J-codes with missing NDC information will be rejected.

This requirement does not apply to commercial claims submitted on the CMS-1450 claim form.

BlueCard®

ADMINISTRATIVE

Marking claim attachments inappropriately may cause delays in response time

BCBST utilizes the Optical Character Recognition (OCR) scannable format to read paper claims and any attachments. Recently we have received a number claims with Explanation of Payments (EOPs) and Remittance Advices (RAs) having highlighted or circled notations reflected on them. While we appreciate the assistance you are attempting to offer, these types of indicators prevent accurate reading of the data during scanning and may delay the adjudication process.

If you wish to bring our attention to a specific area on an attachment, please draw

BlueCard®

ADMINISTRATIVE

Marking claim attachments inappropriately may cause delays in response time (cont'd)

an arrow (use a pen with black ink only) pointing toward the specific line(s) rather than using other methods. Following this tip will help prevent the need for retrieving original document(s) from storage; thus causing untimely delays in the process.

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

ADMINISTRATIVE

Reminder: Reimbursement for ambulatory surgical centers based on OPPS system

Providers are reminded that effective Jan. 1, 2008, reimbursement for ambulatory surgical centers is based on the hospital Outpatient Prospective Payment Systems (OPPS) system. This is in accordance with the Centers for Medicare & Medicaid Services reimbursement guidelines.

Correction: File claims timely to avoid penalties

In December 2007 issue of *BlueAlert*, we reminded providers that claims filed for BlueAdvantage Private Fee-for-Service (PFFS) and BlueAdvantage Preferred Provider Organization (PPO) members must be received within 365 days from the date of service to be considered timely. However, in accordance with federal guideline 42 CFR, this requirement does not apply to BlueAdvantage PFFS claims, which are governed by the Centers for Medicare & Medicaid Services (CMS) timely filing guidelines. CMS timely filing guidelines can be found on the CMS Web site at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=bc033d9a3864bd39aa4a394b403e984f&rgn=div8&view=text&node=42:3.0.1.1.11.3.2.8&idno=42>. We apologize for any inconvenience the original information may have caused.

Advance determinations available online for BlueAdvantage PFFS members*

BlueCross BlueShield of Tennessee providers serving BlueAdvantage Private Fee-for-Service (PFFS) members can submit electronic advance determination requests for inpatient, 23-hour observation and pharmacy (part B drugs only) via *e-Health Services*® located on *BlueAccess*, the secure area on the company Web site, www.bcbst.com. To access *e-Health Services*, enter your user ID and password in the secure area login box or for first-time users, click on the "register now" tab and follow the prompts.

Advance determination requests for Inpatient, 23-hour observation and Part B Pharmacy Drugs will pend into the BCBST real-time system for nurse review and response. This service is available 24-hours-a-day, 7-days-a-week to all BCBST registered providers.

Note: This process is currently not available for BlueAdvantage Participating Provider Organization (PPO) members.

Reminder: E-mail box available exclusively for BlueAdvantage inquiries

Providers now have an e-mail box available for use in submitting questions and/or inquiries specific to BlueAdvantage.

Our goal is to respond to your inquiries within 2 business days. Please send your BlueAdvantage questions/inquiries to BlueAdvantageClaims@bcbst.com or call our BlueAdvantage Provider Service line†.

Cover Tennessee

ADMINISTRATIVE

State removes benefit limitation on outpatient diabetes education services

Recently, the State of Tennessee removed the $500 benefit limit on outpatient diabetes education services for both its CoverKids and AccessTN health care products. Based on this change, BlueCross BlueShield of Tennessee removed the limit Jan. 9, 2008, from its claim processing system, retro-effective to the April 1, 2007, product inception date.

Any claims previously affected by this benefit limit will be reopened and adjusted. You do not need to resubmit these claims for reprocessing to occur.

Reminder: Non-routine diagnostics non-covered when performed in practitioner office

Providers are reminded that non-routine diagnostics, including but not limited to MRIs, CT Scans, and PET Scans are excluded from CoverTN member coverage when performed in the practitioner's office.

• • • • • • • • • • • • • • • • • • •

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; CoverTN; CoverKids; Access TN 1-800-924-7141
(Monday– Friday, 8 a.m. to 5:15 p.m. ET)

Note: If you've moved, acquired an additional location, or made other changes to your practice, choose the new "touchtone" option or just say "**Network Contracting**" when prompted, to easily update your information.

BlueCare 1-800-468-9736
TennCare*Select* 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).

• • • • • • • • • • • • • • • • • • •

*These changes will be included in the appropriate 1Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.