BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

January 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 Feb. 10, 2008

- Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Individuals with NSCLC

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

Modified Milliman Care Guideline updates/changes

BlueCross BlueShield of Tennessee's Web site has been updated to reflect upcoming modifications to select Milliman Care Guidelines®. The *Modified Milliman Care Guidelines* can be viewed on the Utilization Management Web page at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm>.

Effective Feb. 28, 2008

The following as relates to Ambulatory Care:

- Bladder Instillation for Treatment of Interstitial Cystitis
- Sling Operation for Correction of Male Urinary Incontinence

The following as relates to Inpatient and Surgical Care:

- Laparoscopy, Surgical with Radical Hysterectomy
- Transcatheter Permanent Occlusion or Embolization

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

Clarification: Arranging a peer-to-peer discussion

To arrange a peer-to-peer discussion with a BCBST medical director, office staff should call one of the following numbers:

BlueCare or TennCare*Select*
1-800-924-7141

All other lines of business
1-800-228-2096

ADMINISTRATIVE

Coordination of benefits questionnaire available online

Effective Jan. 1, 2008, a coordination of benefits (COB) questionnaire will be available on the company Web site, www.bcbst.com for use in assisting your patients needing to update their "other coverage" information.

To retrieve the form for the member to complete and mail directly to his/her local BlueCross BlueShield Plan, go to the Provider's page, click on "Administration", "Forms", form is located under "Commercial" heading.

The member's COB information only needs updating once within a 12-month period unless there has been a change.

BCBST begins accepting present on admission (POA) codes

Effective Jan. 1, 2008, for all claims for inpatient admissions to general acute care hospitals, BlueCross BlueShield of Tennessee **will begin accepting** the Present on Admission (POA) code on diagnoses for discharges on or after Dec. 31, 2007.

Note: Effective April 1, 2008, the POA code **will be required.**

BCBST partners with American Cancer Society (ACS) in promoting cancer screening guidelines

BlueCross BlueShield of Tennessee and the ACS has partnered to make cancer screening educational material available to providers for sharing with their patients. Regional Nurse Liaisons (RNLs) distribute a pad, similar to a prescription pad, where providers can document what screenings a patient may need and give to the patient. Additionally, providers are supplied with a pad of the *ACS Screening Guidelines* containing age and gender-appropriate screenings for patient use.

We encourage you to use the ACS screening guidelines to educate your patients on obtaining the appropriate cancer screenings.

If you have questions or would like a supply of these materials, please visit the ACS Web site, www.cancer.org or contact your local RNL at one of the following numbers:

Chattanooga	423-535-6458
Jackson	731-664-4136
Johnson City and Knoxville	423-854-6025
Memphis	901-544-2140
Nashville	615-386-8535

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ADMINISTRATIVE

Reminder: Correct reporting of Modifier 59

Modifier 59 represents a procedure/service not ordinarily encountered or performed on the same day by the same physician. It should only be reported when the physician needs to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may be due to a:

- different session or patient encounter;
- different procedure or surgery;
- different site or organ system;
- separate incision/excision;
- separate lesion; or
- separate injury.

When using Modifier 59, it:

- *should **only** be reported* if another modifier does not describe the situation more accurately; or
- *should **only** be reported* on the "edited" code – **NOT** on the primary or comprehensive code. (Example: A provider performs a tendon injection, CPT® 20551, and trigger point injection, CPT® 20552, at the same patient encounter. To indicate that these were separate and distinct procedures, the provider should report a Modifier 59 on the edited code, CPT® 20552, and must be able to provide supporting medical documentation in the patient record.
- *should **NOT** be reported* on Evaluation and Management codes.

For more information on reporting Modifier 59 correctly, visit the Centers for Medicare & Medicaid Web site, www.cms.hhs.gov.

Reminder: NPI reporting requirements

Effective Jan. 1, 2008, commercial institutional providers will be required to submit their NPI number in the applicable fields on the CMS 1450 claim form.

Effective March 1, 2008, NPIs will be required on all commercial professional CMS-1500 claim forms.

For BlueCare and TennCare*Select*, effective Jan. 1, 2008, the State of Tennessee is requiring the NPI be submitted on both institutional CMS-1450 and professional CMS-1500 claim forms.

You may continue to use the legacy number as long as the NPI is also submitted.
Note: All NPI numbers submitted must be on file with BlueCross BlueShield of Tennessee or your claim(s) will be returned unprocessed.

Coding clarification for reporting spinal osteotomy procedures

According to the 2008 CPT® Manual, spinal osteotomy procedures are reported when a portion(s) of the vertebral segment(s) is cut and removed in preparation for re-aligning the spine as part of a spinal deformity correction. This clarification was added to the introductory language of the 2008 CPT® Manual to avoid confusion regarding the use of osteotomy codes. CPT® codes 22206-22226 should **only** be used to report spinal osteotomies for correction of a spinal deformity.

It is important to note that in performing many spinal procedures, an osteotomy is considered an integral part of the comprehensive procedure and should not be separately reported. For example, if removing osteophytes or endplates in preparation for fusion, these procedures would be included in the more comprehensive procedure (laminectomy, discectomy, etc.). The use of CPT® codes 22206-22226 was not intended for purposes other than the correction of spinal deformity.

Reminder: Filing multi-line and multi-page claims appropriately

Professional charges should be submitted on the CMS-1500/ANSI-837 Professional Transaction and Institutional charges on the CMS-1450/ANSI-837 Institutional Transaction. Complete claims data should be filed for all services regardless of whether those services are covered.

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**. Billing multiple lines can result in a multi-page claim. When submitting multi-page claims, place the total amount **only on the last page of the claim**. The total on the last page should reflect the sum of the line items for all pages. Billing guidelines for multi-page claims are found in the provider administration manuals located on the company Web site, www.bcbst.com.

Clinical information essential to timely requests

In order to obtain a timely decision, MedSolutions needs to gather clinical information related to the requested imaging. It is helpful to have the patient's clinical information available and reviewed prior to calling. Standard information needed is listed below.

- History – onset of symptoms and related conditions
- Current Physical Exam – Date of Service and findings
- Medications – related to treatment of symptoms
- Therapy – Date of Service
- Specialist Consultation – Date of Service and findings
- Prior imaging related to the request
- Current or Serial Labs

Commercial code bundling rules updated

Effective for dates of service Jan. 1, 2008 – March 31, 2008, in accordance with BlueCross BlueShield of Tennessee's policy on Quarterly Reimbursement Changes, the code bundling rules for professional commercial claims will be updated.

Providers may review the updated code bundling rules on the company Web site at <http://www.bcbst.com/providers/code_bundling/>.

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ADMINISTRATIVE

e-Health Services enhances patient information

e-Health Services, located on BlueAccess, BCBST's secure area on the company Web site, www.bcbst.com now offers providers enhanced links to member-specific prior authorization requirements and claims information.

A "Prior Authorization Requirements" link has been added to the *Claims and Authorization Inquiry* section on the Patient Information Page. Providers can quickly view whether a patient's BCBST plan requires prior authorization for a specific procedure or service by simply clicking on the new link. As with any data enhancement, it must be rolled out in segments. Therefore, this information is not available for use with all BCBST members at this time. If the information is not available for a particular member, you will be directed to contact Provider Service.

Additionally, providers will receive more enhanced claims information on the "Find Claims" page.

Reminder: Filing sleep study claims appropriately

Sleep studies must be performed in a certified place of service, as required by applicable state and federal regulations, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or American Osteopathic Association (AOA) and/or the American Academy of Sleep Medicine. The evaluating physician and staff are required to have specialized training that meets the standards set forth by the American Academy of Sleep Medicine.

To avoid delays in receiving payments, unnecessary overpayments, and to ensure the most appropriate member benefit is applied, providers are reminded to submit claims with the most appropriate Revenue Code, Procedure Code and HCPCS code in effect on the date of service. The preferred Revenue Code for Outpatient Sleep Studies is 0740 or 0749.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Erythropoietin stimulating agents require prior authorization

Effective Feb. 1, 2008, BlueCare and TennCare*Select* will require prior authorization for self-administered and provider-administered erythropoietin stimulating agents before dispensing from a pharmacy or for outpatient administration.

Authorization will be based on medical appropriateness criteria, such as hemoglobin and hematocrit levels, which can be found online in the *BCBST Medical Policy Manual* at <http://www.bcbst.com/UpcomingMPs/upcoming_mps.htm>. These medications, which include epoetin alfa (Procrit®; Epogen®) and darbepoetin alfa (Aranesp®) are available through the Bureau of TennCare's Pharmacy Benefits Manager, First Health Services Web site at https://tennessee.fhsc.com/.

Updated national drug code (NDC) requirements for filing CMS-1450 claim form

As previously communicated, effective for dates of service on or after Jan. 1, 2008, institutional providers must include NDC information for all J codes for BlueCare and TennCare*Select* claims. We announced that claims containing an NDC 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.

Reminder: Supplying appropriate information improves prior authorization request response time

In the June 2007 issue of *BlueAlert*, we advised that BlueCare and TennCare*Select* can receive authorization requests by fax, phone or electronically through BlueAccess, BlueCross BlueShield of Tennessee's secure area on the company Web site, www.bcbst.com.

Submitting all appropriate medical and demographic information at the time of the request helps ensure you receive a more timely response. Insufficient information can result in a medical necessity denial. Additional clinical information may also be called in within 24 hours of the request to expedite your authorization or determination request.

Reconsiderations

Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may be submitted to BCBST from the provider or provider representative. A provider can request a peer-to-peer discussion at any time during the Utilization Management Provider Appeals Process. The process can be found on our Web site, www.bcbst.com in the *BlueCare Provider Administration Manual*.

If you have any questions, please call the appropriate **Notification/Prior Authorization** number listed below:

BlueCare 1-888-423-0131
TennCare*Select* 1-800-711-4104

BlueCard®

ADMINISTRATIVE

Blues move to automatic crossover for all Medicare claims

All claims will be automatically submitted to the secondary payer

Effective Jan. 1, 2008, all Blue Plans will crossover Medicare claims for services covered under Medigap and Medicare

BlueCard®

ADMINISTRATIVE

Blues move to automatic crossover for all Medicare claims (cont'd)

Supplemental products. This will result in automatic claims submission of Medicare claims to the Blue secondary payer, and reduce or eliminate the need for the provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide.

Providers can learn more about the Medicare crossover process by visiting the company Web site at http://www.bcbst.com/providers/news/.

BlueCard eligibility line expands hours of operation

Effective Jan. 1, 2008, the BlueCard Eligibility line's automated voice response system, 1-800-676-BLUE, will be accessible to providers 24 hours-a-day, 7 days-a-week. This enhancement will support the growing trend of self-service and help ensure providers have access to Plans' self service eligibility information at all times.

The BlueCard Eligibility Call Center is a centralized service which transfers providers to members' Home Plans for benefit and eligibility information, using a member's alpha prefix. Previously, the line was available Monday through Friday, 7 a.m to10 p.m. (ET).

Identifying Blue Precision members

Effective Jan. 1, 2008, Blue Precision, a cost-effective plan option with a more limited but efficient network will be available to the Wal-Mart group in the Knox County area. Members can easily be identified by their BlueCross BlueShield member identification number. The alpha prefix "WMZ" will be reflected on the front of the member ID card along with the Blue Precision and empty suitcase logos.

Cover Tennessee

ADMINISTRATIVE

Important changes to AccessTN Health Plans

Effective Jan. 1, 2008, the following changes will apply to AccessTN plans:

Plan Option	Change
AccessTN 1000 AccessTN 5000	Maximum annual benefit increased to $200,000
AccessTN 1000 AccessTN 1250 AccessTN 5000	Pre-existing waiting period will remain 6 months during which time, plan will pay 50 percent of the allowed amount for medical services. ***Excludes***: ➢ Outpatient behavioral health services ➢ Outpatient chemotherapy and radiation therapy for treatment of cancer ➢ Prescription medications

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Reminder: Use preventive diagnosis codes for annual physical examinations

It is important to use preventive diagnosis codes when filing AccessTN member claims for annual physical examinations. If a condition is found during the exam, that diagnosis will supersede the preventive exam diagnosis causing the services to possibly be subject to pre-existing review. This could result in increased member cost-sharing and possible claims payment delays.

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

ADMINISTRATIVE

BlueAdvantage begins accepting present on admission (POA) codes

Effective Jan. 1, 2008, for all BlueAdvantage claims for inpatient admissions to general acute care hospitals, BlueCross BlueShield of Tennessee will begin accepting the Present on Admission (POA) code on diagnoses for discharges on or after Dec. 31, 2007. BlueAdvantage claims submitted without the POA code on or after April 1, 2008, will be returned to the hospital for correct submission of POA information.

Critical Access Hospitals, Maryland Waiver Hospitals, Long Term Care Hospitals, Cancer Hospitals and Children's Inpatient Facilities are exempt from this requirement as are all hospitals paid under any other type of Perspective Payment System (PPS) system other than the acute care hospital PPS system.

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†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).

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*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.

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