BlueAlert
provider news flash
BlueCross BlueShield of Tennessee
plans for better health. plans for a better life.
Please Route to all Providers & Office Staff
June 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 July 12, 2008

- Acoustic Immittance Measures for Hearing
- Gene Expression Profiling Assays as a Technique to Determine Prognosis for Managing Breast Cancer Treatment

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

New drugs added to commercial specialty pharmacy listing

The following drugs have been added to our specialty pharmacy listing. Drugs requiring prior approval are identified with a "PA".

Self-administered via medical benefit
- Acthar (HP) Gel (PA)

Provider-administered via pharmacy benefit
- Acthar (HP) Gel (PA)
- Somatuline

Changes to commercial preferred drug listing (PDL)

The following drug has been added to the PDL prior authorization list:

- Lamisil Oral Granules (for ages 4 years and older and for the diagnosis of Tinea Capitis).

The following drug has been added to the PDL quantity limitation list:

- Plavik 300mg, one tablet/30 days: primarily used for one-time initial dosing.

Clinical Practice Guidelines Adopted

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

ACC/AHA 2005 Guideline Update for the Dx and Mgt. of Chronic Heart Failure in the Adult
<http://www.acc.org/qualityandscience/clinical/guidelines/failure/update/index.pdf>
American Academy of Neurology Practice Parameter: Evidence-Based Guidelines for Migraine Headache (an Evidence-Based Review)
<http://www.neurology.org/cgi/reprint/55/6/754.pdf>

AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update
<http://circ.ahajournals.org/cgi/content/full/113/19/2363>

2008 Pediatric Immunization Schedules and Childhood, Adolescent and Catch-up Schedule
<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>

AHA/ASA Guidelines: Guidelines for the Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack
<http://stroke.ahajournals.org/cgi/content/full/37/2/577>

ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina/Non–ST-Elevation Myocardial Infarction
<http://www.cardiosource.com/guidelinefocus/gfc_acs.asp>

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.

ADMINISTRATIVE

No Vaccines? – Remember your local health department

BCBST understands that not all providers maintain an inventory of, or administer vaccines such as Typhoid, Meningitis, Zostavax and Pneumonia in the office. As a reminder, patients needing vaccinations unavailable to them in your office should be referred to the local health department for these services.

Reminder: Submitting claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

DMEPOS claims must be billed on a CMS-1500 claim form using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers, i.e., NU, RR, and UE are required if published on the DMEPOS fee schedule. Fee schedules can be viewed online on Cigna's Web site under Coverage & Pricing at <http://www.cignagovernmentservices.com/partb/index.html>.

Some common supplies requiring pricing modifiers are blood glucose test strips and continuous positive airway pressure (CPAP) supplies. Pricing modifiers should be entered in the first modifier position in Block 24D and descriptive modifiers required by Medicare should be entered in the second and subsequent modifier fields. Claims filed without appropriate modifiers will be returned to the provider resulting in claims payment delays.

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ADMINISTRATIVE (cont'd)

BCBST adds new physician specialty*

BCBST now recognizes Hospital Medicine as a new BCBST approved specialty. In an effort to better direct BCBST members for health care, we will reflect this new specialty in our participating provider directory. Hospitalists, which are currently listed under Internal Medicine and new practitioners requesting hospitalist participation, will be listed under Hospital Medicine as their primary specialty.

Reminder: Health care debit cards

The number of Blue Cross and/or Blue Shield members carrying health care debit cards has substantially increased since their inception in 2005. These unique ID cards have value-added features to assist providers in collecting member cost-sharing amounts.

Some debit cards have the nationally recognized Blue Cross and/or Blue Shield logos, along with a major debit card logo such as MasterCard® or Visa®.

At the time services are rendered, the card should be debited for no more than the member copayment. If that amount is unknown, providers should **not** debit the card until the Remittance Advice is received reflecting member liability.

Reminder: Accessing physician quality and cost information

As previously communicated, the Physician Quality and Cost Information will be available for physician[1] review June 30, 2008. Prior to the release, physicians should have a BlueAccess user ID and password to access their quality and cost information.

First-time users can register by logging on to www.bcbst.com and clicking on "register now" in the BlueAccess section. Select "Provider" and follow registration instructions available at https://www.bcbst.com/secure/providers/.

YOU WILL NEED TO "REQUEST A SHARED SECRET"[2] FOR ALL PROVIDER ID NUMBERS THAT YOU NEED TO ACCESS.

After you have completed the registration process, you will be able to access the "Physician Quality and Cost Information link" on the main menu of BlueAccess.

For more information on BlueAccess registration, contact eBusiness Solutions at (423) 535-5717 or e-mail ecomm_marketing@bcbst.com.

[1] Hospital-based physicians and physicians who are in a specialty that is not board-eligible are excluded.
[2] A "Shared Secret" is required. Your staff may already have your "Shared Secret".

Reminder: Duplicate claims mean delays

What should you do if you haven't received a response to your initial claim submission?

- Don't automatically submit another claim
- Do wait 30 days
- Do check claims status online before re-submitting

Before you resubmit a claim because you haven't received your payment or a response regarding your payment, think again!

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.

If you resubmit a claim within 30 days, BlueCross BlueShield of Tennessee may deny the claim as a duplicate or suspend the claim for investigation. The member may also be confused and dissatisfied if they have to call customer service regarding a second Explanation of Benefits (EOB). After you have ensured all the necessary information is accurate, including the member's complete identification number, (which incorporates the three-character alpha prefix); we suggest that you wait at least 30 days before resubmitting a claim.

The next time you do not receive your payment or a response regarding your payment, please contact BlueCross BlueShield of Tennessee or visit our Web site, www.bcbst.com to check on the status of your claim, or submit electronic claims status inquiries.

If you have any questions, please call 1-800-705-0391.

~Claims filing tips~

In an effort to help alleviate some of the more common billing errors, we offer the following tips when filing claims for BCBST members:

- **Outlier and Threshold claims** require an occurrence **code** of **47** and the date the claim moved into this status.
- **Therapy claims** require a modifier if the services rendered are under a plan of care.
- When making a **correction** to a previously submitted CMS 1500 claim form, you must include all prior reimbursed line items plus the changes to be made in order to avoid a refund request on previously submitted charges.
- When **adjusting** a previously submitted **facility claim,** use the applicable bill type:
  XX7=Adjustment
  XX8=Cancel

Billing guidelines are outlined in the Billing and Reimbursement section of the *BCBST Provider Administration Manual* found on the Provider page on the company Web site, www.bcbst.com .

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ADMINISTRATIVE (cont'd)

Reminder: Check your electronic confirmation report

If you file electronic claims to BlueCross BlueShield of Tennessee, please remember to review your EM735 Confirmation Report for errors. Providers should correct any errors identified on this report and resubmit the claims to us in order to ensure prompt payment.

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

ADMINISTRATIVE

Reminder: Risk adjustment medical record authentication

For purposes of risk adjustment data submission and validation, Medicare Advantage Organizations, such as BlueCross BlueShield of Tennessee, are required to ensure that the provider of service for face-to-face encounters is appropriately identified on the medical records via his/her signature and physician specialty credentials. All dates of service identified for review must be signed (with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner). This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider.

Acceptable physician authentication includes handwritten signatures or initials, signature stamps, and electronic signature with authentication by the respective provider. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note.

For additional information related to Risk Adjustment visit the Centers for Medicare and Medicaid Web site <http://mcoservice.com/new/usergroup/traininginfo.html>.

For additional information related to Practice Site Standards/Medical Record Practices visit the Credentialing section of the BCBST Provider Administration Manual located online at http://www.bcbst.com/providers/manuals/.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Use of dedicated fax number helps expedite standard appeals

BlueCare/TennCare*Select* recently added a dedicated toll-free fax number, 1-888-357-1916 solely for use in faxing standard appeals for denied services. This enhanced process will help expedite standard appeals and ensure the most current information is available to providers when checking the status of an 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 being appealed.

Reminder: LabOne no longer exclusively providing routine outpatient laboratory services

Effective March 1, 2008, providers may utilize any BlueCare/TennCare*Select* participating independent lab. Previously, LabOne exclusively provided routine outpatient laboratory services to BlueCare/TennCare*Select* members. Lab services provided by participating labs do not require prior authorization; however, authorization is required when services are provided by non-participating labs.

New name of TennCare*Select*'s Best Practice Network (BPN) Unit

Volunteer State Health Plan's BPN Unit, which provides assistance for children in custody of the Department of Children's Services, is changing its name to *Select*Kids.

Only the name is changing; the services provided by the *Select*Kids Unit will not change. Providers may verify eligibility by calling 1-800-451-9147, Monday through Friday, 8 a.m. to 6 p.m. (ET).

Reminder: Healthcare Effectiveness Data and Information Set (HEDIS®) global procedure code information letter

In a letter dated May 1, 2008, we advised the Amended and Restated Contractor Risk Agreement between the State of Tennessee and Volunteer State Health, Inc., (VSHP) requires VSHP to report HEDIS® performance measures developed by the National Committee for Quality Assurance (NCQA) annually for its BlueCare and TennCare*Select* populations. Performance measures that require medical record review in order to obtain required report data include prenatal/postpartum care.

Beginning June 1, 2008, global codes will not be considered for reimbursement unless the Category II codes have been submitted prior to receipt of the global code or the global code is accompanied by one of the Category II codes. Reimbursement of global obstetric delivery services may be recouped unless the postpartum care visits (0503F) are submitted within 21 to 56 days of delivery.

CPT® Codes and Descriptions

59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care.

59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care.

BlueCare/TennCare*Select*

ADMINISTRATIVE (cont'd)

Reminder: Healthcare Effectiveness Data and Information Set (HEDIS®) global procedure code information letter (cont'd)

59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.

59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

Category II Codes and Descriptions

0500F - Initial prenatal care visit.

0501F - Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum: blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period – LMP.

0502F - Subsequent prenatal care visit.

0503F – Postpartum care visit.

Current Procedural Terminology (CPT®) contains a set of supplemental tracking codes (Category II) that can be used for performance measures in patient management. These codes can be used for performance measurement purposes in lieu of sending medical records or scheduling an onsite medical record review.

Typically, the clinical component of these Category II codes may be included in the evaluation and management, or other clinical service codes, and does not have a relative value. The entire code description can be viewed in the *2008 CPT® Manual*. Providers should refer to the *CPT® Manual* and other CPT® coding resources for additional guidelines in effect for the date of service.

If you have any questions, please call the appropriate BlueCare or TennCare*Select* toll-free Provider Service line†.

BlueCard®

ADMINISTRATIVE

New BlueCard Web page up and running*

Visit our new BlueCard Web page located on the company Web site, www.bcbst.com. There you will find printable brochures, BlueCard tutorials, program description and much more. Watch for more information being added in the near future.

Reminder: How to identify BlueCard out-of-area plan members

There's an easy way to identify out-of-area members through BlueCard. When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

Each BlueCard member's identification number on the card may contain alphanumeric characters but will always begin with at least three alpha characters. The alpha prefix is key to facilitating prompt payments. The member ID is a combination of alpha and numeric characters.

Once you find the alpha prefix, you should call BlueCard *Eligibility®* at 1-800-676.BLUE (2583) to verify the patient's membership and coverage (*for faster processing, use electronic capabilities.)* Provide the member's alpha prefix and you will be routed to the member's Blue Plan.

In addition, the ID cards may have logos that appear on the front of Blue Plan member ID cards:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

When you see these logos, it means that the cardholder participates in the BlueCard Program, which provides health care coverage for members outside their Blue Plan's area.

When either the blank suitcase or "PPO in a suitcase" logo appears on a Blue Plan member ID card, you should submit claims to BlueCross BlueShield of Tennessee.

Note: You may also see ID cards without a suitcase logo from other Blue National Account Members; you should submit all Blue claims to BlueCross BlueShield of Tennessee. For more information, please call 1-800-705-0391.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses"

Commercial Lines; Cover Tennessee; 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 "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 3Q 2008 provider administration manual update. Until then, please use this communication to update your provider administration manuals.

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