

March 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 April 11, 2008

- Genetic Testing for Warfarin Dose
- Intrauterine Laser Ablation of Placental Vessels for Twin-to-Twin Transfusion Syndrome (TTTS)
- Genetic Testing for BRCA1 and BRCA2 for Breast Cancer

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

New drugs added to commercial specialty pharmacy listing

Effective Dec. 12, 2007, the following drugs have been added to our specialty pharmacy listing. Those requiring prior approval are identified by a (PA).

Provider-administered via medical benefit

- Reclast
- Torisel
- Xolair (PA) – (Previously listed on specialty pharmacy listing as *self-administered*. Effective Oct. 1, 2007, moved to *provider-administered*.)

ADMINISTRATIVE

Electronic funds transfer (EFT)

Providing safe, secure and cost-effective payments

EFT provides a method of transferring payments automatically from BCBST's account directly to your bank by electronic means without any paper money changing hands. EFT is available for all BCBST lines

of business including BlueCare, TennCareSelect, BlueCard, Federal Employee Program (FEP) and Preferred Dental.

The growing popularity of EFT for online bill payment is paving the way for a paperless universe where stamps, checks, and paper bills are obsolete. Sign up today for EFT and enjoy benefits such as:

- Increased efficiency
- More secure payment process – less chance for check misplacement
- Earlier receipt of payments than when mailed
- Reduced administrative costs
- Simplified bookkeeping – less paper

In order to participate in the EFT process, providers must complete the **EFT Enrollment Form** and return it along with a voided check to:

BlueCross BlueShield of Tennessee
Attn: Provider Network Mgmt – 3TC
801 Pine Street
Chattanooga, Tennessee 37402

The EFT Enrollment Form and Frequently Asked Questions (FAQs) containing important information about the EFT process can be found on the Provider page of the company Web site, www.bcbst.com. To access the form and FAQs, choose "Administration" and click on the "Forms" tab.

Billing units for MRI/MRA contrast materials*

HCPCS codes A9576, A9577, A9578, and A9579 became effective Jan. 1, 2008.

Based on the code descriptions, 1 unit of the code is equivalent to 1 milliliter (ml) of the contrast material.

Code A9579, a '*not otherwise specified*' code, will require the contrast name, a valid NDC number, and the appropriate number of units billed in accordance with the code description to determine correct

reimbursement. Contrast material(s) billed with these codes is considered separately only with those MRI/MRA procedure codes containing the phrase "*without contrast material, followed by contrast material(s) and further sequences*".

Health care fraud

More damaging than you imagine

According to the National Health Care Anti-Fraud Association, health care fraud accounts for at least three percent of total health care spending, resulting in over \$60 billion in losses in 2005.

Health care fraud is intentional, unlawful and sometimes repetitive deception for the purpose of gaining unauthorized benefits, financial or otherwise.

Perhaps you have heard about multi-state fraud rings that devise schemes to defraud patients and insurance companies, or the increasing number of medical ID thefts. These high-profile cases command our attention but are dwarfed by more common examples that happen every day. Some of these include:

- deliberately submitting or filing false claims;
- billing for services not rendered;
- purposely misrepresenting a condition or the types of services provided;
- intentionally omitting information about a condition, symptoms or services received; and
- patients utilizing false IDs.

Fraud damages the credibility of our health care system, eroding trust among patients, doctors, hospitals and insurance companies.

Providers can report possible health care fraud anonymously by calling our 24-hour confidential hotline, 1-800-496-9600 or by completing the form found under the "**fight fraud**" tab located on the Home page of our company Web site, www.bcbst.com.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

ADMINISTRATIVE

Requesting benefits for nuclear stress testing

When requesting benefits for nuclear stress tests, please have the procedure code available and/or indicate if the service is considered routine or non-routine (advanced radiological imaging). Because benefits for nuclear stress testing vary based on whether the service is routine or non-routine, having the specific procedure code will assist our Customer Service staff in providing more accurate benefits information. If you do not have the procedure code available, please request benefits for both routine and non-routine.

Billing for compound drugs

Per Centers for Medicare & Medicaid Services (CMS) guidelines, when using compounded drugs, providers must bill with either J3490 (unclassified drug) or J9999 (not otherwise classified anti-neoplastic drug) as appropriate to the situation. Providers should **not** use a specific HCPCS code when billing for compounded drugs.

When billing for compound drugs with miscellaneous codes, the following is required for appropriate reimbursement:

- Name of the drug component(s)
- Valid NDC number for component(s)
- Specific dosage of each component administered in unit of weight (i.e. milligrams) rather than volume (i.e. cubic centimeters)

Reporting modifier 25 appropriately*

Under certain circumstances, the physician may need to indicate that a significant and separately identifiable evaluation and management (E&M) service was performed beyond the usual pre-procedure, intra-

procedure, and post-procedure physician work; or beyond the normal components of another E&M service (e. g., preventive medicine service, anticoagulation management service, osteopathic manipulative treatment, chiropractic manipulative treatment, ophthalmological evaluation service) requiring significant additional work. The E&M service may or may not require a different diagnosis.

Correct Reporting of Modifier 25 includes, but is not limited to the following:

- There is documentation of a significant, separately identifiable E&M service which must contain the required number of key elements (history, examination, and medical decision making) for the E&M service reported
- The E&M service is provided beyond usual preoperative, intraoperative, or postoperative care associated with a procedure performed on the same day
- A symptom or procedure presents that prompts the E/M service (may not require a separate diagnosis)
- An initial hospital visit, an initial inpatient consultation, and a hospital discharge service is billed for the same date of service as an inpatient dialysis service
- Critical care codes are billed within a global surgical period
- A Medically Necessary visit is performed on the same day as routine foot care

Inappropriate Reporting of Modifier 25 includes, but is not limited to the following:

- E&M service that resulted in decision for surgery
- Ventilation management in addition to E&M service
- Use on surgical codes
- Use on same day of minor procedure

- Use within global surgical period (pre- or postoperative care)

Use of Modifier 25 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement. Documentation for the E&M service must be able to stand alone.

For more information, please refer to the Current Procedural Terminology (CPT®) Manual.

BlueCare/TennCareSelect

ADMINISTRATIVE

Completing “patient relationship information” claim fields appropriately

Effective for dates of service on or after April 1, 2008, all BlueCare and TennCareSelect claims submitted on paper CMS-1500 and CMS-1450 Health Insurance Claim forms or submitted electronically in the ANSI-837 version 4010A1 format without the correct insured and patient relationship information will be returned to the provider unprocessed. The required data form content and field description format for completing these fields can be viewed in the Billing and Reimbursement section of the *BlueCare Provider Administration Manual* available on the Provider page of the company Web site, www.bcbst.com or on BlueSource, BCBST’s quarterly provider information CD.

Additional reference sources include:

- *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version and*
- *National Uniform Billing Committee UB04 Data Specifications Manual*

To help avoid delays in payment, please have someone review your billing system to ensure that all required information is being submitted correctly.

BlueCare/TennCareSelect
ADMINISTRATIVE

Verifying eligibility for undocumented aliens*

Eligibility information for undocumented aliens will not be reflected on the Tennessee Anytime Web site. Providers should call TennCareSelect at 1-800-276-1978 to verify eligibility

Medical emergency services (inpatient and outpatient), along with maternity services are the only benefits available to the Undocumented Alien population. Maternity benefits consist of labor and delivery services only.

Reminder: filing dialysis claims appropriately

Effective April 1, 2008, BlueCare and TennCareSelect dialysis claims will be denied if the claim is filed with:

- condition code 71 billed with revenue code 084X and 085X, or
- revenue codes 0380, 0381, or 0382 are billed with value code 37, and no units are indicated.

We encourage providers to review the dialysis billing guidelines available in the *BlueCare Provider Administration Manual* located on the Provider page of the company Web site, www.bcbst.com and on the *BlueSource Provider Information CD*.

If you have questions, please call the appropriate BlueCare or TennCareSelect Provider Service line†.

BlueCare and TennCareSelect migrates to BCBST claims processing system

Beginning April 1, 2008, BlueCare and TennCareSelect will transition their claims processing system to the processing system used for BlueCross BlueShield of Tennessee commercial lines of business. This migration will modify the appearance of some reports providers receive, as they will more closely match documents generated

from our commercial processing system. Transitioning to one processing system for both our Medicaid and commercial business brings more uniformity for providers who service both populations. Some key changes resulting from this transition are outlined below:

Clinical Editor

Effective April 1, 2008, Clear Claim Connection, BlueCare and TennCareSelect's interactive online code auditing disclosure tool will be available for claims with dates of service prior to the April 1 date. Commercial Code Bundling (which will become Commercial and Medicaid Code Bundling) will be utilized for all claims submitted with dates of service April 1, 2008, and after. Bundling rationale can be found on the Provider page of the company Web site, www.bcbst.com.

Explanation of Capitation Detail (EOC) and Retro checks

Capitated providers will notice a layout modification on their monthly EOCs. During the system migration, providers may receive up to four EOCs and checks depending on their membership mix and any capitation retroactivity – one from each processing system for each line of business.

Interim Bills

Effective with date of service April 1, 2008, and after, front-end paperless edit modifications will require all BlueCare and TennCareSelect interim bills be billed in 30-day increments thus aligning the interim billing guidelines between our commercial and Medicaid lines of business. This modification will apply the following five additional paperless edits to BlueCare and TennCareSelect claims:

Code	Edit Description
150010	FACILITY TYPE CODE NOT ACCEPTED
150056	STMT ROM DT <> ADMIT DT - 1 ST INTERM
150057	TOB 113 FROM DT NOT >=ADM DT +29
150074	TOB 112/113 ACCOM DAYS NOT 30 OR >
150075	TOB 112/113 THRU DT NOT >=FROM DT+30

More information regarding paperless edits may be found in the E-Commerce section on our Web site, www.bcbst.com.

Negative Balances

Any negative balances which may be created from claim overpayment activity will appear in a similar format as the commercial line of business

New BlueCare and TennCareSelect Group Number

BlueCare and TennCareSelect member group numbers will change to **125000**. This new number will be reflected on member ID cards, EOCs, letters generated through our core processing system and when performing member-specific activities in BlueAccess, the secure area on our Web site, www.bcbst.com.

Primary Care Practitioner (PCP) Membership Listings

PCP Membership Listings will have slight formatting changes; however the overall content and layout will remain the same as current listings.

Remittance Advice Explanation Codes

Remittance advice explanation codes and descriptions will reflect those found on commercial remittance advices. These same codes and descriptions will also apply to online remittance advices, available in BlueAccess.

Remittance Advices (RA) Adjustments and Subrogation Claims

RAs and the adjustment summary page will be redesigned to have the same format as the commercial RA. Subrogated claims will also display on RAs in a similar format as commercial claims.

Third Party Liability (TPL) Claims Report

Formatting changes to the TPL Claims Report will continue to provide other insurance information for any BlueCare or TennCareSelect member whose claim was denied due to the existence of a primary carrier.

Web site

BlueAccess will continue to support eligibility and claims inquiry capability, as well as authorization submissions for BlueCare and TennCareSelect members. Additionally, providers will be able to access commercial, BlueCare and TennCareSelect information through a single BlueAccess entry point.

If you have questions about these changes, please call the appropriate BlueCare or TennCareSelect Provider Service line†.

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

ADMINISTRATIVE

Terms and Conditions Web finder now available

Any Blues Plan offering a private fee-for-service (PFFS) product must publish the Plan's *Terms and Conditions of Plan Payment* on its Web site.

In conjunction with the BlueCross BlueShield Association, all Blue Plans now have a "neighborhood" link allowing providers access to the appropriate Plan's document by entering the first three letters of the member's ID number.

Providers may view/utilize this tool on the BlueCross BlueShield of Tennessee Web site at <http://www.bcbst.com/providers/macheck.shtml>.

Correction: Code edit changes for oral supplements

In the November 2007 issues of BlueAlert we advised that claims filed to BlueCare and TennCareSelect for oral supplements with a "BO" modifier for members age 21 years and older will pend for retrospective claims review based on guidelines listed in the Medicaid and Standard TennCare Exclusion Rules. In the article, we inadvertently listed an incorrect code. The correct codes are:

- B4102
- B4149
- B4150
- B4152
- B4153
- B4154
- B4155

Additionally, B4100 will pend for retrospective claims review; however, it is not to be billed with "BO" modifier.

We apologize for any inconvenience this error may have caused.

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

ADMINISTRATIVE

Medical record documentation and proper ICD-9-CM coding

The Centers for Medicare & Medicaid Services (CMS) risk adjustment model relies on accurate ICD-9-CM diagnosis codes to prospectively reimburse Medicare Advantage Organizations, including BlueCross BlueShield of Tennessee, based on the health status of their enrolled beneficiaries.

To help ensure proper payment, providers should:

- conduct regular patient appointments while reporting the patient's conditions at a minimum of once per year;
- include documentation of all conditions treated or monitored at the time of the visit in support of the reported diagnoses codes;
- report ICD-9-CM diagnosis codes to the highest level of specificity and accuracy; and
- ensure documentation in medical records is accurate, legible, and authenticated by the respective provider.

Providers are required to report any erroneous data that has been submitted to the health plan. Identifying and correcting these errors can help ensure appropriate reimbursement. Using up-to-date superbills and coding tools may reduce errors and improve accuracy in coding to the highest level of specificity. More information on reporting errors is found in the *BCBST Provider Administration Manual* located on the Provider page on the company Web site, www.bcbst.com.

BlueCross BlueShield of Tennessee's Risk Adjustment department continually conducts medical record reviews to monitor and improve medical record documentation.

Providers may receive requests by the Risk Adjustment area for medical records with specific dates of service for review. Medical records can be mailed, faxed or retrieved

from the provider's office by a Risk Adjustment Nurse Coordinator.

Cover Tennessee

ADMINISTRATIVE

Front end claim edits being implemented for diagnostic and therapeutic radiopharmaceutical services

Effective April 1, 2008, BlueCross BlueShield of Tennessee will implement front end edits on Cover Tennessee claims for Revenue Codes 0343 (Diagnostic Radiopharmaceuticals) and 0344 (Therapeutic Radiopharmaceuticals). These services are not separately reimbursed under the Cover Tennessee Plans. No adjustments will be made on claims incurred prior to the April 1 effective date.

.....

†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
TennCareSelect 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 2Q 2008 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. ®Registered marks of the BlueCross BlueShield Association of Independent BlueCross BlueShield Plans CPT® is a registered trademark of the American Medical Association