

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL (cont'd)

Changes to commercial 2011 preferred drug listing (PDL) (cont'd)

- Humalog products (requires trial of Novolog products)
- Diabetic Testing Strips (Abbott and LifeScan products require trial of Bayer and Roche products)
- Tier 3 Angiotensin–Receptor Blockers (ARBs) (require trial of generic Angiotensin-Converting Enzyme (ACE), generic ARB, Benicar, Benicar HCT, Micardis, Micardis HCT)
- Sedative Hypnotics: Ambien, Ambien CR, Lunesta, Rozerem, Sonata (require trial and failure of both zaleplon and zolpidem)

Add/Change to quantity limit (QL) list:

- Vimpat: 3 x 50mg; 3 x 100mg/day
- buprenorphine (Subutex): 24mg/day; max 6 months therapy
- buprenorphine/naloxone (Suboxone): 24mg/day; max 6 months therapy
- Diabetic supplies: 200 qty/30 days; 900 qty/90 days
- Insulin-pens: 3 pks/30 days; 9 pks/90 days; vials: 30 mL/30 days; 90 mL/90 days

ADMINISTRATIVE

Changes to dialysis billing guidelines *

Effective Jan. 1, 2011, for all dialysis providers, BCBST will no longer accept the HCPCS Level II Code J0886 for Epoetin (EPO) alfa injection, 1000 units. The replacement code will be Q4081 for Epoetin alfa injection, 100 units. This billing guideline has been in affect for the Centers for Medicare & Medicaid Services (CMS) since 2007. HCPCS code J0886, will be denied for dialysis providers (see billing guidelines) when filed on and after Jan. 1, 2011.

Please be advised that all related authorization requests for EPO injections should utilize code Q4081 as well for proper claim adjudication.

Reminder: Filing ancillary claims appropriately

Ancillary claims, e.g., laboratory, radiology, anesthesia, must be filed with the same place of service as the associated facility claim. If the ancillary charges are filed as inpatient and the facility claim is filed as outpatient, the ancillary provider must file a corrected bill with an outpatient place of service for the claim to be considered for payment.

Hospital outpatient code bundling edits reinstated

Effective Jan. 1, 2011, hospital outpatient National Correct Coding Initiative (NCCI) code bundling edits will be reinstated for all commercial lines of business. Those code edits, temporarily discontinued last year, will result in recoveries of any overpaid dollars.

The recovery of such dollars will be communicated and managed per established Provider Audit processes. An overview of those processes can be found in the BCBST Provider Administration Manual located on the company website, www.bcbst.com.

Changes to readmission policy for VSHP *

Effective Jan.1, 2011, Volunteer State Health Plan will no longer authorize preventable, unplanned readmissions occurring to the same facility with like or related diagnosis within fourteen (14) days. This is a change from the VSHP previous thirty (30) days requirement for readmissions. Members that are readmitted under these circumstances are not eligible for two payments.

Exceptions to this policy include, but are not limited to the following:

- cancer diagnoses for chemotherapy,
- complications of pregnancy, or
- admissions for coronary artery bypass surgery following an admission for chest pain.

This policy applies for Cover Tennessee, BlueCare and TennCareSelect members effective Jan. 1, 2011, and was implemented Dec. 1, 2010, for commercial lines of business.

Note: The member can not be held liable for payment of services received when not authorized.

BlueCare/TennCareSelect

CLINICAL

Health literacy and cultural competency information 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 being conveyed is key.

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

The *Health Literacy and Cultural Competency Provider Tool Kit* is available on the Provider page on the company website, www.bcbst.com, under “Administration.” This tool kit provides health care professionals additional resources to better manage patients with diverse backgrounds.

Providers may also utilize **Quality Interactions**[®], an e-learning program that uses case-based instruction on cross-cultural health care and is accredited for up to 2.5 hours of CME, CEU or CCM credits. This training is also available at the same location on our website at no cost to BCBST providers. Click on the Quality Interactions link and follow the instructions for registration.

BlueCare/TennCareSelect
CLINICAL (cont'd)

Clinical advisory panel releases helpful guide

The SelectCommunity Clinical Advisory Panel recently released a handbook to assist providers working with persons with Intellectual Disabilities. The guide may be found on the company website at <http://www.bcbst.com/providers/bluecare-tenncaresselect/SelectCommunity/handbook_for_providers.pdf>.

BlueCare/TennCareSelect
ADMINISTRATIVE

Changes to transplant evaluation requirements*

Beginning Jan. 1, 2011, transplant evaluations will require notification. Notification requests may be submitted:

- via BlueAccess, BCBST's secure area on its websites, www.vshptn.com and www.bcbst.com,
- by facsimile to 1-423-535-1994, or
- by calling Transplant Case Management at 1-888-207-2421 prior to the service being rendered.

Transplants will continue to require prior authorization.

Reminder: TENNderCare Screenings

The importance of laboratory testing and immunizations

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.

The American Society for Clinical Laboratory Science has a website with

information and resources for you and your patients at www.ascls.org/labtesting/.

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.

Reminder: CareCentrix to provide DME services in member home

As communicated earlier, effective Nov. 1, 2010, CareCentrix will administer and manage all durable medical equipment (DME) and medical supply services used in the home by BlueCare and TennCareSelect members.

Please note the following:

- Applicable DME claims for dates of service Nov. 1, 2010, and after should be submitted to CareCentrix. Claims for equipment used in the home that was authorized by VSHP before Nov. 1, 2010, should be submitted to VSHP.
- This arrangement with CareCentrix only affects DME, specialty DME and medical supply providers.

Reminder: National Drug Code (NDC) claim filing requirements

The Deficit Reduction Act of 2005 requires providers to include the NDC of any drug(s) administered, along with the correct NDC and quantity qualifiers, quantity, and unit. This drug information is required on all claims even if BlueCare or TennCareSelect is a secondary or tertiary payer. The NDC number is not required for vaccines, inpatient services, or radiopharmaceuticals, unless the drug is billed separately from the procedure. Claims received on or after Jan. 1, 2011, that do not contain all of the required data elements for physician-administered drugs

will be considered non-compliant, and will be returned to the provider unprocessed. This applies to both professional and institutional claims.

Due to the sensitive placement of the data required on UB04 and CMS-1500 claim forms, we strongly encourage providers to avoid submitting handwritten claim forms. To avoid potential delays in payments, we suggest all claims containing physician-administered drugs be submitted electronically, or via typed UB04 or CMS-1500 claim forms. Please refer to the NDC billing guidelines on the company website www.vshptn.com.

Change to medical management hours of operation*

VSHP Medical Management recently changed its hours of operation for obtaining prior authorization for its BlueCare and TennCareSelect members. For physical and behavioral health prior authorization services call 1-888-423-0131 for BlueCare and 1-800-852-2683 for TennCareSelect, Monday through Friday, 8 a.m. to 6 p.m. (ET), 7 a.m. to 5 p.m. (CT), excluding holidays.

Update: National Correct Coding Initiative Edits

Under Health Care Reform, Medicaid plans are mandated to begin using the National Correct Coding Initiative edits (NCCI). In a letter dated Nov. 5, 2010, VSHP notified you we would edit all claims for dates of service as of Oct. 1, 2010 or later effective Dec. 1, 2010. **Under new legislative guidelines, VSHP will edit claims processed after Dec. 6, for dates of service Oct. 1, 2010 or later.**

These edits will integrate Facility and Professional claims and deny line items on the claims that fail the edit. These edits include Procedure-to-Procedure and Medically Unlikely Edits (MUEs). Procedure-to-Procedure edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural

BlueCare/TennCareSelect

ADMINISTRATIVE (cont'd)

Update: National Correct Coding Initiative Edits (cont'd)

Terminology (CPT®) codes that should not be reported together for a variety of reasons. MUEs are units-of-service edits that define for each HCPCS/CPT® code the number of units of service beyond which the reported number of units of service is unlikely to be correct. For example, there may not be claims for removal of more than one gallbladder.

NCCI edits are published on the Centers for Medicare & Medicaid (CMS) website, <http://www.cms.gov/MedicaidNCCICoding/>

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

ADMINISTRATIVE

Reminder: Changes to timely filing for private fee-for-service (PFFS)

As previously communicated in the August 2010 issue of BlueAlert, the Centers for Medicare & Medicaid Services (CMS) is updating timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. Claims with dates of service on or after Jan. 1, 2010, received later than one (1) calendar year beyond the date of service will be denied by Medicare and BlueCross BlueShield of Tennessee's BlueAdvantage PFFS plan. Please ensure your billing staff is aware of this important change.

This change does not affect BlueAdvantage Preferred Provider Organization (PPO) as those guidelines currently indicate claims must be submitted within three hundred sixty-five (365) days from the date of service.

For more detailed information on these timely filing requirements, visit the CMS website at http://www.cms.gov/prospmedicarefeesvc/pmtgen/downloads/Health_Reform_Timely_Filing_Provider_Notice.pdf

Reminder: Billing end stage renal disease (ESRD) 50/50 modifier appropriately

The Centers for Medicare & Medicaid Services (CMS) published a notification on March 23, 2010, validating the billing of ESRD 50/50 modifier. See document at <http://www.medicarefind.com/searchdetails/Transmittals/Attachments/R661OTN.pdf>

The payment of certain ESRD laboratory services performed by an independent laboratory is included in the composite rate calculation for ESRD facilities. When billing for Automated Multi-Channel Chemistry (AMCC) ESRD-related tests, laboratories must indicate which tests are included, or are not included within the ESRD facility composite rate.

To ensure proper reimbursement, the laboratory must include one of the following modifiers for each test:

- **Modifier "CD"** – part of the composite rate and is not separately billable;
- **Modifier "CE"** – a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity; or
- **Modifier "CF"** – not part of the composite rate and is separately billable.

AMCC ESRD-related laboratory test claims without the appropriate modifier will be denied as not separately billable.

Reminder: Screening colonoscopy coding expanded

In January 2010, BCBST expanded the configuration and code mapping for screening colonoscopy. The intent of this change was to more accurately identify screening colonoscopies and apply appropriate benefits. A *Description of Codes that Point to Screening Colonoscopy Benefits* flyer is available online at http://www.bcbst.com/providers/news/Screening_Colonoscopy_09-0041.pdf.

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†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)

BlueCare/TennCareSelect Medical Management Hours
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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BlueCross BlueShield of Tennessee offices will be closed Dec. 23 & 24, and Dec. 31, 2010 in observance of the Holiday Season

