BlueAlert
provider news flash

of Tennessee
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Please Route to all Providers & Office Staff

July 2010

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/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 Aug. 14, 2010

- Trastuzumab (Herceptin®)
- Collagenase Clostridium Histolyticum (Xiaflex™) for Dupuytren's
- Filgrastim (Neupogen®) Pegfilgrastim (Neulasta®)
- Sargramostim (Leukine®)
- Molecular Anatomic Pathology Testing
- Whole Body Dual X-Ray Absorptiometry (DEXA) to Determine Body Composition
- Cranial Orthosis for the Treatment of Plagiocephaly
- Hyperbaric Oxygen Pressurization Therapy (HBO2)

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

Modified utilization management guideline updates/changes

BCBST's website has been updated to reflect upcoming modifications to select Utilization Management guidelines. These modified guidelines can be viewed on the Utilization Management Web page at <http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm >.

Effective Aug. 25, 2010

The following as relates to Ambulatory Care:

- Sling Procedures, Male
- Uvulopalatopharyngoplasty (UPPP)

The following as relates to Home Care:

- Hyperemesis Gravidarum

The following as relates to Inpatient and Surgical Care:

- Liver Transplant

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

Behavioral health clinical practice guidelines adopted

BCBST has adopted the following guidelines as recommended best practice:

Updated Helping Patients Who Drink Too Much-A Clinician's Guide (NIAAA)
<http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>

Clinical Practice Guideline for Assessing and Managing the Suicidal Patient and Tipsheet

<https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_prac_guidelines/suicide.pdf>

<https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_prac_guidelines/prov_suic_tipsheet.pdf>.

American Psychiatric Association's (APA) Guidelines for Major Depressive Disorder
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx>

Practice Guideline for the Treatment of Patients with Eating Disorders Third Edition
<http://www.psychiatryonline.com/pracGuide/pracGuideTopic_12.aspx>

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CLINICAL (cont'd)

Adherence to drug therapy program begins July 11, 2010

Adherence to Drug Therapy is a new drug therapy monitoring program being launched on July 11 by BlueCross BlueShield of Tennessee's Pharmacy Management in cooperation with CVS Caremark, our pharmacy benefit manager. This program emphasizes medication management, helping ensure a member's appropriate adherence to his or her prescribed medication therapy. The program includes nine top disease states that affect many of our members:

Behavioral health	Heart failure
BPH	Osteoporosis
Diabetes	Parkinson's disease
High cholesterol	High blood pressure
Respiratory	

Program-specific triggers include:

1. Identifying patients who are new to a specific therapy and sending educational material and encouragement. Educational material is specific to the disease state and its common drugs.
2. Sending refill reminders to members. Although many pharmacies send reminders, our program will also target members taking a maintenance medication.
3. Monitoring for discontinuation after the first fill. If a member fails to refill a new medication for one of these disease states, and/or
4. Notifying the prescribing physician (usually by fax) if the member appears to discontinue a maintenance medication. There may be various reasons why a member stops taking medication, which happens frequently. To better serve the patient, the physician needs to be aware of the discontinuation. Stopping drug therapy can have significant health consequences. Patients are surveyed to determine reasons for not taking their medications and will assist in customizing our outreach to members.

Outcomes from this program will be reported to the groups.

If you have questions, please call the BlueCross BlueShield of Tennessee Provider Service line†.

New materials for Childhood Obesity toolkit coming soon

Prior to the 2010-2011 school year, new materials to combat childhood obesity and diabetes will be mailed to pediatricians and family practice physicians.

The new toolkit will be available in both English and Spanish and contains tip sheets, wall posters, physician reference materials, tracking sheets and brochures with educational information.

We are advocates for healthy choices as a part of every day life. Our hope is to support you in preventing future cases of diabetes by instilling healthy behaviors in America's youth today. The BlueCross and BlueShield Association was fortunate to share this vision with the following organizations, which were consulted in the development of the toolkit*:*

- The American Academy of Pediatrics (AAP)
- The American Diabetes Association (ADA)

The *Childhood Obesity and Diabetes* toolkit will be available on our company website, www.bcbst.com in coming months.

For more information on childhood obesity, please visit: http://www.cdc.gov/obesity/childhood**.**

ADMINISTRATIVE

Reminder: BCBST automates 2BC secondary claims processing

BCBST automates processing of secondary claims for members having two (2) BlueCross BlueShield of Tennessee health care benefit plans. For these members the remittance advice will reflect remark code ***Z2B,*** "this claim is being processed under your secondary coverage".

On an electronic remit, the remark code "MA18" will appear in either data element MOA03 or MIA05 to indicate the claim is being forwarded to the secondary plan.

If the member has coverage with **another** Blue plan (i.e. BlueCross BlueShield of Alabama) or Federal Employees Plan (FEP), the claim will be crossed-over manually. These codes will **not** appear when the secondary coverage is FEP or another Blue plan.

If Z2B or MA18 appears on the remit, it is not necessary for you to submit the secondary claim. In most cases, the secondary payment will be made the following week.

For more information, please call the eBusiness Service Center at 423-535-5717, 8 a.m. to 6:30 p.m. (ET).

Reminder: Always include reason you are refunding monies to BCBST

BCBST receives a high volume of refund checks daily; so it is always important for providers to include the reason they are refunding any monies to us. Two ways to help ensure the refund is applied appropriately and timely are:

1. Return a copy of the refund request letter along with the refunded amount; or
2. Complete and attach a copy of the BCBST overpayment information form located on the company website at <http://www.bcbst.com/providers/forms/OverpaymentInformationForm_gcb.pdf>.

Reminder: Wal-Mart associates receive new member ID cards

Effective Jan. 1, 2010, we reported that Wal-Mart associates had changed their Home Plan and were being issued new ID cards reflecting alpha prefix "**WMW**" as part of the member ID number.

Effective July 1, 2010, BCBST will no longer accept claims filed with the **old** alpha prefixes "**WLA**", **WMR**" or "**MRT**"

To ensure claims are processed correctly, verify the ID card at every visit and make sure your have the correct number on file.

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ADMINISTRATIVE

Reminder: Billing hospice services appropriately

Hospice services must be billed in accordance with BlueCross BlueShield of Tennessee billing guidelines to include but not limited to:

- Hospice claims must be billed on a CMS-1450/ANSI-837I.
- To facilitate claims administration, a separate line item must be billed for each date of service.
- Hospice Providers may bill with either Type of Bill (081X or 082X) in Form Locator 4 as long as the inpatient and outpatient services are on separate claims.
- The Statement From/Thru Dates must also correspond with the total days billed on the inpatient care.
- Hospice claims should be billed with the Hospice provider number and/or NPI referenced in the Network Attachment.
- For Continuous Home Care, RC 0652, one unit will equal 15 minutes. Continuous Home Care will not be reimbursed when less than 8 hours (32 units) and will be capped at 24 hours (96 units) per calendar day.
- Reimbursement allowable rate per unit will be rounded up to the second decimal amount (e.g. $8.7110 would reimburse at $8.72).

In all cases reimbursement for Hospice services is based on:

- Per diems allowed on a per day basis, not per visit;
- The lesser of total covered charges or maximum allowable Hospice Fee Schedule

Note: *Charges submitted for non-Covered Services are not eligible for meeting the per diem amount.*

BlueCare/TennCare*Select*

ADMINISTRATIVE

Bureau of TennCare implements new "plain language" initiative

The Bureau of TennCare has implemented a new initiative called "Plain Language." This is part of a national program encouraging health care providers to promote health literacy among their patients by ensuring they understand written and oral health information.

The *National Adult Literacy Survey* found that 66 percent of adults age 60 years and over have inadequate or marginal literacy skills. Many informed consent forms and medication package inserts are written at high school level or higher, while the average patient reading level is closer to 6th grade. In one study, out of 659 hospital patients, those with poor health literacy skills were five (5) times more likely to misinterpret their prescriptions than those who had adequate literacy skills. Most patients will not tell you they do not understand. Using plain language allows your patients to understand their treatment plan, know how to take their prescriptions properly, and better follow your instructions. For additional information on Health Literacy, please refer to the Department of Health and Human Services website at <http://www.hrsa.gov/publichealth/healthliteracy/>.

Patient Protection and Affordable Care Act (PPACA) hospice amendment for children

Effective immediately, children who elect to receive hospice care may also elect to continue to receive curative treatment for their terminal illness.

Section 2302 of the Patient Protection and Affordable Care Act (PPACA) amends Section 1905 (o) (1) of Title XIX of the Social Security Act and states that a "voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payment for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made". The provision applies only to children, including children who elected hospice care prior to the date of enactment; i.e., if the child entered hospice care in February 2010 but now wishes to receive concurrent treatment, the previous election to receive hospice services cannot be construed as a waiver of the right to receive curative services. **Note**: The rules continue to prohibit concurrent treatment for adults in Medicaid.

Reminder: BlueCare non-risk contract ends

On June 30, 2010, all claim processing activity ended for the BlueCare "non-risk" contract between the State of Tennessee and VSHP. After June 30, 2010, providers are reminded to remit any checks and/or requests for payment to the **Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243.**

Note: This does not apply to the current BlueCare or TennCare*Select* Networks. If you have any questions, please contact your Provider Network Manager.

Reminder: Civil penalties imposed for presenting false or fraudulent claims

Under the Deficit Reduction Act (DRA) of 2005, there are civil penalties for presenting false or fraudulent claims for payment or approval by the government. Providers receiving any federal funds are required to have policies and procedures in place addressing the DRA, False Claims Act, and what employees should do if they suspect fraud, waste, or abuse. The policies and procedures should include verbiage to address whistle blower's protection. You should also have training available for all of your staff to include this information.

As directed by the Bureau of TennCare, Provider Network Managers will be asking to view your policies and procedures, as well as training provided to your staff regarding the Deficit Reduction Act and False Claims Act. You may access BCBST training materials on the Provider page on our website, www.bcbst.com for use in training your staff, or your Network Manager can provide you with a copy. Please ensure your policies and procedures and training are easily accessible.

BlueCare/TennCare*Select*

ADMINISTRATIVE

CHOICES coming to East and West grand regions

Beginning Aug. 1, 2010, Volunteer State Health Plan (VSHP) is implementing CHOICES, the Bureau of TennCare's long-term care program, in the East and West Grand Regions. All East and West Tennessee residents participating in the State's existing Statewide Home and Community-Based Service (HCBS) Waiver for the Elderly and Disabled will be automatically transitioned into the CHOICES Program. TennCare's goal is to integrate the CHOICES benefits with the member's medical and behavioral health services which are administered by managed care organizations. Per TennCare, "Providing continuity of care for these individuals during the transition is our primary concern. We want to ensure that services currently delivered under the Statewide Waiver continue to be provided, without interruption, in CHOICES".

Individuals aged 65 and over and adults with physical disabilities, who qualify for Medicaid, require the level of care provided in a nursing facility, and who need long-term care, including nursing facility services, or HCBS such as personal care, homemaker services, or home delivered meals, are eligible to participate in CHOICES.

CHOICES will utilize an Electronic Visit Verification (EVV) System for tracking some of the HCBS services provided. The EVV monitors delivery of services and allows immediate action to occur so that members receive timely assistance. To learn more about the CHOICES program, visit the company websites, www.vshptn.com and www.bcbst.com, on the Provider page for Frequently Asked Questions regarding CHOICES, or on the Bureau of TennCare's website at www.tennessee.gov/tenncare/long-faq.html.

A list of services provided under the CHOICES program can be found on the State of Tennessee's website at <http://state.tn.us/comaging/waiver.html#SERVICES>.

BlueCard®

ADMINISTRATIVE

Reprocessing claims for UAW retirees

Effective April 1, 2010, some General Motors, Ford Motor Company and Chrysler Corporation (Auto) UAW retiree claims began being reprocessed due to retroactive membership updates.

Impacted are processing of claims for GM, Ford and Chrysler UAW retirees, surviving spouses and dependents who are part of the UAW Retiree Medical Benefit Trust (URMBT) group.

Retroactive retirements occur when the membership records are not updated until after the member's true retirement date. This process covers hospital, medical, surgical and hearing claims administered by Blue Cross Blue Shield of Michigan on behalf of UAW retirees of GM, Ford and Chrysler, including original claim submissions, adjusted claims, BlueCard and non-BlueCard claims.

If you have any questions or need additional information, please contact your Provider Network Manager.

Tips for submitting out-of-area Blue Plan member claims

To help ensure prompt and accurate processing, please make sure you have a copy of the patient's current member ID card for use in submitting claims.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will help ensure you have the most up-to-date information in your patient files.
- Make copies of the front and back of the member's ID card and pass this key information to your billing staff.
- Blue Plan member ID cards include a three-digit alpha prefix in the first three positions of the member ID number. This alpha prefix identifies the member's Blue Plan and is critical for eligibility/benefits verification and for claims processing. The alpha prefix may be followed by ***up to fourteen (14) additional characters of any combination of letters and numbers.***
- When filing the claim, always enter the identification number exactly as it appears on the member's card, including the alpha prefix. ***Do not add, omit or alter any characters***.

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

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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; CoverTN; CoverKids; AccessTN 1-800-924-7141

Operations –
Monday–Friday, 8 a.m. to 5:15 p.m. (ET)

Medical Management –
Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CHOICES	**1-800-782-2433**
SelectCommunity	**1-800-292-8196**

(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 Monday, July 5, 2010, in observance of the Fourth of July Holiday