November 2010

**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 Dec. 11, 2010**

- Ranibizumab
- Cabazitaxel
- Hematopoietic Stem Cell Transplantation in the Treatment of Germ Cell Tumors
- Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis
- Use of Common Genetic Variants to Predict Risk of Nonfamilial Breast Cancer
- Total Ankle Replacement
- Home Uterine Activity Monitoring (HUAM)
- Sacral Nerve Neuromodulation/Stimulation for Pelvic Floor Dysfunction

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

**New drugs added to commercial specialty pharmacy listing**

Effective Oct. 1, 2010, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by a (PA).

- **Provider-administered via medical benefit:**
  - Implanon
  - Ozurdex
  - Jevtana
  - Quetenza
  - Lumizyme

- **Self-administered via pharmacy benefit:***
  - Extavia
  - Samsca
  - Suclraid
  - Gilena (PA)

**Controlled substance prescribing**

BCBST recognizes the use of pharmacologic and non-pharmacologic modalities in the treatment of chronic pain are prescribed according to the judgment of the practitioner. However, it is expected there be evidence in the member’s medical record to support chronic controlled substance prescribing.

Network practitioners who engage in activities that violate the below listed recommendations for prescribing, administering, dispensing, monitoring, and/or documenting of controlled substances are subject to disciplinary review and/or action by BCBST that may result in termination from BCBST network and may be reported to HealthCare Integrity and Protection Data Bank (HIPDB) or other entities as mandated by law.

In accordance with the Model Policy for the Use of Controlled Substances for the Treatment of Pain, May 2004, BCBST recommends practitioners keep complete and accurate records to include:

- the medical history and physical examination;
- diagnostic, therapeutic and laboratory results;
- evaluations and consultations;
- treatment objectives;
- evidence of underlying pathology to support chronic controlled substance prescribing;
- use of/or contraindication of ongoing conservative treatment modalities;
- discussion of risks and benefits;
- informed consent and written pain contract between the patient and practitioner outlining patient responsibilities and consequences;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements;
- periodic reviews will include urine drug screens, pill counts and results from monitoring of the state controlled substance database; and
- records should remain current and be maintained in an accessible manner and readily available for review.

**Draft medical policies on company website**

The following medical policies have been reviewed and revised, and are now consistent with MedSolutions Guidelines. A draft of these policies can be viewed online under “Draft Medical Policies” at http://www.bcbst.com/providers/mpm.shtml:

- Computed Tomography Angiography for Coronary Artery Evaluation
- Computed Tomography Scanning for Lung Cancer Screening
- Computed Tomography for Virtual Colonoscopy
- Magnetic Resonance Imaging (MRI) of the Breast
- Positron Emission Tomography for Oncologic Applications

**Toolkit now available to help fight childhood obesity**

In the July issue of BlueAlert, BCBST announced a new good health toolkit would be available on our website in coming months. The Good Health Club Physician Information and Toolkit, which consists of materials to help combat childhood obesity and diabetes is now on the Provider page on our company website, www.bcbst.com. The toolkit, available in both English and Spanish contains tip sheets, wall posters, physician reference materials, tracking sheets and brochures for use in distributing to your patients.
BlueCross BlueShield of Tennessee, Inc.  
(BCBST) (Applies to all lines of business unless stated otherwise)

**ADMINISTRATIVE**

**Reminder: Flu season is here**

Flu season can begin as early as October and as late as May. However, in Tennessee, flu activity is typically worse in February and March.

Providers are reminded not all Blues health care plans cover influenza immunizations. Benefits can be verified by calling the appropriate BCBST or BlueCard Provider Service line†.

Each year the formulation of the “seasonal flu vaccine” is determined based on information from the World Health Organization (WHO) and the Centers for Disease Control (CDC). This vaccine contains different “strains” of flu expected to be active for that year. For the 2010-2011 flu season, the “regular” flu vaccine will contain the H1N1 strain so providers should continue to bill the “flu vaccine” codes normally billed for the seasonal flu vaccine.

The following influenza immunization guidelines for BlueCross BlueShield of Tennessee apply:

**Commercial**

- **Vaccine and administration**
  - Covered if offered under the member’s health care plan

- **FluMist® nasal spray** (recommended for healthy individuals ages 2-49)
  - Covered if offered under the member’s health care plan

**BlueCare or TennCareSelect**

- **Vaccine and administration**
  - Covered

**Note:** Providers who normally receive influenza vaccine through the Vaccine for Children (VFC) program may use their purchased supply and submit claims using a Modifier 32 to receive fee for service reimbursement only when the VFC supply is depleted or delayed.

- **FluMist® nasal spray** (recommended for healthy individuals ages 2-49)
  - Covered

  **Note:** FluMist® is available under the Vaccines for Children (VFC) Program for children ages 5 through 18 years.

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**When verifying benefits check member eligibility screen closely**

Some commercial group members have full coverage, but only carry dental and/or vision coverage on a dependent. When verifying eligibility via BlueAccess, BCBST’s secure area on its website, <www.bcbst.com>, providers may see an “N” beside a dependent’s name, however, this only means there is no medical coverage. Providers are encouraged to click on the dependent’s name to verify if other benefits, e.g., dental/vision information is available.

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**Changes to readmission guidelines for commercial lines of business**

Effective Dec. 1, 2010, BCBST will no longer authorize unplanned readmissions occurring within 14 days to the same facility with like or related diagnosis.

**Some examples of diagnoses that MAY NOT be authorized are:**

- Upper respiratory admissions, e.g., asthma, COPD, pneumonia;
- Complications from surgical procedures; and
- Abdominal pain.

**Some examples of diagnoses that MAY be authorized are:**

- Cancer diagnoses for chemotherapy;
- Complications of pregnancy; or
- Admissions for CABG following an admission for chest pain.

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

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**BlueCare/TennCareSelect**

**CLINICAL**

**New diabetes initiative helps close gaps in care**

Volunteer State Health Plan, Inc. (VSHP) has partnered with LabCorp in a new initiative for BlueCare and TennCareSelect members to use “Lab-In-An-Envelope”, an alternative approach to closing gaps in comprehensive diabetes care. Our goal is to work with providers to increase the rate of members receiving HbA1c and LDL-C testing.

Some providers may receive an onsite visit from our clinical team and receive an educational packet that includes member details you might find useful in treating your BlueCare and TennCareSelect patients who suffer from diabetes.

Please support this initiative by authorizing VSHP to send Lab-In-An-Envelope kits to your diabetes patients who show gaps in care. Providers may send individual or batch authorizations for identified members.

Upon receipt of your authorization, Lab-In-An-Envelope kits with easy-to-follow instructions will be mailed to diabetic members who have gaps in care for LDL-C and HbA1c testing. This is a dry spot testing kit that contains all the necessary collection supplies. The kit is then mailed back in a pre-paid envelope. Lab results will be faxed to your office to help in managing your patient’s care.

If you have any questions, please call VSHP’s Disease Management department at 1-888-416-3025, Monday through Friday, 9 a.m. to 6 p.m. (ET). The Lab-In-An-Envelope MD Fax Form may be found on our company website at <http://www.bcbst.com/providers/forms/>, or you may request a form from Disease Management.

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November 2010
Reminder: Lead screening required for TennCare children

Federal Medicaid regulations require all TennCare children aged twelve (12) and twenty-four (24) months have a capillary (finger or heel stick) blood test for lead screening. Additionally, the following guidelines apply:

- All children aged 36-72 months who have not previously undergone a blood test for lead screening should be tested.
- A lead risk assessment questionnaire should be completed at each well-child checkup on all children aged 6 - 72 months. This will help determine the child’s risk for lead exposure and identify any changes in the child’s environment that could increase his/her risk level.
- Lead screening is a component of TENNderCARE examinations, and screening results must be included in the medical record documentation.

Primary care providers may review detailed lead screening information via the company website, www.bcbs.com, or directly on the Tennessee Department of Health’s website at http://health.state.tn.us/lead/professionals.htm.

Our Elevated Blood Lead Management Program provides counseling and education to parents/caregivers and can assist with management and follow-up of members who have elevated blood lead levels (EBLLs). Providers are encouraged to call VSHP at 1-800-225-8698, or fax 423-535-7790 upon identifying members having EBLLs.

Reminder: VSHP contracts with CareCentrix for DME services provided in member’s home

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. CareCentrix will authorize and arrange for delivery of all DME and medical supply services provided in the member’s home.

Requirements for authorization of services performed when a member is receiving treatment in a physician’s office, the emergency room or in an inpatient setting will not change.

All requests for in-home DME services should be submitted to CareCentrix via one of the following methods:
- Phone 1-888-571-6022
- Fax 1-888-571-6018
- Web submission <https://www.carecentrixportal.com/ProviderPortal/>

Reminder: Filing facility claims appropriately

When filing the CMS-1450 (UB-04) facility claim form for services provided to CHOICES members the following information is required:

- NPI Number (to ensure correct provider reimbursement)
Annually, the Centers for Medicare & Medicaid Services (CMS) randomly select Medicare Advantage (MA) Organizations for risk adjustment data validation. Data validation audits occur after risk adjustment data has been collected and submitted, and payments are made to the organizations. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the data collection period, and ensuring the provider’s signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

Because accurate documentation and coding are critical to the risk adjustment process, BCBS is publishing a series of articles with feedback from medical record reviews on some of the more common conditions that are seen in the Medicare Advantage population.

Part 1 - Cardiology

CAD or ASCVD are general terms. Coding and medical record documentation should be as specific as possible including underlying causes, e.g., A Fib, Old MI, etc.

Myocardial Infarction (MI)

- A common documentation problem for MI is that the site of the infarction isn’t identified. For accurate code selection, the site of the infarction should also be documented.
- The 4th digit in the 410 category identifies the site of the acute MI as identified on the EKG.

Example:
- 410.0x Acute MI of anterolateral wall
- 410.1x Acute MI of other anterior wall
- 410.2x Acute MI of inferolateral wall – STEMI
- 410.3x Acute MI of inferoposterior wall – STEMI
- 410.7x Acute MI-NSTEMI

Old MI

- Documentation of an MI outside of the 8 week patient recovery period is coded to 412.

Example: Hx of MI in ’04
- Past MI diagnosed on EKG or other special investigation, but currently presenting no symptoms.
- This refers to symptoms related to the previous MI, not cardiac symptoms in general.
- Any condition documented to 412 but presenting with symptoms after 8 weeks from date of infarction is coded to 414.8 (Chronic Ischemic Heart Disease) if the documentation states that it is the lasting affect of the MI.

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