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- **Improved ePrescribing** makes filling prescriptions much easier for you and your patients. ePrescribe also features formulary information and allows authorized staff members to prescribe on a physician’s behalf.

- **Comprehensive medication lists** allow you to sort medications by various column headings and see how a medication was prescribed (ePrescribed, claimed, or portal entered).

- **Enhanced intra-practice communication** allows authorized clinicians within a practice view the patient list of another registered user. In addition, registered Shared Health users can securely exchange messages.

- **Customized patient information** allows you to group patients into priority categories and create a “favorite search” for the patient information you access most often.

- **Streamlined information resources** Clinical Xchange enables you to quickly prepare documents such as WellChild forms and immunization schedules.

- **Better immunization recordkeeping** Clinical Xchange lets you add immunizations to a patient’s CHR.

- **Improved claims data** allows you to see claim numbers assigned by payers, making it easy to look up records for adjustments, and sort claims data by procedure and diagnosis codes.

To learn more or to speak with a Shared Health representative, call 1-888-283-6691 or visit [www.sharedhealth.com](http://www.sharedhealth.com) today.

**Notice: Code bundling edits**

Effective Oct. 1, 2010, BCBST will only publish the code edit and source.

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**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](http://www.bcbst.com/providers/mpm.shtml).

**Effective Oct. 9, 2010**

- Sipuleucel-T (Provenge®)
- Capecitabine (Xeloda®)
- Bendamustine (Treanda®)
- Everolimus (Zortress®)
- Ablation Treatments for Barrett’s Esophagus
- Multi-gene Expression Assay for Predicting Recurrence in Colon Cancer

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

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**Administrative**

**Guidelines for use of locum tenens**

A “locum tenens” is a temporary practitioner who fills in for a practitioner on a short-term basis. A practitioner who is to be a permanent member of a practice or who performs services for over sixty (60) days does not meet the definitions of a “locum tenens” and must initiate contracting and credentialing with BCBST.

Any practitioner that has been denied credentials by BCBST and has not successfully appealed that denial can not serve as a locum tenens and treat BCBST members as an in-network provider or bill under an in-network provider’s number.

The BCBST locum tenens policy can be found in its entirety in both the BCBST and VSHP provider administration manuals located on the company websites, [www.bcbst.com](http://www.bcbst.com) and [www.vshptn.com](http://www.vshptn.com).

### Reminder: Protecting patient health identifiable information

Providers are reminded that patient health identifiable information (PHI) is protected under the Health Insurance Portability and Accountability (HIPAA) Act of 1996. As such, it is the provider and their staff’s responsibility to ensure that patient information is not compromised.

For example, when providing a patient with a copy of an explanation of benefits (EOB) that shows a patient’s copay, any documentation of payment history or patient financial responsibility, please ensure the document is being sent to the appropriate address and remember to secure other patient’s information, if applicable. More than one patient’s PHI is reflected on a number of documents, so always mark through or black out other patients’ information in order to protect the security and privacy of all your patients.

### Shared Health® customizable features for the way you operate

With the Shared Health Clinical Health Record (CHR), you get actionable, clinically relevant information at the point of care. And soon, you’ll gain the ability to prepare a wide variety of reports and other evaluation documents, giving you a complete, long-term view of how your practice operates. New features in Clinical Xchange include:

- **Problem List and Care Opportunities**
  - **Problem List** provides an at-a-glance view of a patient’s conditions based on data from a number of sources.
  - **Care Opportunities** delivers treatment and preventive care checklists based on patient data analysis.

- **Add-a-patient** lets you add patients via the “Add-a-patient” function.
Blue Cross and Blue Shield Association expands Blue Distinction program

The Blue Cross and Blue Shield Association (BCBSA) recently announced the expansion of its Blue Distinction designation program to include Blue Distinction Centers for Spine Surgery and Blue Distinction Centers for Knee and Hip Replacement. Blue Distinction designations are awarded to facilities that have demonstrated a commitment to quality care by meeting objective, evidence-based thresholds for clinical quality and safety developed with input from expert clinicians and leading professional organizations.

The Blue Distinction designation is awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery and transplants. The program is part of The Blues efforts to collaborate with physicians and medical facilities to improve the overall quality and safety of specialty care.

For a complete listing of Blue Distinction Centers for Spine Surgery and Blue Distinction Centers for Knee and Hip Replacement, or for more information on all designated Blue Distinction Centers, please go to www.bcbs.com/bluedistinction/ or call 1-800-810-BLUE.

Correct coding of bevacizumab (Avastin®) for intravitreal injection

Commercially distributed bevacizumab is supplied from the manufacturer in 400 mg and 100 mg vials with a concentration of 25 mg / mL. It is typically repackaged into single dose syringes with a concentration of 1.25 mg / 0.05 mL for intravitreal injection and must be prepared under sterile conditions by a compounding pharmacy prior to ocular use.

Any legend drug altered from its manufactured form for use by a specific patient is considered a compound. Since compounded medications do not have an NDC number, specific HCPCS Level II codes may not be used. Eligible compound drugs must be billed with the most appropriate HCPCS Level II unclassified/ not otherwise classified code.

Billing guidelines for compound drugs can be reviewed in the billing and reimbursement section of both the BCBST and VSHP provider administration manuals found online at www.bcbs.com

New look for the member provider directory

There is a new look to the members’ online Provider Directory located in the Member Section on the company website, bcbs.com. These changes were made to simplify the process for our members when searching for a provider within one of our provider networks. The Provider Directory located in the Provider Section on our website, www.bcbs.com has not changed and is the same directory that you have become familiar.

Reminder: Consumer Directed Health Care Plan (CDHC)

Providers continue to see more patients having a Consumer-Directed Health Care (CDHC) Plan. CDHC is a term used to describe new health care options designed to make consumers aware of the true costs of health care and to become more responsible for consumption of these

BlueCare/TennCareSelect

Neonatal care management program to be implemented*

Pending State of Tennessee approval, VSHP will partner with Alere® Women’s and Children’s Health Division to provide comprehensive neonatal care management services for premature and medically complex newborns admitted in NICUs and special care nurseries.

Slated to begin this Fall, Alere®’s neonatologists and experienced nurse care managers will coordinate services and assist parents and neonatal staff in meeting pre- and post-discharge needs of these newborns.

If you have any questions regarding this neonatal care management program, please call the appropriate Provider Service line†, or contact your Provider Network Manager.

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services.
The primary components under the CDHC plans are High Deductible Health Plans (HDHP) and financial options.

Key elements under an HDHP plan:

- Providers participating in the member’s assigned network may collect any applicable deductible, copayment and coinsurance amounts;
- Providers are reimbursed via Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), or Flexible Spending Account (FSA); and
- Members are issued a standard BCBST ID card;

Real Time Claims Adjudication (RTCA) provides many Tennessee practitioners the ability to determine member financial responsibility either prior to services or while the member is on-site. RTCA is used to gain an estimate of member financial responsibility.

We encourage providers to work with their patients in determining if the member financial responsibility can be paid after the claim has been submitted and adjudicated by BCBST.
BlueCare/TennCareSelect
ADMINISTRATION (cont’d)
Reminder: Access and availability guidelines

Contractually, VSHP shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

For Primary Care Provider or Physician Extender:
- Distance/Time between the practitioner and member in urban area: 20 miles or 30 minutes;
- Distance/Time between the practitioner and member in rural area: 30 miles or 30 minutes;
- Member Load: 2,500 or less for physician; 1,250 or less for physician extender;
- Appointment/Wait Times: Usual and customary practice not to exceed 3 weeks from date of Member’s request for regular appointments and 48 hours for urgent care; and
- Office Wait Times: Wait times should not exceed 45 minutes.

Note: Appointments for BlueCare and TennCareSelect members must reflect local practice, and be on the same basis as all other patients served by the practitioner.

Health Care Reform: National Correct Coding Initiative edits

Under Health Care Reform, Medicaid health care plans are mandated to begin using the National Correct Coding Initiative edits (NCCI). The Centers for Medicare & Medicaid (CMS) will determine the methodology, and have until Sept. 1 to notify states of the specific requirements. This legislation will go into effect on Oct. 1, 2010.

We will provide updates via our website, www.vshptn.com as we receive them. Please check the website frequently for updates.

Update: BlueCare “Non-risk” contract

Providers were recently notified that on June 30, 2010, all claims processing activity ended for the BlueCare “non-risk” contract between the State of Tennessee and VSHP affecting claims filed for dates of service July 1, 2002, through December 31, 2008. Additionally, providers were advised to remit any checks and/or requests for payment to the Bureau of TennCare.

Most recently, all claims processing activity for this non-risk contract has reverted back to VSHP. Please remit any recoupment checks, correspondence, or adjustment requests to VSHP.

Note: This does not apply to the TennCareSelect network. Please continue to send TennCareSelect claims to TennCareSelect. If you have questions, please contact your Provider Network Manager or call the BlueCare Provider Service line.

CoverKids
ADMINISTRATION
Missed appointments for CoverKids Members

There has been some confusion as to whether or not members with coverage under the CoverKids Program can be billed by providers when they miss their scheduled appointment. Federal regulations require that providers not bill CoverKids members when they fail to appear for their scheduled appointments.

In order to minimize these occurrences, we will work to educate CoverKids members and parents on the importance of keeping scheduled appointments and providing advance notice when they will be unable to keep an appointment. We appreciate your cooperation in this matter and your support of the CoverKids Program.

BlueAdvantage (BlueCross BlueShield of Tennessee’s Medicare Advantage Product)
ADMINISTRATIVE
Reminder: Risk Adjustment-Coding to the highest specificity

For risk adjustment purposes, the Centers for Medicare & Medicaid Services (CMS) utilizes ICD-9-CM diagnosis codes to support Hierarchical Condition Category (HCCs).

ICD-9-CM codes have three, four, or five digits. Diagnoses should be reported to the highest level of code available for that category. Reporting the highest level of specificity on a claim not only accurately reflects the patient’s condition, but may also additionally support the complexity level of your medical decision making in evaluation and management services.

Example 1:
Diabetes (250.62): The fourth digit designates manifestations or complications of diabetes such as neurological conditions, eye disorders, or diabetic ulcers. The fifth digit subclassification specifies type and controlled or uncontrolled. In this example, the fourth digit “6” specifies neurological complications, such as neuropathy or gastroparesis; and the fifth digit “2” is used for patients type II or unspecified type, uncontrolled, even if the patient requires insulin.

Example 2:
Acute myocardial infarction (410.72): The fourth digit designates subendocardial infarction and the fifth digit “2”, is a subsequent episode. All initial care for a new MI should have the fifth digit of “1”.

Documentation and coding resources:
American Health Information Management Association (AHIMA) www.ahima.org
American Academy of Professional Coders (AAPC) www.aapc.com
American Hospital Association (AHA) www.aha.org
Clarification: MedSolutions to provide prior authorization reviews for elective outpatient advanced imaging services

BCBST recently notified providers in a June 24, 2010, letter and reminded them via August BlueAlert that effective for dates of service Aug. 1, 2010, and after, MedSolutions, Inc., would be providing prior authorization reviews of elective outpatient advanced imaging services for BlueAdvantage PPO members. Providers are reminded this authorization requirement is only for BlueAdvantage PPO members and does not apply to BlueAdvantage Private Fee-for-Service (PFFS) members.

Neither BCBST nor MedSolutions, Inc. will provide prior authorization reviews of elective outpatient advanced imaging services for BlueAdvantage PFFS members. However, upon request, an Advance Determination can be done, but is not required.


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

ADMINISTRATIVE

Risk Adjustment: Medical record documentation requirements

For purposes of risk adjustment data submission and validation, Medicare Advantage organizations, such as BlueCross BlueShield of Tennessee are required by the Centers of Medicare & Medicaid Services (CMS) to ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials.

Acceptable physician signatures and credentials:

- Hand-written signature or initials, including credentials, i.e., Mary C. Smith, MD or MCS, MD;
- Electronic signature, including credentials-
  - Requires authentication by responsible provider (for example, but not limited to “Approved by”, “Signed by”, “Electronically signed by”); or
  - Must be password protected and used exclusively by the individual physician.

Unacceptable physician signatures and credentials

- Typed name (unless authenticated by the provider);
- Non-physician or non-physician extender (unless co-signed by acceptable physician); or
- Provider of services’ signature (unless name is linked to provider credentials or name on physician stationery).

BlueCard®

ADMINISTRATIVE

Access to out-of-area Blue members’ medical policy and prior authorization requirements soon available online*

Effective Oct. 1, 2010, you will easily be able to look up medical policy applicable to your out-of-area Blue patients, along with general prior authorization requirements, and contact information for initiating prior authorization.

To access medical policy and prior authorization requirements:

- Go to www.bcbst.com
- Log onto BlueAccess
- Click the BlueCard/FEP link
- Click on Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization
- Enter the patient’s three-letter alpha prefix

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You will be routed to the Home plan’s medical policy and/or prior authorization requirements. Once medical policy and/or prior authorization requirements are viewed, you will be reconnected to the local plan’s website.

We are always interested in your feedback and would be pleased to answer any questions you might have. Please contact us at 1-800-705-0391.

*These changes will be included in the appropriate 4Q 2010 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