BlueCross BlueShield of Tennessee, Inc. (BCBST) (Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. Full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the “Upcoming Medical Policies” link.

Effective May 14, 2011

- Eribulin Mesylate
- Botulinum Toxin
- Naltrexone (Vivitrol™)
- Hematopoietic Stem-Cell Transplantation for Miscellaneous Solid Tumors in Adults
- Manipulation of the Musculoskeletal System Under Anesthesia
- Deep Brain Stimulation
- Electrical Stimulation and Electromagnetic Therapy for the Treatment of Wounds/Ulcers
- Plasma Exchange
- Proteomics-based Testing for the Evaluation of Ovarian (Adnexal) Masses

Note: These effective dates also apply to BlueCare®/TennCareSelect pending State approval.

Clinical Practice Guidelines adopted

BlueCross BlueShield of Tennessee has adopted the following guidelines as recommended best practice references:

- ACC/AHA 2007 Guidelines for the Mgt. of Patients with Unstable Angina/Non-ST-Elevation MI
  <http://circ.ahajournals.org/cgi/reprint/116/7/e148>
- Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack. A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association
  <http://stroke.ahajournals.org/cgi/reprint/STR.0b013e3181f7d043v1>
- AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update
  <http://circ.ahajournals.org/cgi/content/full/113/19/2363>
  <http://circ.ahajournals.org/cgi/content/full/120/22/2271>
- The 7th Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
- Standards of Medical Care in Diabetes - 2011
  <http://care.diabetesjournals.org/content/34/Supplement_1/S11.full.pdf+html>
- Treatment of Patients with Eating Disorders, Third Edition
- Treatment of Patients with Major Depressive Disorder, Third Edition
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder

Hyperlinks to these guidelines are also available within the BlueCross BlueShield of Tennessee Health Care Practice Recommendations Manual, which can be viewed in its entirety on the company Web site at http://www.bcbst.com/providers/hcpr/.

Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Reminder: IV flush solutions not separately reimbursed

BlueCross BlueShield of Tennessee considers heparin, saline, and fluids utilized to mix, facilitate administration of primary medication therapy, flush or maintain intravenous access devices to be supplies included in professional infusion services or home infusion therapy (HIT) per diems.

Based on CPT® guidelines, “if performed to facilitate” an infusion or injection, the flush at conclusion, standard tubing, syringes and supplies are included in the service provided and “fluid used to administer the drug(s) is considered incidental”.

Historically, allowances for fluids used to facilitate administration, heparin and saline flushes were included in calculations for development of HIT per diem allowances.
Preconception counseling

When preconception counseling is provided, you will find the Centers for Disease Control and Prevention (CDC) is a rich source of information for men and women in their child bearing years. The CDC’s recommendations are considered evidence based and designed for optimal reproductive health outcomes for women and couples. The CDC provides resources for women with pre-existing conditions, and recommends a reproductive life plan to set personal goals about having (or not having) children. Access the CDC’s website at <http://www.cdc.gov/nchdddis/preconception/QandA_providers.htm>.

Additional information is available through the March of Dimes at http://www.marchofdimes.com/pregnancy/getready_indepth.html.

New crisis hotline announced

The Tennessee Department of Mental Health (TDMH) announced a new statewide phone number for mental health and substance use crisis services. Please visit their website at <http://news.tennesseeanytime.org/node/6719> for the announcement and complete information.

BILLING GUIDANCE FOR NECESSARY MEDICATION WASTAGE

When necessary to discard a portion of a single dose vial, documentation of time, date, drug name, dosage administered, amount wasted and route of administration in the medical record is expected.

Wastage amounts may be billed for medications only manufactured in single dose vials (SDV). The provider is responsible for using the most economical packaging to achieve the required dosage with the least amount of wastage necessary.

Bill the total amount of the discarded and administered medication on a single line with a “JW” modifier appended. The units are to be billed in accordance with the amount defined by the code description.

If a provider renders a non-covered service, or the member requests a non-covered service that is considered investigational or cosmetic, it is recommended the provider have the member complete the Acknowledgement of Financial Responsibility form for the cost of the services. This form will make the member aware the services will not be covered under their health benefit plan. The Acknowledgement of Financial Responsibility form can be found in the BCBST and VSHP Provider Administration Manuals located on the company website, www.bcbst.com or on the BlueSource Provider Information CD.

Valid member ID required for phone inquiries

When calling BlueCross BlueShield of Tennessee Provider Service for benefits, eligibility or claims information, you are asked to give a valid member identification number. This information is necessary for us to help you in the most efficient manner. Beginning April 12, you will no longer be able to access member information without a valid member ID.

Reminder: Accessing Physician Quality and Cost Reporting Program

The Physician Quality and Cost Information, including 2011 program updates, will soon be available for physician's review. Prior to the release, physicians should have a BlueAccess user ID and password to access their quality and cost information.

First-time users can register by logging on to www.bcbst.com and clicking on "Register Now!" in the BlueAccess section, selecting “Provider” and following registration instructions available at https://www.bcbst.com/secure/providers/. You will need to “request a shared secret” for all provider ID numbers that you need to access.
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**Administrative (cont’d)**

**Reminder: Accessing Physician Quality and Cost Reporting Program (cont’d)**

For more information or BlueAccess training, contact eBusiness Solutions at (423) 535-5717 or e-mail at ecomm_techsupport@bcbst.com

1 Hospital-based physicians excluded  
2 A “Shared Secret” is required. Your staff may already have your “Shared Secret”.

Note: At this time, this tool is not available for BlueCare, TennCareSelect, FEP or Cover Tennessee plans.

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**State of Tennessee public sector plan outpatient authorization requirements**

Effective Jan. 1, 2011, all outpatient invasive procedures require prior authorization. This does not apply to procedures performed in an office setting. The requirement applies to all State of Tennessee commercial members with member ID prefixes of STA, STT, STG and STL under Group # 80860.

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**BlueCare/TennCareSelect**

**Clinical**

**Reminder: Request for lead screening results**

Under the TennCare program, children receive a lead screening as part of their TENNderCARE exams. You may be contacted by phone or letter from Volunteer State Health Plan requesting lead screening results so we can follow up with members where appropriate.

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

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**BlueAdvantage®**

**Administrative**

**Reminder: Filing BlueAdvantage claims appropriately**

For BlueAdvantage members who have elected the Medicare hospice benefit, services that are not related to the member’s terminal diagnosis should be billed to the provider’s Intermediary or Medicare Administrative Contractor. Services that should be filed to your local BlueAdvantage Plan and not to the Intermediary or Medicare Administrative Contractor during a hospice election include non-Medicare covered services, such as routine dental, vision and hearing services.

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**Reminder: Guidelines for reopening, reconsideration and appeal of adverse determinations/denials**

**Reopening**

A Reopening is filed when a provider disagrees with a denial related to medical necessity. A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

There must be new material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.

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**Reminder: TennCare member appeal poster must be displayed**

The Bureau of TennCare requires the Member Appeal Poster be displayed in a visible location within provider offices in the event the member has a grievance with the managed care organization or the provider. The poster is available on the company website at http://www.bcbst.com/providers/forms/ and on the Bureau of TennCare’s website at <http://www.tn.gov/tenncare/forms/medical_appeal.pdf>.

Please be sure to display this poster in your office for BlueCare and TennCareSelect members.
Reminder: Guidelines for reopening, reconsideration and appeal of adverse determinations/denials (cont’d)

The following are guidelines for a reopening request:

- The request must be made in writing
- Must be clearly stated;
- Must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted).
- Timely submission of additional information (CMS 130.2)

For additional information on Guidelines for a Reopening go to The Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/manuals/downloads/mc86c13.pdf>

Reconsideration

Reconsiderations are filed when a provider disagrees with a denial related to coding or reimbursement.

The Inquiry/Reconsideration Level is the first step in the Provider Dispute Resolution Procedure.

A written request for a standard reconsideration of the denial must be submitted within sixty (60) calendar days from the date of the notice of the determination. If applicable, include all pertinent information including prior correspondence, medical records, and all documentation you wish to have considered in the final determination of the dispute.

Appeal

If dissatisfied with the outcome of the reconsideration review, providers can file an appeal request within 30 days of receipt of the reconsideration response.

The appeal request should state:

- The reason for the appeal
- Why the provider is dissatisfied with the reconsideration response
- Any additional information the provider would like considered in support of the appeal request

Guidelines for requesting a reconsideration or appeal are outlined in the Provider Dispute Resolution Procedure (PDRP).

The procedure and Provider Dispute Form are available in the BlueCross BlueShield of Tennessee Provider Administration Manual located on the BlueSource Provider Information CD and also on the Provider page of the company website, www.bcbst.com.

*These changes will be included in the appropriate 2Q 2011 provider administration manual update. Until then, please use this communication to update your provider administration manuals.*

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