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

CLINICAL  
Medical Policy updates/changes  
The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The 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 Oct. 20, 2011
- Small Bowel/Small Bowel-Liver/Multivisceral Transplantation

Effective Nov. 16, 2011
- Bariatric Surgery for Morbid Obesity

Effective Dec. 12, 2011
- Lipid Risk Factors in risk Assessment and Management of Cardiovascular Disease

Effective Jan. 8, 2012
- Breast Duct Endoscopy

Effective Jan. 14, 2012
- Pemetrexed
- Home Hyperalimentation (Total Parenteral/Enteral Nutrition)
- Platelet Rich Plasma as a Treatment for Wound Healing or Other Conditions
- Retinal Telescreening for Diabetic Retinopathy
- Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
- Fecal Calprotectin Testing
- Intracellular Micronutrient Analysis

Effective Feb. 22, 2012
- Corticotrophin Therapy
- Endovascular Stent Grafting for Treatment of Abdominal Aortic Aneurysm and Thoracic Aortic Aneurysm and Dissections

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:


(AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder (2007)  


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 website at http://www.bcbst.com/providers/hcpr/. Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

Changes to 2012 commercial drug formulary

The following drug changes are effective Jan. 1, 2012:

Drugs added to the formulary:
- Sumavel DosePro (Quantity Limit)

Drugs requiring prior authorization (PA):
- Xyrem

Drugs requiring step therapy (ST):
- Antara, Lipofen, Fenoglide, Tricor, Triglide, Trilipix: requires trial of fenofibrate or gemfibrozil
- Becosene AQ, Nasonex, Omnaris, Rhinocort Aqua, Nasacort AQ: requires trial of flunisolide, fluticasone, triamcinolone or Veramyst
- Lantus SoloSTAR: requires trial of Levmir pens
- Lunesta, Rozerem: requires trial of zolpidem, zolpidem ext-rel or zaleplon
- Tekturna, Tekturna HCT: requires trial of generic ACE, generic ACE combo, generic ARB, Azor, Benicar, Benicar HCT, Micards, Micardis HCT, Tribenzor or Twynsta
- Testim: requires trial of Androderm or Androgel

Drugs moving from 2nd tier to 3rd tier
- Lantus vials
- Noritate
- Tricor (ST)
- Trilipix (ST)
- Climara
- Cyclessa
- Nasacort AQ (ST)
- Xalatan
- Yaz

Drugs being excluded from formulary:
- Aciphex
- omeprazole/sodium bicarbonate (Zegerid)
- Oracea
- Provigil
- Veltin
- Ziana
BlueCross BlueShield of Tennessee, Inc. (BCBST)
(Appplies to all lines of business unless stated otherwise)

CLINICAL (Cont’d)

Reminder: Changes to prior authorization requirements for select procedures

As previously communicated, for dates of service Jan. 1, 2012, and after, prior authorization is required for commercial lines of business, including Cover Tennessee, for the following procedures in an inpatient or outpatient setting:

- Panniculectomy
- Varicose Veins (color photos required)
- Blepharoplasty (color photos required)
- Tonsillectomy and Adenoidectomy under age three (3)
- Tonsillectomy under age three (3)
- Bariatric Surgery
- Breast Surgery for Augmentation or Reduction
- 72-hour Ambulatory Glucose Monitoring
- Neurobehavioral Status Exam
- Destruction of Cutaneous Vascular Proliferative Lesions less than 10 sq. cm (laser technique)
- Gastrointestinal Tract Imaging
- Hysterectomy
- Spinal Surgery

Prior authorization is not required for outpatient procedures for TRH members.

ADMINISTRATIVE

Prenatal ultrasound payment policy change

In keeping with American Congress of Obstetricians and Gynecologists (ACOG) recommendations, BlueCross BlueShield of Tennessee and Volunteer State Health Plan are changing the number of approved prenatal ultrasounds. Effective Feb. 1, 2012, one routine prenatal ultrasound for fetal anatomic survey per member per pregnancy will be covered. This affects procedural codes 76801, 76805 and 76811.

Consistent with ACOG guidelines, additional prenatal ultrasounds for fetal and maternal evaluation or follow up of suspected abnormality require a medical diagnosis and will be paid only with the appropriate diagnosis. Current billing guidelines may be found in the BlueCross BlueShield of Tennessee Provider Administration Manual which is available on the company website www.bcbst.com/providers/manuals/, and in the Volunteer State Health Plan Provider Administration Manual available on the VSHP website, www.vshptn.com/providers/.

BlueCross focuses on improved quality care and service

The BlueCross BlueShield of Tennessee’s Quality Improvement Program (QIP) focuses on improving the quality and safety of clinical care and service received by its commercial, TennCare and Medicare Advantage members. As part of the QIP, BlueCross conducts member education and other activities to improve rates on clinical initiatives.

Despite efforts by BlueCross BlueShield of Tennessee and our network providers to increase screenings, several rates continue to be below the national benchmark. The following HEDIS® 2011 results show more emphasis is needed to increase rates for the following measures:

<table>
<thead>
<tr>
<th>Product</th>
<th>Retinal Eye</th>
<th>Mammogram</th>
<th>PAP Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare - East</td>
<td>46.13%</td>
<td>48.78%</td>
<td>66.05%</td>
</tr>
<tr>
<td>BlueCare - West</td>
<td>38.95%</td>
<td>45.19%</td>
<td>71.04%</td>
</tr>
<tr>
<td>TennCareSelect</td>
<td>52.85%</td>
<td>24.81%</td>
<td>37.97%</td>
</tr>
<tr>
<td>Commercial</td>
<td>50.55%</td>
<td>67.26%</td>
<td>76.55%</td>
</tr>
<tr>
<td>CoverTN</td>
<td>23.66%</td>
<td>55.47%</td>
<td>63.31%</td>
</tr>
<tr>
<td>AccessTN</td>
<td>39.41%</td>
<td>68.17%</td>
<td>66.46%</td>
</tr>
<tr>
<td>Medicare Advantage - PEFS (HSS84)</td>
<td>59.06%</td>
<td>72.43%</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicare Advantage - LPO</td>
<td>62.29%</td>
<td>78.4%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The Quality Improvement and Outreach Departments at BlueCross BlueShield of Tennessee continue to plan new initiatives to specifically promote these screenings. Health care providers, due to their direct patient contact, also play an essential role in actively encouraging patients to undergo appropriate screenings.

VSHP providers can help improve preventive screening rates for their BlueCare and TennCareSelect members by participating in VSHP-sponsored community health events featuring onsite screening clinics. Providers who offer screenings at these events are eligible for reimbursement at their contracted rates. Providers can also host an outreach event for their BlueCare and TennCareSelect patients at their practice location.

Reminder: New mandate requires hearing aid benefit for children

Recent legislation mandates coverage of up to $1,000 per hearing aid, per ear every three years for children under age 18. According to the mandate, "hearing aid" includes ear molds and services to select, fit and adjust the hearing aid. That means fittings are covered and included in the $1,000 limit. Any accessories, including batteries, cords and other assistive listening devices – such as FM systems – are excluded.

This benefit is effective for fully insured and non-ERISA self-funded groups upon new sale or renewal and for members with individual products on or after Jan. 1, 2012. Benefits are subject to deductible and coinsurance.

In order to process claims, providers will need to include the RT or LT (Right or Left) modifiers with the hearing aid codes. Hearing aid claims filed without one of these modifiers will be returned to providers.

Reminder: Continue to take action for ICD-10 readiness

Previously, we communicated about preparing for implementation of ICD-10. Although the implementation date, October 2013, seems far away, the necessary work that needs to be done prior to this date needs to happen now.

By now you should have an implementation plan and timeline of the potential impacts of
December 2011

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

ADMINISTRATIVE (Cont’d)

Reminder: Continue to take action for ICD-10 readiness (Cont’d)

the transition from ICD-9 to ICD-10. The ICD-10 implementation includes changes in the number of codes, number of characters per code, and increased code specificity. Key action items for you to consider:

- Reach out to your trading partners (clearinghouses, billing services, and other vendors) to determine their readiness
- Evaluate internal systems to determine need for upgrades and/or replacements
- Perform impact assessment to identify work flow, forms and business processes changes
- Prepare to train staff on any document changes and requirements
- Train coding and clinical staff that use ICD codes

BlueCross BlueShield of Tennessee will keep you informed as we move toward becoming ICD-10 compliant. For more information regarding ICD-10 implementation, please visit <http://www.bcbst.com/providers/ecommerce/ICD10FrequentlyAskedQuestions.pdf>

State of Tennessee member ID number

In January 2011, BlueCross BlueShield of Tennessee members covered under the State of Tennessee Public Sector plan (Group # 80860) had a change in how their member ID number was created. Every member was issued a new ID card in December 2010 reflecting this change.

This December, BlueCross will again issue all public sector members new ID cards containing the same new member ID number. All State of Tennessee Public Sector member claims filed after Dec. 31, 2011, must contain the new member ID number or the claim will be denied. Make sure you have a current copy of the new ID card. You will know it is the current card by the date (1/12) found in the bottom right hand corner on the back of the ID card (see picture below).

Drug prior authorization forms now available

Drugs requiring prior authorization can be requested by completing and faxing the forms that are available on the Provider page on bcbst.com: <http://www.bcbst.com/providers/pharmacy/Utilization_Management_Forms.shtml>

DRG threshold update *

Effective Jan. 1, 2012, DRG facilities will no longer be required to call in threshold reviews except on stays greater than eight (8) days. Discharge dates need to be called in or entered via the web on the day of discharge. If entered via the web, users can document in the same manner in which threshold reviews would normally have been entered. Transition of care nurses are available to assist with any discharge arrangements. Call 1-800-225-8698 for assistance with discharge arrangements or to initiate a referral to case management.

New maternity referral form available *

Effective immediately, the Global OB Form has been replaced with the new Maternity Care Management Notification Form. The new form may be used for three Managed Care Organizations including BlueCare/TennCareSelect and has been approved by the Bureau of TennCare. The form is located on the Provider page of the company website www.bcbst.com under forms. If you have any questions, please call JoAnne Foster, Member and Provider Clinical Education Consultant at (423) 535-7737.

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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Outpatient emergency room facility billing guidelines *

In keeping with current correct coding standards, effective Jan. 1, 2012, Volunteer State Health Plan (VSHP) will require all providers to file the most appropriate HCPCS code in accordance with the National Uniform Billing Guidelines on CMS-1450/ANSI 8371 facility claim forms for emergency room revenue code 450. When an outpatient emergency room facility claim is received without an appropriate HCPCS code, the claim will be rejected with reject reason code 150155 “PROC CD MISSING/REV CD 0450 PRESENT”. The provider must then submit a corrected claim that includes the appropriate HCPCS code. This guideline is applicable to outpatient facility claims.

New BlueCare/TennCareSelect supplemental edits

Effective Jan. 1, 2012, two additional supplemental edits will be added as listed below:

**8E0121 QUANTITY CANNOT BE < OR ≠ TO ZERO**
- Service Line Quantity cannot be less than or equal to zero.

**8E0129 COUNTRY CODE INVALID**
- Country Code (N404) is invalid (the N404 is a segment not a value)
- TennCare requires services to be provided in the United States
- This will apply to:
  - Billing, Pay-To and Service Facility Providers on Institutional claims
  - Billing, Pay-To, Service Facility, Service Facility Location and Ordering Providers on Professional Claims

Additional information may be found at [www.vshptn.com/providers/](http://www.vshptn.com/providers/)

If you have questions, please call the appropriate BlueCare or TennCareSelect Provider Service line.

New explanation code created for corrected bills

Effective Jan. 1, 2012, claims not filed according to corrected claim billing guidelines will be denied using EX WD1: *this service is not eligible since it was not filed according to the corrected billing guidelines; please submit a corrected claim.*

Prior to May 2008, these claims were denied EX TT: Possible Corrected Bill - additional information is needed and since then have been returned to the provider on the front-end with no EX code.

Corrected claim billing guidelines may be found in the VSHP Provider Administration Manual available online at [www.vshptn.com/providers/](http://www.vshptn.com/providers/).

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueCare/TennCareSelect Medical Management Hours
Monday-Friday, 8 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

December 2011

**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)

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)

**eBusiness Technical Support**
Phone: 423-535-5717
e-mail: ecom_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

BlueCross BlueShield of Tennessee offices will be closed
Dec. 23 & 26, 2011
and
Jan. 2, 2012
in observance of the Holiday Season

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