BlueCross BlueShield of Tennessee, Inc. (BCBST)  
(Appplies 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 June 11, 2011

- Minimally Invasive Coronary Artery Bypass Graft Surgery
- Cervical Traction Devices for Home Use
- Bariatric Surgery for Morbid Obesity
- Electrical Bone Growth Stimulation
- Ultrasound Accelerated Fracture Healing Device
- Radioembolization for Primary and Metastatic Tumors of the Liver

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

Non-preferred Angiotensin II Receptor Agonists (ARB) Step Therapy.

Several months ago, you were notified that members taking non-preferred ARBs and combination drugs will be placed on a Step Therapy process starting Jan. 1, 2011. However, members currently taking a non-preferred ARB were grandfathered until April 1, 2011, to give the prescriber an opportunity to evaluate alternative drug treatments.

We did not apply the step edit on April 1, 2011, for members who were grandfathered. Grandfathered members can continue their current medication with no disruption.

Any members who are a new start on an ARB will have to meet the Step Therapy requirements as outlined in the formulary booklet.

New codes established for ophthalmological services

Effective Jan. 1, 2011, AMA published three (3) new CPT® codes (92132, 92133 and 92134) for special ophthalmological services.

92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

The description for each of these codes includes the wording “unilateral or bilateral.” It is not appropriate billing to report these codes on multiple lines or with multiple units to indicate a bilateral procedure. The correct way to report these services, whether performed on one or both eyes, is with one (1) code and one (1) unit.

New drugs added to commercial specialty pharmacy listing

Effective April 1, 2011, the following drugs have been added to our commercial Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit: Krystexxa (PA) Gemzar Makena (PA) Xgeva (PA)

The drug Benlysta (PA) has been removed from self-administered specialty pharmacy products and added to our provider-administered specialty pharmacy products.

BCBST agreement with Progeny expands to self-funded groups

Beginning May 1, 2011, BlueCross BlueShield of Tennessee is pleased to announce that under our agreement with ProgenyHealth, benefits provided to fully insured members will also be available to self-funded groups.

ProgenyHealth is a company specializing in neonatal care management services throughout the first year of life. Under our agreement, ProgenyHealth’s Neonatologists, Pediatricians and Neonatal Nurse Care Managers will work closely with families, attending physicians and nurses to promote healthy outcomes for our fully insured members with premature and medically complex newborns.

For our hospitals, ProgenyHealth will serve as a liaison for BCBST, providing inpatient review services and assisting with the discharge planning process to ensure a smooth transition to the home setting.

If you have questions or need additional information, please contact Beverly West, Manager Condition Management at 423-535-3523, or e-mail Beverly_West@bcbst.com.
ICD-9-CM classifies neoplasms by system, organ, and/or site. But, the alphabetic index should first be checked to see if there is a specific code assigned to a morphological type, such as sarcoma, adenoma, or melanoma.

- If the reason for admission is determined to be a neoplasm, then the focus of the treatment can be utilized to select the correct code for the principal diagnosis. If treatment is directed at the primary neoplasm, then the malignancy is the principal diagnosis. If the reason for treatment is directed only at a secondary site, the metastatic site is the principal diagnosis and the primary site is the secondary diagnosis.
- An exception to the above is when the admission is ONLY for administration of radiotherapy, immunotherapy or chemotherapy during the admission, the malignancy is listed as the principal diagnosis or first-listed diagnosis with V-codes not being assigned.
- If a patient is admitted with a symptom, sign, or ill-defined condition associated with an existing primary or secondary site malignancy, the malignancy is the principal or first-listed diagnosis.
- When the reason for an admission is management of pain due to the neoplasm, the principal or first-listed diagnosis is 338.3 followed by the underlying neoplasm. When the admission is management of the neoplasm and pain is also documented as related to the neoplasm, code 338.3 can be submitted as a secondary diagnosis with the primary or first-listed diagnosis being the neoplasm.

**Note:** These guidelines are in accordance with the BCBST Institution Agreement and are referenced from Ingenix 2011 ICD-9-CM for Hospitals Coding Guidelines, Chapters 2 and 6 and The Coding Edge Archives. Contact your local Provider Network Manager for any questions concerning your provider contract.

**Reminder: Collection of member copayments**

A copayment is the amount a member pays each time he or she receives services at a participating provider’s office. Some member copayment amounts may be $0 on annual Well Visits. Member copayments vary based on the member’s health benefit plan. You can collect a copayment from the member at the time of the office visit, however, you may only collect the amount specified in the member’s health benefit plan.

You can verify the member copayment by calling our Provider Service line, 1-800-924-7141, Monday through Friday, 8 a.m. to 5:15 p.m. (ET). When you speak with a representative, please have available the member’s identification number that is reflected on the member ID card.

You can also obtain the member copayment amounts on BlueAccess, BCBST’s secure area on its website, www.bcbst.com. You will need a shared secret number to access this site. If you have not registered, just click “Register Now” and follow the easy instructions.

**Pathology and laboratory coding updates**

A new code, CPT® 80104, effective Jan. 1, 2011, was created to report a qualitative drug screen of multiple drug classes (other than chromatographic method). The description of CPT® 80104 is Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure. This new code was established to allay confusion when reporting qualitative analysis using a multiplexed method for 2-15 drugs or drug classes (e.g., multi-drug screening kit).

CPT® code 80104 represents a kit and is used once per kit. The language of the code says “each procedure” so it would be reported for each procedure that is used. It isn’t billed by drug or drug class but rather by procedure(s) used other than chromatography.

These test kits are commercially available for twelve (12) or more analytes, and are often called "multiplexed” because of the ability to qualitatively assay multiple drugs simultaneously. It is effectively running multiple tests at once, in a single procedure, due to the test kit design. In 2010, the HCPCS code G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay) was created to describe a non-chromatographic method wherein multiple drug classes were screened in a single procedure. The new 2011 CPT® code 80104 represents this same procedure, more accurately reflecting the resources used in a multiplex test kit as compared to multiple runs using a single class methodology. Medicare does not recognize 80104 but rather accepts G0431. CPT® 80104 would be used for commercial carriers. G0431 would be used for Medicare Advantage. Either should be billed with one unit per encounter. Additional information can be obtained at the CMS website, www.cms.gov/ or the AMA CPT® Assistant.
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ADMINISTRATIVE (cont’d)

Reminder: BCBST refund requests

For all BCBST provider networks, other than those supporting the TennCare Program, BlueCross’ request for reimbursement shall be made no later than eighteen (18) months after the paid date, except in the case of provider fraud, in which case no time limit shall apply. This is in accordance with Tennessee State Statute TCA 56-7-110.

Note: This policy does not apply for BlueCare or TennCareSelect.

Changes to Patient Protection and Affordable Care Act (PPACA)

With the recent passage of the Patient Protection and Affordable Care Act, commonly known as the Health Care Reform Act, there are some changes that address the topic of “Overpayments.” The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act (FERA).

This provision of the Health Care Reform Act applies to providers of services, suppliers, Medicaid Managed Care Organizations (MCOs), Medicare Advantage organizations, and Medicare Prescription Drug Program Sponsors. It does not apply to beneficiaries.

The provision directly links the retention of overpayments to false claim liability and makes explicit that overpayments must now be reported and returned to States within sixty (60) days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After sixty (60) days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including damages of three times the amount in penalties. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the Affordable Care Act.

Please follow the link to the State of Tennessee website for further materials on the issue. http://www.tn.gov/tenncare/

Note: This information applies to BlueCare, TennCareSelect and BlueAdvantage only.

Reminder: Screening colonoscopy is covered at 100 percent by most benefit plans*

Under the Affordable Care Act, preventive services with an A or B rating from the U.S. Preventive Services Task Force are covered with no member cost share. Colorectal cancer screening is one of the A or B rated items. Prior to the Affordable Care Act, many employer groups chose to cover colorectal cancer screenings with no member cost share, or minimal cost share such as a modest copay. However, some members in these groups complained that when presenting for a screening colonoscopy they received benefits for a diagnostic colonoscopy, often subject to deductible and coinsurance.

In 2010, code mapping was expanded for screening colonoscopy so that members obtaining colonoscopy procedures intended to be screenings will receive benefits for screenings.

For a description of codes that point to screening colonoscopy benefits see the Provider page on the company website at www.bcbst.com.

* May not apply to grandfathered plans as defined in the Affordable Care Act

BlueCare/TennCareSelect

CLINICAL

Smoking cessation support for pregnant women

TennCare and Volunteer State Health Plan have joined together to tackle the issue of smoking among pregnant women in Tennessee, and we need your help. As a health care provider, you are in the best position to assist in this endeavor. It could be as easy as asking two key questions: “Do you smoke?” and “Would you like to quit?”

Did you know that if a pregnant woman answers yes to those key questions, you can refer them the very same day for counseling through the Tennessee Tobacco QuitLine’s fax referral service? All that is required is for the provider and patient to complete the TN Tobacco QuitLine Fax Referral Service Enrollment Form that is found online at http://health.state.tn.us/tobaccoquitline.htm, then fax the completed referral form to 1-800-646-1103.

Many patients may not be aware of the consequences of smoking while pregnant. They may not know their baby may be at a greater risk for ear infections, asthma, bronchitis, sinus infections, colds and even learning disabilities if they continue to smoke. So, they may just need someone to point out these risks to them.

They may also be unaware of the resources available to them. For instance, did you know the Tennessee Tobacco QuitLine is a FREE program that will work with expecting mothers? The QuitLine will send you a status report of your enrolled patients to keep you informed of their progress.

The toll free number to the Tennessee Tobacco QuitLine is 1-800-QUIT-NOW (1-800-784-8669).

TennCare Specialty Pharmacy Master Clinical Drug List updated

Please note there have been updates to the TennCare Specialty Pharmacy Master Clinical Drug List, and an addition of Specialty Pharmacy Medication Requiring Prior Authorization on company websites, www.vshptn.com and www.bcbst.com on the BlueCare/TennCareSelect Provider page.
BlueCare/TennCareSelect
ADMINISTRATIVE

Hearing aid replacement batteries

Hearing aid replacement batteries are covered for BlueCare and TennCareSelect members under the age of 21. Audiologists should provide batteries to members as part of their covered services. If you have questions, please call the appropriate BlueCare or TennCareSelect Provider Service line.

Reminder: Behavioral health services

Behavioral health services are based on a fiscal year (July to June) and not the calendar year. Outpatient services that fall in the “by pass” category should be reviewed for the need for authorization. Please contact Provider Network Services if you have any questions.

VSHP contracts with CareCentrix for DME and medical supply services

Beginning Nov. 1, 2010, VSHP contracted with CareCentrix to authorize DME and Medical Supply services and arrange for delivery of the services through their network of credentialed and contracted DME and Medical Supply providers. All requests for services should be sent to CareCentrix. CareCentrix will require prior authorization for all durable medical equipment and medical supply services prescribed for BlueCare and TennCareSelect members, and for use in the member’s home.

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

BlueAdvantage
ADMINISTRATIVE

BlueAdvantage provider questions

Have questions? We have answers! No matter what is on your mind, don't hesitate to call our BlueAdvantage Provider Service team for help. When you need us, we're only a phone call away. You may reach us at 1-800-841-7434, Monday through Friday, 8 a.m. to 5 p.m. (ET).

Medicare home health face-to-face encounter

The Centers for Medicare and Medicaid Services (CMS) issued an update to the Home Health Prospective Payment System for 2011. One provision of interest is the face-to-face encounter. Under the new rule, a physician certifying a patient’s eligibility for Medicare’s home health benefit must have a face-to-face encounter with the patient prior to certification of the patient’s eligibility for home health services. As a condition of payment, documentation regarding the face-to-face encounter must be present starting April 1, 2011. The face-to-face encounter must occur within ninety (90) days prior to the start of home care or within thirty (30) days after the start of care.

Although this rule pertains to Medicare, it is optional for Medicare Advantage plans. As a Medicare Advantage plan, Blue Advantage will require the face-to-face encounter and will validate through random audits.

For more information on this rule, home health agencies can go online to www.cms.gov/center/hha.asp.

Cover Tennessee
ADMINISTRATIVE

Reminder: Refer patients to in-network providers

Patients with coverage through CoverKids or the HealthyTNBabies Programs must see providers participating in Blue Network S to receive benefits. Unless the visit is determined to be an emergency, there will be no benefits payable for services rendered by a provider who does not participate in Blue Network S. This includes pregnant women who see an in-network OB-GYN but deliver at an out-of-network facility. Therefore, we ask that you please refer these patients to providers and/or facilities participating in Blue Network S.

Overpayments for maternity services

A number of providers were recently made aware of overpayments made by BCBST for multiple office visits for maternity services that were provided to pregnant women for various lines of business, but primarily CoverKids. These overpayments were identified as a result of a recent claims audit. Although we are currently implementing system changes which should help identify possible overpayments before payment is made to the provider, we encourage providers to ensure they bill for these services according to BCBST and nationally accepted billing guidelines.

*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

**May 2011**