BlueAlert
provider news flash

of Tennessee
plans for better health. plans for a better life.™

Please Route to all Providers & Office Staff

August 2012

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 Sept. 9, 2012

- Minimally Invasive Procedures for Weight Loss
- Optical Coherence Tomography for Imaging of Coronary Arteries
- Photodynamic Therapy for Choroidal Neovascularization
- Vertebral Fracture Assessment with Densitometry

Effective Sept. 12, 2012

- Treatment of Congenital Port Wine Stains and Hemangiomas
- Bendamustine
- Panitumumab
- Rituximab

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

ADMINISTRATIVE

Reminder: Filing surgical equipment claims correctly

Providers are reminded that charges for any device or medical equipment used in conjunction with a surgical procedure must be billed by the facility. Separate claims submitted by a DME supplier for any charges related to the facility service will result in zero reimbursement, e.g., pneumatic compression devices. The member cannot be held liable in these cases, as reimbursement for DME is part of the all-inclusive global payment for inpatient and/or outpatient surgeries to contracted facilities.

Should a facility choose to partner with a DME supplier to provide equipment/ supplies associated with the facility services, the facility will be responsible for submitting all charges to BlueCross as well as payment to the DME supplier.

These guidelines are in accordance with the BlueCross BlueShield of Tennessee Institution Agreement. Contact your local Network Manager for any questions concerning your provider contract.

2012-2013 Reimbursement for FluMist® and Fluzone® Intradermal Influenza Vaccine

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 BlueCross BlueShield of Tennessee 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. In order to allow providers to prepare for the upcoming 2012-2013 flu season, the following influenza immunization guidelines for BlueCross BlueShield of Tennessee apply with dates of service of beginning Aug. 01, 2012:

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
- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  Covered if offered under the member's health care plan

BlueCare or TennCare*Select*

- ***Vaccine and administration***
  Covered
- ***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
- ***Fluzone® Intradermal, Influenza Virus Vaccine*** (recommended for persons 18 through 64 years of age)
  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.

Correct coding of compound drugs

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.

An example of a compounded medication is **bevacizumab (Avastin®) for intravitreal injection.** Bevacizumab is supplied from

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ADMINISTRATIVE (Cont'd)

Correct coding of compound drugs (Cont'd)

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.

Effective Aug. 1, 2012, for each date of service compound drugs are administered, instilled, inserted, or implanted, a reasonable compounding fee will be reimbursed for commercial and BlueAdvantage claims if the pharmacy compounding fee is submitted on a separate line item billed with the appropriate HCPCS code for Pharmacy compounding and dispensing services.

Billing guidelines for compound drugs can be reviewed in the billing and reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual* found online at www.bcbst.com.

Where do labs, DME and specialty pharmacy providers file Blues claims?

By Oct. 14, 2012, Blue Cross Blue Shield Association is requiring all Blue Plans to implement new ancillary provider claim filing rules. The new rules state that for independent clinical laboratory services, the local plan is the plan in whose service area the specimen is obtained. For durable medical equipment and supplies, the local plan is the plan in whose service area the equipment was shipped to or purchased at a retail store. For specialty pharmacy, the local plan is the plan in whose state the ordering physician is located.

If you contract with more than one plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either plan. Please note the referring physician must be on the claim or it will be rejected.

For more information please visit our website, www.bcbst.com, and look for New Claim Filing Procedures for Ancillary Providers in the News section of the provider page.

Reminder: Continue to prepare for ICD-10

Since the U.S. Department of Health and Human Services announced their intent to initiate a process to postpone the compliance date for ICD-10, it is easy to delay or even forget about preparing for implementation. However, this is an opportunity for refining new processes and training staff. Continue to prepare for ICD-10 so that when the new implementation date is announced, you will not lose ground in moving forward to being ICD-10 compliant. The ICD-10 conversion will impact nearly all provider systems and many processes, with the largest impacts likely to be in clinical and financial documentation (billing and coding). It is critical not to delay planning and preparation.

- **Review** business and technical processes to evaluate the impacts of ICD-10 to your processes and plan accordingly.
  - Research the changes needed to your existing work flow and business process and update accordingly.
- **Focus** on improving clinical documentation; this can make the transition from ICD-9 to ICD-10 easier and will also have a positive effect on quality of care and reporting.
  - Educate coders with the additional time, the ICD-10 coding system is more specific and detailed than ICD-9.
  - Refresh knowledge of anatomy and medical terminology
  - Train staff to handle ICD-10 codes and adapt to coding, authorization, and billing changes.
- **Work** with vendors and Practice Management Systems to ensure they will be ready by the compliance date.
- **Test** with vendors and payers to ensure claims files will be accepted and transmitted correctly after the compliance date.

BlueCross BlueShield of Tennessee will keep you informed as to the progress that we are making toward becoming ICD-10 compliant.

For more information regarding ICD-10 implementation, please visit the provider page on our website at www.bcbst.com.

Changes to commercial business peer-to-peer review process *

Based on feedback from the provider community, BlueCross BlueShield of Tennessee has implemented changes in our commercial peer-to-peer process by streamlining the scheduling of these reviews and eliminating the need to talk to multiple people. By calling the Provider Service line† you can reach the dedicated voicemail system for requests which now allows providers to leave necessary information, prompting a return phone call. All messages left *before* 3 p.m. (ET) will be returned the same day. Messages left *after* 3 p.m. (ET) will be returned the next business day. The new voicemail system requires two (2) specific dates and times to schedule the peer-to-peer review as well as other member demographics as indicated by voicemail prompts.

BlueCross values your input as we strive to provide, not only the best medical coverage for our members, but also the best experience for our providers.

Reminder: Are you submitting paper claims to the correct address?

When submitting paper claims for all BlueCross BlueShield of Tennessee lines of business, providers are reminded to use the current address:

BlueCross BlueShield of TN
Claims Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37402-0002

*These changes will be included in the appropriate 3Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

BlueCare/TennCare*Select*

CLINICAL

Quest Diagnostics now providing lab services

Volunteer State Health Plan (VSHP) recently introduced its plans to consolidate lab services to Quest Diagnostics in an effort to rein in rapidly escalating lab expenditures within its TennCare business. Based on discussions with the provider community, several changes have been made to the original program design, including a decision to exclude the following:

- Inpatient lab services (already excluded from the original program)
- Outpatient dialysis (already excluded from the original program)
- Emergency room-based lab services
- Outpatient observation services
- Certain pathology services (List of specific codes to be published)
- Certain Obstetric services (List of specific codes to be published)

A revised Exclusion List will also be available on the VSHP provider website in August. Visit www.VSHPTN.com/providers for more information.

Reminder: Behavioral health consultation line available

Volunteer State Health Plan (VSHP) can assist you in obtaining referrals for your **BlueCare** and **TennCare*Select*** patients having mental health and substance abuse treatment needs. The behavioral health staff is available to consult with you and share ideas regarding clinical treatment approaches, management of difficult cases (e.g., eating disorders and ADHD), and utilization of new treatment modalities.

VSHP has established a toll-free primary care provider consultation line staffed by Peer Advisors who are Board Certified Psychiatrists. The staff will be available to you for telephone consultation regarding all aspects of mental health and substance abuse treatment including medications.

This service is currently available Monday through Friday, 9 a.m. to 5 p.m. (ET). Call 1-877-241-5575 and identify yourself as a TennCare primary care provider seeking psychiatric consultation services.

We encourage you to visit our company websites, www.vshptn.com and www.bcbst.com where you can find useful information including treatment guidelines for many mental disorders.

Reminder: Access and availability requirements

Volunteer State Health Plan has regulation requirements to 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;
- Patient load: 2,500 or less for physician; 1,250 or less for physician extender;
- Appointment/waiting times: Usual and customary practice should not exceed three (3) weeks from the date of the member's request for regular appointments and 48-hours for urgent care; and
- Office waiting times should not exceed 45 minutes

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

Pending Medicaid Number?

Providers waiting to receive a Medicaid Number should go ahead and file claims to meet timely filing requirements. Claims will deny for no Medicaid Number, but they will be on file. Once you receive the Medicaid Number and update your information, claims can be paid.

BlueAdvantage

CLINICAL

Reminder: Medicare annual wellness visit - not the same as a member's yearly physical

Effective for dates of service on or after Jan. 1, 2011, BlueAdvantage provides coverage for two annual wellness visits (AWV), an initial preventive physical exam (IPPE) or first AWV and a subsequent AWV with personalized prevention plan services (PPPS).
BlueAdvantage pays for only one IPPE per member per lifetime. However, a member may receive subsequent AWVs annually thereafter.

Note: The AWV is a preventive wellness visit and is not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner.

Elements of the First AWV

- Health risk assessment
- Establishment of patient's medical/family history
- Review of patient's risk factors for depression
- Review of patient's functional ability and level of safety
- Physical assessment
- Establishment of current providers and suppliers
- Detection of cognitive impairment
- Establishment of a written screening schedule
- Establishment of a list of risk factors for primary, secondary and tertiary interventions are recommended
- Provision of personalized health advice to the patient and a referral to health education or preventive counseling services as appropriate

Elements of the Subsequent AWV

- Update of health risk assessment
- Update of patient's medical/family history
- Physical assessment
- Update of current providers and suppliers
- Detection of cognitive impairment
- Update of written screening schedule
- Update of list of risk factors for primary, secondary and tertiary interventions
- Provision of personalized health advice to the patient and a referral to health education or preventive counseling services as appropriate

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BlueAdvantage

CLINICAL (Cont'd)

Reminder: Medicare annual wellness visit - not the same as a member's yearly physical (Cont'd)

For more information about the AWV with PPPS visit <http://www4a.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf >.

BlueCross focuses on improved preventive care and wellness

BlueCross BlueShield of Tennessee's Preventive Screening Programs focus on improving the quality of preventive clinical care and service received by its BlueAdvantage members. As part of the clinical improvement process, BlueCross conducts member education and other activities to promote prevention and help ensure continued health and wellness within our member populations and to improve the preventive screening rates as determined by HEDIS®.

Preventive screening reminders are disseminated through various avenues including, but not limited to postcards, telephone reminder messages and Care Management education. However, despite such efforts by BlueCross and our network providers to increase screenings, several rates continue to fall below the CMS established four-star threshold*. The following HEDIS 2012 results show more emphasis is needed to improve colorectal cancer screening rates.

2012 Rate		
Colorectal Cancer Screening	PFFS**	PPO**
	38.84%	55.00%

The Medicare Advantage CMS Quality Rating Management Department at BlueCross continually plans new initiatives to specifically promote these screenings. It is hoped these interventions will improve screening rates.

Preventive screenings are a covered benefit of Medicare Advantage health plans. Health care providers, due to their direct patient contact, play an essential role in actively encouraging patients to undergo appropriate screenings. Providers who perform these screenings are eligible for reimbursement at their contracted rates. The Preventive Services section on the Provider page on the company website, www.bcbst.com, offers links and resources to assist providers in performing and promoting preventive care.

*CMS four-star threshold for colorectal cancer screening is 58%.

** Private Fee For Service (PFFS)
Preferred Provider Organization (PPO)

BlueCard

ADMINISTRATIVE

National Consumer Cost Tool available to members

Effective Sept. 6, 2012, BlueCross BlueShield of Tennessee members will be able to view cost data for network facilities, surgeons and radiologists within the National Consumer Cost Tool (NCCT). This is part of our ongoing effort to support transparency and empower members in their health care decision-making process.

Additionally, specific facilities and physicians have the opportunity to review the data prior to it being published within the NCCT. A recent update of the claims data was mailed for review in July. If you did not receive cost data, there was not enough claims data available for your facility or office to be included in the tool at this time. In the future, your cost data may be included in the National Consumer Cost Tool as the claims data will be updated every six months.

Using the NCCT, members of Blue plans across the country are able to choose a treatment category, select a zip code and see estimated, average cost ranges for facilities, surgeons and radiologists in their area. The tool is available for a variety of common, elective treatment options and conditions. Currently, there are a total of 168 treatment categories.

If you have any questions, please email us at NCCTquestions@bcbst.com.

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†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**
TennCare*Select* **1-800-276-1978**
CHOICES **1-888-747-8955**
SelectCommunity **1-800-292-8196**
Monday – Friday, 8 a.m. to 6 p.m. (ET)

BlueCare/TennCareSelect Medical Management Hours
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: Select Option 2 at **423-535-5717**
e-mail: ebusiness_support@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)