BlueAlert
provider news flash

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

Please Route to all Providers & Office Staff

February 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 March 9, 2012

- Biofeedback and Neurofeedback
- NOTCH 3 Genetic Testing for the Presence of Mutations Associated with CADASIL

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

High-tech imaging medical policy revised

The medical policy, **Magnetic Resonance Imaging (MRI) of the Breast,** has been reviewed and revised, and is now consistent with MedSolutions guidelines. A draft of this revised policy is available on BlueCross BlueShield of Tennessee's web site at: http://www.bcbst.com/providers/mpm.shtml

ADMINISTRATIVE

Accessing Physician Quality and Cost Reporting Program

Updates to the Physician Quality and Cost Information will soon be made available for private physician[1] review on our secure BlueAccess Web portal.

Physicians will once again have a 45-day review period to update their data before it is released to our customers.

In order to access their quality and cost information, physicians must have a *BlueAccess* user ID and password.

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 www.bcbst.com/secure providers/.

You will need to "request a shared secret"[2] for all provider ID numbers you need to access.

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, TennCare*Select***, FEP or Cover Tennessee plans.

Reminder: Credentialing/ Recredentialing application submissions

Providers are reminded their credentialing and/or recredentialing applications can be submitted via the following methods.

Email : Credentials@bcbst.com

Fax: 1-423-535-8357
1-423-535-6711

Mail: BlueCross BlueShield of TN
Credentialing Dept – CH 2.4
1 Cameron Hill Circle, Suite 0007
Chattanooga, TN 37402-0007

Reminder: Documentation requirement for Evaluation & Management (E&M) services

BlueCross BlueShield of Tennessee audit functions uphold recognized coding and billing guidelines. The CPT® Manual and both the 1995 and 1997 Centers for Medicare & Medicaid Services *Documentation Guidelines for Evaluation & Management Services* specify the documentation that must be present in a provider's medical records to support the level of office visit billed for professional services. For most visits, practitioner documentation must include the required elements for the key components History, Examination, and Medical Decision Making.

BlueCross auditors have identified one element frequently missing in practitioner office notes is the patient's past, family, and social history (PFSH). A PFSH obtained during an earlier encounter does not need to be re-recorded **IF** there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:

- describing in the note any new PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier PFSH.

PFSH may be recorded by ancillary staff or on a form completed by the patient. To document the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

In addition to individual requirements of E/M services, medical necessity of the service is the overarching criterion for code selection. It would not be medically necessary or appropriate to bill a higher level of E/M based solely on the volume of documentation, when a lower level of service was provided to the patient.

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ADMINISTRATIVE (Cont'd)

Reminder: Documentation requirement for Evaluation & Management (E&M) services (Cont'd)

It may be appropriate to bill some E/M visits based on contributory components including counseling, time, and other factors. These require specific and thorough documentation.

To review all elements required to support an E/M level and its medical necessity, please access the CMS Documentation Guidelines at www.cms.gov or review your current CPT® manual.

Reminder: Be aware of member rights and responsibilities

As a BlueCross BlueShield of Tennessee network provider, you should know what our members are being told to expect from you and what you have the right to expect from those members. To comply with regulatory and accrediting requirements, we periodically remind members of their rights and responsibilities. These reminders are intended to make it easier for members to access quality medical care and to attain services.

Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and Volunteer State Health Plan Provider Administration Manuals, which are available on *BlueSource*, BlueCross's quarterly provider information CD and online on our company web sites www.bcbst.com and www.vshptn.com.

Reminder: Musculoskeletal Management

As previously communicated, select procedures now require prior authorization. Musculoskeletal is one of the areas in focus to help patients receive higher quality care and improve clinical outcomes for patients suffering from musculoskeletal pain.

Effective March 1, 2012, BlueCross BlueShield of Tennessee will begin requiring prior authorization for the following musculoskeletal procedures for both commercial fully-insured and Medicare Advantage plans.

- Pain Management
- Spinal Surgery
- Joint Surgery (Hip, Knee & Shoulder)
- Physical Medicine (MedAdvantage only)

Blue Cross is focusing on helping patients receive higher quality care and improving clinical outcomes for patients suffering from musculoskeletal pain.

Please note medical records may be required for the **initial** authorization review. Requests for authorization can be submitted by calling 1-800-388-8978, via www.bcbst.com web authorization or by fax to 1-800-520-8045. Musculoskeletal codes requiring prior authorization may be subject to change.

For questions about this program, please contact Beverly West at 423-535-3523.

Reminder: Predetermination of benefits provided as a courtesy

Predeterminations are never required, but are performed as a courtesy for Commercial, Cover Tennessee and BlueAdvantage lines of business. Providers can request a predetermination review to check benefits/coverage, exclusions/riders, possible pre-existing conditions and to ensure services meet medical criteria/ guidelines. Predetermination reviews do not take the place of any prior authorization requirements. Failure to obtain any necessary authorization may result in a denial or reduction in benefits. Predeterminations are normally handled within 15 days of receiving the request.

Promote health literacy through plain language

Have you heard of "Plain Language?" This is part of a national program encouraging health care providers to promote health literacy among their patients by ensuring they **understand** written and oral health information.

The National Adult Literacy Survey found that 66 percent of adults age 60 and over have inadequate or marginal literacy skills. Many informed consent forms and medication package inserts are written at high school level or higher, while the average patient reading level is closer to sixth grade. In one study, out of 659 hospital patients, those with poor health literacy skills were five times more likely to misinterpret their prescriptions than those who had adequate literacy skills.

Most patients will not tell you they do not understand. Using plain language allows your patients to understand their treatment plan, know how to take their prescriptions properly, and better follow your instructions. This is also important for your patients who do not speak English as their primary language.

For additional information on health literacy, please refer to the Department of Health and Human Services web site at http://www.hrsa.gov/publichealth/healthliteracy/.

February is American heart month/national wear red day

Heart disease is the leading cause of death in the United States. Coronary heart disease is the most common, and often appears as a heart attack. 785,000 Americans had a new coronary attack in 2010, and roughly 470,000 had a recurrent attack. (Statistics from the Centers for Disease Control and Prevention).

National Wear Red Day is Feb. 3, 2012. Please support this initiative to raise awareness about women and heart disease among your patients, family and friends. More information about National Wear Red Day may be found at the National Heart Lung and Blood Institute web site <http://www.nhlbi.nih.gov/educational/heartttruth/materials/wear-red-toolkit.htm>.

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ADMINISTRATIVE (Cont'd)

Web authorization system enhanced

The following improvements have been made to the web authorization process based on comments from network providers:

- The web authorization form timeout for idol behavior has been increased from 20 minutes to 35 minutes, which allows the clinician more time to gather clinical information and complete the authorization form without receiving a timeout message. To reset the session timeout, either save your authorization or simply use the back button to maneuver to a different screen inside the web authorization system. Moving from one screen to another within the system will continue to reset the session timeout and prevent your receiving the timeout message.

- Authorizations submitted through the web authorization system are housed in the clinical update section of the Authorization/Advance Determination Submissions section of eHealth Services. The system has been enhanced to expand the authorization history to 35 days past the last clinical update date.

- You have spoken, and we have listened! eHealth Services has been enhanced to include an "Announcement" section as the Home page header. Updates and changes to the eHealth Services forms will be listed in this section as well as in monthly *BlueAlert* newsletters.

- Recently, the confirmation numbers surpassed seven (7) characters and are now the automatically assigned confirmation numbers are eight (8) characters. This enhancement increases the confirmation number field to allow eight (8) characters instead of the current seven (7) character limitation throughout the web authorization application.

BlueCare/TennCare*Select*

ADMINISTRATIVE

Reminder: Claims subject to retrospective review

BlueCross BlueShield of Tennessee retrospectively audits VSHP claims for improper payments. The identification of improper payments will occur for claims according to provider contractual requirements. Claims submitted by a provider to BlueCross on a CMS-1450 (UB04) or CMS-1500 claim form are subject to audit. BlueCross will perform two types of reviews, Complex and Automated.

Complex Reviews are a thorough review of a medical record for coding validation and utilization review. **Automated Reviews** do not require a medical record. All complex reviews are performed with Corporate Medical Director oversight by physicians, RNs and certified coders. For more information, please refer to the Frequently Asked Questions (FAQs) available on the Provider page of the company web site, www.bcbst.com.

Reminder: Non-emergency medical transportation

Non-emergency transportation services are provided for **BlueCare** and **TennCare*Select*** members to and from their health care appointments. All non-emergency transportation should be scheduled and receive prior authorization from Southeastrans, Inc. before a service is provided. A notice of at least seventy-two (72) hours is requested prior to the member's appointment.

Volunteer State Health Plan communicates how to arrange non-emergency transportation services to members via the member handbook.

Members are not required to travel excessive distances. Examples of possible excessive distance requests include a request for transportation services to a provider that is not in the area where the member resides, or a request for Medicaid transportation services to a provider that is not in the same county, bordering county or metropolitan area in a bordering state for beneficiaries living in rural areas. The general guideline is that PCP appointments greater than 30 minutes or 30 miles or appointments for specialty services greater than 90 miles must be evaluated by the plan.

Reminder: Non-urgent prior authorization requests

Telephone inquiries regarding prior authorization requests should be directed to Provider Service at 1-800-468-9736 for **BlueCare** and 1-800-276-1978 for **TennCare*Select***. Please have the reference number available so we can quickly assist you.

Also have your reference number available when contacting the **BlueCare/ TennCare*Select*** Prior Authorization Department. Due to high call volume, it may be necessary to leave a message including your reference number. Your call will be returned by the next business day.

Remember that non-urgent prior authorization request decisions may take up to fourteen (14) calendar days from the receipt of the request.

Reminder: Disclosure of Ownership and Control Interest Statements

BlueCare/TennCare*Select* providers are required by federal guidelines to complete a current disclosure form with Volunteer State Health Plan (VSHP). The disclosure form must be submitted at the time the provider is initially accredited or re-accredited by VSHP at least once every three years. **Effective April 1, 2012, claims payments will be suspended until such time as a current form is on file**.

In accordance with federal requirements under 42 USCA § 1396a(p) and 42 C.F.R. §438 *et seq* requiring payments of Medicaid funds to providers be monitored, and the contract between VSHP and the State of Tennessee Bureau of TennCare, VSHP must maintain disclosure information on all its providers and tax reporting entities with billing activities.

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BlueCare/TennCare*Select*

ADMINISTRATIVE (Cont'd)

Reminder: Disclosure of Ownership and Control Interest Statements (Cont'd)

Tax reporting entities with billing activities (groups and facilities) and each rendering practitioner under the entities tax identification number are required to complete a disclosure form in accordance with federal guidelines. **For example:** If a group (entity) contains ten (10) practitioners, each practitioner should complete one (1) *Disclosure Form for a Provider Person*. Additionally the group as a whole (tax-reporting billing entity) should complete one (1) *Disclosure Form for Provider Entities*. A total of 11 disclosure forms would be required in this example.

If you have any questions please call BlueCross BlueShield of Tennessee's Provider Service line† and choose the "Network Contracting" option.

The **BlueCare/TennCare*Select*** disclosure forms and FAQs are available on the company web site at www.bcbst.com/providers/bluecare-tenncareselect/index.shtml under the **BlueCare/TennCare*Select*** Disclosure section.

Cover Tennessee

ADMINISTRATIVE

Reminder: Disclosure form requirement for CoverKids

If you are a provider that participates in BlueNetwork S, one of the programs you service is CoverKids. Effective immediately, CoverKids providers must complete a disclosure form. This is in keeping with federal regulations in 42 C.F.R. § 457.935 and Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) federal health care programs pursuant to Sections 6504 {et seq.} of the Affordable Care Act, which amends § 1902 (a)(39) of the Social Security Act. Federal regulations require that the CoverKids/Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) program monitor the payments of federal funds to Providers. CoverKids will implement these federal requirements by the use of a disclosure form (*CoverKids Provider Disclosure Form* and/or the *Bureau of TennCare Disclosure Form*) to collect the information required in 42 C.F.R. § 455 et seq, as well as other information deemed necessary by the State. Failure to provide the disclosure form or to accurately supply the required information may lead to sanctions and exclusion from federal healthcare programs, including CoverKids.

Providers in BlueNetwork S who do not participate in the **BlueCare/ TennCare*Select*** Networks with no disclosure form on file were sent letters in December with this information, an instruction sheet, and disclosure form. If the requested information has not returned, please do so immediately. Disclosure forms are available in the Cover Tennessee section on the Provider page of the company web site, www.bcbst.com. They may be faxed to Medicaid Network Strategy – OWDC at (423) 535-5808, (423) 535-3066, or (423) 591-9342.

If you have any questions, please contact the BlueCross BlueShield of Tennessee Provider Service Line† and choose the "Network Contracting" option.

Non-discrimination compliance training

Non-Discrimination Compliance Training may be found on the company web site at http://www.bcbst.com/providers/ under Cover Tennessee. The training includes information about Title VI, and requirements for providing translation services for CoverKids members. This training is self-guided so you may view the information at your leisure.

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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: ecom_techsupport@bcbst.com
Monday – Friday, 8 a.m. to 6:30 p.m. (ET)

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