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 Aug. 11, 2012

- Alemtuzumab
- Filgrastim/Pegfilgrastim
- JAK2 and MPL Mutation Analysis in Myeloproliferative Neoplasms
- Bioengineered Skin and Soft Tissue Substitutes

Effective Aug. 15, 2012

- Bortezomib
- Ofatumumab

Note: Effective dates also apply to BlueCare /TennCare Select pending state approval.

Modified Utilization Management Guideline updates/changes


Effective Aug. 15, 2012

Revised or recently developed BlueCross Modifications

The following as relates to Home Care:
- Hyperemesis Gravidarum

The following as relates to Inpatient and Surgical Care:
- Psychiatric Observation in the Medical Setting: Observation Care
- Repair of Enterocutaneous Fistula

BlueCross modifications will be archived in favor of the Milliman Care Guideline

The following as relates to Ambulatory Care
- Loop Electrosurgical Excision Procedures (LEEP, LLETZ), Cervix
- Sling Procedures, Male
- Uvulopalatopharyngoplasty (UPPP)

Note: Effective dates also apply to BlueCare and TennCareSelect pending state approval.

New drugs added to commercial specialty pharmacy listing

Effective July 1, 2012, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
- Elelyso (PA)
- Omontys (PA)
- Eylea will no longer require prior authorization.

Self-administered via pharmacy benefit:
- Gamunex C (PA)
- Korlym (PA)

To obtain prior authorization for provider-administered specialty drugs, call the BlueCross BlueShield of Tennessee Provider Service line.

For prior authorization of self-administered specialty drugs, call Caremark at 1-877-916-2271.

Reminder: Correct coding for pneumococcal conjugate vaccine (PCV)

Providers are reminded production of product matching CPT® code 90669 (7-valent – Prevnar®) was suspended by the manufacturer Dec. 22, 2010 and is no longer available.

Prevnar 13®, the pneumococcal 13-valent conjugate vaccine (90670), received U.S. Food and Drug Administration approval February 24, 2010.

Providers should verify the CPT® code billed matches the description of the vaccine administered.

New legislation passed for interventional pain management

The Tennessee Legislature recently passed the Interventional Pain Management Bill (SB1935/HB1896). This legislation has new restrictions and requirements specific to nurse practitioners and physician assistants who work in the area of pain management. For your reference this bill is available on the State of Tennessee website at http://state.tn.us/sos/acts/107/pub/pc0961.pdf.

ADMINISTRATIVE

Changes in coding for well-woman exams

Effective Aug. 1, 2012, BlueCross BlueShield of Tennessee will no longer consider the following procedure code/diagnosis code combinations valid for well-woman exams: 99201 – 99205 and 99211 – 99215 when filed with V723, V7231 or V7232.

Commercial claims filed with these code combinations will be denied as “procedure/diagnosis code conflict”.

For prior authorization of self-administered specialty drugs, call Caremark at 1-877-916-2271.
**BlueCross BlueShield of Tennessee, Inc. (BCBST)**
*(Applies to all lines of business unless stated otherwise)*

**ADMINISTRATIVE (Cont’d)**

Changes in coding for well-woman exams (Cont’d)

Correct codes for well-woman exams are:
- S0610, S0612
- 99385 – 99387
- 99395 – 99397
- G0438, G0439

**Pharmacy medication review request fax form**

To provide more efficient and accurate management of commercial and Cover Tennessee pharmacy medication reviews, the Pharmacy Medication Review Request Fax Cover Form must accompany these requests. The form is available on the provider page of the company website at http://www.bcbst.com/pharmacy/provider/forms/ and http://www.bcbst.com/providers/forms/.

This fax form is a cover sheet only and is to be used for appeal requests for authorization denials or review requests for coverage of an excluded pharmacy product. Pertinent medical information that supports the pharmacy-related request is still required to be submitted with the fax cover form.

**Change in Reimbursement for FluMist® and Fluzone® Influenza Vaccine**

BlueCross BlueShield of Tennessee is changing reimbursement standards for FluMist® and intradermal Fluzone® thanks to recent collaborations with the Tennessee Pediatric Council and the Tennessee Chapter of the American Academy of Pediatrics.

Beginning Aug. 1, 2012, BlueCross will implement changes for FluMist® and Fluzone® influenza vaccine. Except for Medicare Advantage, all lines of BlueCross commercial business will reimburse FluMist® and Fluzone® influenza vaccine at 100 percent AWP. There is no change to traditional reimbursement standards for lines of business such as BlueCare, TennCareSelect and CoverKids. When billing for these services, please use the appropriate published CPT® code for billing these products.

Future communications will specifically describe BlueCross’s influenza vaccine standards in more detail, but we wanted to alert network providers to this change in reimbursement policy in advance of the Aug. 1, 2012, implementation. Again, our many thanks to the Tennessee Pediatric Council and the Tennessee Chapter of American Academy of Pediatrics for collaborating with BlueCross on the influenza vaccine program and we look forward to implementing this change in reimbursement soon.

**State of Tennessee**

**ADMINISTRATIVE**

Prior authorization requirement removed for certain procedures

Effective July 1, 2012, the State of Tennessee Public Sector Plan (#80860) no longer requires prior authorization for sigmoidoscopy, proctosigmoidoscopy and colonoscopy. This change covers all procedure codes in the range of 45300 through 45392.

**BlueCare/TennCareSelect**

**CLINICAL**

Reminder: Quest Diagnostics now providing lab testing services

Effective July 1, 2012, BlueCross BlueShield of Tennessee has partnered with Quest Diagnostics® to provide lab testing services for members covered by Volunteer State Health Plan.

All lab testing are to be referred to Quest Diagnostics with the following limited exceptions:


**Reminder: Follow-up care for Attention Deficit/Hyperactivity Disorder**

It is important that children with newly prescribed Attention Deficit/Hyperactivity Disorder (ADHD) medication be seen for follow-up visits by a practitioner with prescribing authority. Medication is considered to be newly prescribed if the child has not received such medication in the immediately preceding four-month period, regardless of when the child was first diagnosed with ADHD.

During the first thirty (30) days after the new ADHD medication prescription (initiation phase) the child should have at least one follow-up visit. Children who remain on ADHD medication for 210 days or more (continuation and maintenance phase), should have two (2) additional follow-up visits after the initiation phase visit, for a total of at least three (3) visits within the ten-month period after ADHD medication is newly prescribed.

VSHP Behavioral Health has additional information that may assist you in the diagnosis and treatment of ADHD available at www.bcbst.com/providers/behavioral_health/organizations.shtml.

**Breast cancer screening initiative**

Volunteer State Health Plan (VSHP) is working to improve Breast Cancer Screening gaps in care and is requesting to partner with you to ensure your BlueCare and TennCareSelect patients receive appropriate preventive screenings.

Please review the medical histories of your BlueCare and TennCareSelect members to determine if a mammogram screening is appropriate to ensure they receive comprehensive wellness care. The Adult Preventive Health Flow Sheet, a useful tool for documentation of these services, is available under the Adult Preventive Services heading on our company websites, www.vshptn.com and www.bcbst.com.

*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.

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Cuts restored from January 2012 rate reduction

The Appropriations Legislation to restore 1.75% to the January 2012 rate reductions has been signed by the Governor. Claims were previously paid based on the additional 4.25% rate reduction that was effective Jan. 1, 2012, with a total rate reduction of 8.50%.

Claims that are affected will be adjusted accordingly. Fortunately, most of the adjustments can be made with the automated adjustment process and should be done in three (3) weeks. For those adjustments requiring additional review, we anticipate it may take up to 14 weeks. Thank you for your patience as this change is implemented. We will notify you via the BlueAlert and on the company websites once all adjustments have been completed.

Claims affected include those listed below:
- All pathology, lab, and radiological services which includes all professional, inpatient and outpatient services.
- All emergency and non-emergency transportation, defined as HCPCS Codes A0000 – A0999.
- All home health services except respite, hospice, and home and community based services.

Patient billing reminder

There are times when it may or may not be appropriate to bill your patients directly. Please refer to the Volunteer State Health Plan Provider Administrative Manual for complete information regarding medical billing.
- Providers may bill Class 77 (uninsured/disabled with Medicare) for the Medicare coinsurance and deductibles.
- Class 17 (Medicare/Medicaid dual eligible) members may not be billed for coinsurance and deductibles.
- Providers may not bill a member for services that were denied based on late claims submission.
- If a denial is based on a referral, or determination was made that there was no referral on file, the Provider may not bill the member or plan.

New ASH explanation code for anesthesia claims

Effective, Aug, 1, 2012, anesthesiologists will no longer receive a letter requesting medical records and/or forms related to abortion, sterilization, or hysterectomy (ASH) services. Claims will be denied “W1T” to advise we are waiting on medical records. Claims will be automatically re-adjudicated once the information is received and a determination has been made related to the ASH service - no need for providers to submit a corrected bill.

- Members may not be billed for services that VSHP does not consider medically necessary.
- Providers may not bill the member for charges that exceed the member’s liability.
- Providers may not bill the member for the transfer of medical records from one provider to another provider.
- For non-emergent care, providers may only bill patients for normal TennCare co-payments and deductible amounts.
- Providers may not bill members for missing a scheduled appointment.
- Providers may seek payment from a person whose TennCare eligibility is pending at the time services are rendered if the provider informs the person that TennCare assignment will not be accepted, whether or not eligibility is established retroactively.
- Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility is established.

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Quickly as possible. Coordinating these preventive services is an improvement effort by scheduling and/or appointing. Please support these quality efforts to assist members in setting up these transactions. From someone representing BlueAdvantage, your Blue Advantage patients may get calls for these services and as a result, your practice may be prompted, to easily update your information.

Osteoporosis management

BlueCross BlueShield of Tennessee is working to improve osteoporosis management in women who have a fracture. We would like to partner with you to ensure your Blue Advantage patients receive appropriate preventive screenings and treatment.

BlueCross will be calling members who have a gap in care for this measure and will be encouraging them to seek their physician’s advice in determining appropriate treatment options. If you are treating BlueAdvantage members over the age of 65 for a fracture, please screen them for osteoporosis and treat positive findings by prescribing appropriate medications.

Preventive care campaign

Over the next few months, representatives from the BlueAdvantage health plan will be contacting members to engage them in their own health care and assist them in making appointments to obtain much needed preventive services such as screenings for osteoporosis, glaucoma, breast cancer, colorectal cancer and diabetes.

We expect an increase in member demand for these services and as a result, your practice may get calls from BlueAdvantage members to schedule an appointment or from someone representing BlueAdvantage to assist members in setting up these appointments. Please support these quality improvement efforts by scheduling and/or coordinating these preventive services as quickly as possible.

New remittance format for BlueCard claims complete

The remittance format for BlueCard claims has completed its transition. As previously communicated in the January 2010 BlueAlert, the format is now similar to the commercial line of business. BlueCard are now in the process of phasing out the legacy payment system.

Adjustments for claims processed under the legacy system will be handled as “net” transactions on the new system.

- If the result of an adjustment is an add-pay, the remittance advice will reflect only the additional dollars owed to you.
- If an adjustment results in a recovery, the remittance advice will reflect a recovery for the specific amount owed BlueCross. These will be reflected in the Adjustment Summary section of the remittance advice.

If you have any questions, please contact the BlueCard Provider Service line.

BlueCard

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 transactions on the new system. 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.bcbs.com, and look for New Claim Filing Procedures for Ancillary Providers in the News section of the provider page.

BlueCross BlueShield of Tennessee offices will be closed Wednesday, July 4, 2012, in observance of the Fourth of July Holiday.

July 2012

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