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 April 13, 2012
- Analysis of Proteomic Patterns in Serum for Early Detection of Cancer
- Functional MRI
- Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy
- Cytoreduction and Hyperthermic Intraperitoneal Chemotherapy
- DNA-Based Testing for Adolescent Idiopathic Scoliosis
- Ventricular Assist Devices (VAD) and Total Artificial Heart

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

ICD-10 Implementation Guides available
Although the ICD-10 implementation effective date of October 2013 seems far away, it is important that you have already begun preparations and are taking the necessary steps to be ready.

To help with your preparation for ICD-10, The Centers for Medicare & Medicaid (CMS) has developed Implementation Guides and has made them available on the CMS website. These guides are for those who are just beginning the process or in the middle of preparing for the transition. There is a guide available for large group providers, small/medium group providers and vendors.

Each guide provides systematic plans and relevant templates for planning and executing the ICD-10 transition process. You can download the templates in either Excel or PDF files. They are customizable and created to help entities clarify staff roles, set internal deadlines/responsibilities and assess readiness.


Changes to commercial specialty pharmacy listing
Effective March 1, 2012, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Self-administered via pharmacy benefit:
- Erivedge (PA)
- Kalydeco (PA)
- Inlyta (PA)

Berinert® can now be obtained as provider-administered (PA) or self-administered (PA).

Soliris® is provider-administered and requires prior authorization effective March 1, 2012.

ADMINISTRATIVE
Reminder: State of TN vision services

Please remember that the State of TN does not have routine vision benefits. The member is only eligible for one non-refractive vision screening per calendar year. The State of TN has been configured so that only CPT® Code 99174 counts as the member’s annual non-refractive vision screening. All other codes and routine vision diagnosis codes have been configured to deny as a non-covered service.

Reminder: Filing corrected bills appropriately

Providers often times find themselves needing to make changes to a previously submitted claim. When this is necessary, ALWAYS remember to file a corrected bill according to guidelines in the Billing and Reimbursement Sections of both the BlueCross BlueShield of Tennessee and Volunteer State Health Plan provider administration manuals.

Corrected claims not submitted according to these guidelines can result in the charges being denied as a duplicate rather than being processed as “corrected”, or in some cases even paid a second time in error.

It may then be necessary for the provider’s office to call the Provider Service Line† and speak with a Consumer Advisor to correct the situation, or submit a refund to BlueCross for the duplicate payment.

Use of accredited facilities for advanced radiology imaging services

Effective April 1, 2012, services for advanced radiology imaging services must be performed at an accredited facility. If a request for prior approval is submitted to MedSolutions and the service is to be performed at a non-accredited facility, you will receive a message that a non-accredited facility has been chosen. Use of a non-accredited facility may result in the service(s) being denied as non-covered with no member liability. For help in choosing an accredited facility contact MedSolutions at 1-888-693-3211.
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ADMINISTRATIVE (Cont’d)  

Reminder: Changes to prior authorization requirements for select procedures

New authorization requirements were implemented Jan. 1, 2012, for commercial lines of business, including Cover Tennessee for the following procedures in an inpatient or outpatient setting:

- Panniculectomy
- Varicose Veins
- Blepharoplasty
- 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

A grace period has been allowed and no denials have been issued due to lack of authorization. **Beginning April 1, 2012 if no authorization is obtained, denials will begin to be issued and benefits will not be eligible.**

**Note:** Prior authorization is not required for outpatient procedures for TRH members.

**New options coming for electronic claims submission**

Currently, BlueCross BlueShield of Tennessee transmits claims electronically through ECGateway using dial-up modem. BlueCross will soon offer several options using the Internet including a secure website, Secure File Transfer Protocol (SFTP) and File Transfer Protocol (FTP) over SSL. Watch for information on start dates and times in upcoming BlueAlerts.

**Reminder: Diabetic mail order modifier required**

Diabetic Mail Order companies are reminded to include the KL modifier when submitting claims. The Centers for Medicare and Medicaid Services (CMS) added the KL modifier for use on claims for diabetic supplies that are delivered via mail with dates of service July 1, 2007, and after.

Per CMS, “The KL modifier shall be used with diabetic supplies identified by the codes (A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259) that are ordered remotely and delivered to the beneficiary’s residence by common carriers (e.g., US postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier store fronts.”

BlueCross BlueShield of Tennessee follows CMS guidelines for pricing and modifier usage. Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule are required for correct claim adjudication. Providers can view this document on the CGS website, [http://www.cgsmedicare.com](http://www.cgsmedicare.com).

**OB Delivery Admissions**

Effective immediately, facilities will no longer be required to notify BlueCross BlueShield of Tennessee of maternity delivery admissions for commercial lines of business. **All NICU admissions will continue to require authorization.**

**BlueCare/TennCareSelect**

**CLINICAL**

**Spirometry testing**

For the assessment and diagnosis of Chronic Obstructive Pulmonary Disease (COPD), the most common pulmonary function test is the spirometry test. It can be performed with a hand-held device and can easily be used by your patients with the help of an experienced technician. This noninvasive procedure could be a big help in diagnosing a respiratory problem. **BlueCare/TennCareSelect members 40 years of age and older will be receiving information about COPD and the use of spirometry testing in March.**

**Low back pain diagnosis and treatment**

Low back pain ranks as the fifth highest reason that patients go see a physician. Roughly 25% of U.S. adults have reported having low back pain that lasted for at least one whole day in the past 3 months. The corresponding costs for care and missed work add up quickly. Most patients who seek medical care usually improve rapidly in the first month. There are large variations in diagnostic tests and treatments, but the outcomes are similar despite significant differences in the costs of care. Guidelines published by the American College of Physicians (ACP) have offered new recommendations on the treatment of Low Back Pain (LBP) based on their research in partnership with the American Pain Society (APS).

Prior to ordering imaging studies, providers are recommended to do a focused history and physical examination. Providers should give patients evidence-based information on low back pain with their course of action and effective self-care options, as well as encouraging them to remain active.

Providers should consider the use of medications that have proven benefit results when used with back care information and patient self-care. For most patients, the first-line medication options would be acetaminophen or nonsteroidal anti-inflammatory medication.

For patients who do not improve with self-care options, providers may consider adding nonpharmacologic therapy that has proven benefits such as or intensive interdisciplinary rehabilitation, exercise therapy, cognitive-behavioral therapy or progressive relaxation for patients with chronic or subacute low back pain.

*These changes will be included in the appropriate 2Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual. BlueCross BlueShield of Tennessee is an Independent Licensee of the BlueCross BlueShield Association. CPT® is a registered trademark of the American Medical Association.*
**BlueCare/TennCareSelect**  
**CLINICAL (Cont’d)**  
**Low back pain diagnosis and treatment (Cont’d)**

If there are severe or progressive neurologic deficits present, or serious underlying conditions are suspected based on the results of the history and physical examinations, diagnostic imaging and testing are recommended along with the inclusion of the other conditions on the claim for easy reference. Patients with persistent low back pain and symptoms or signs of radiculopathy or spinal stenosis should be evaluated with magnetic resonance imaging (MRI) or computed tomography only if they are potential surgery candidates or will be treated with an epidural steroid injection (for suspected radiculopathy).

Quality of care for the patient is top priority. Part of that is not having patients go through unnecessary tests or treatment. Progressive treatment levels for low back pain are strongly encouraged.

Resource: *Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society*. Roger Chou, MD; Amir Qaseem, MD, PhD, MHA; Vincenza Snow, MD; Donald Casey, MD, MPH, MBA; J. Thomas Cross Jr., MD, MPH; Paul Shekelle, MD, PhD; and Douglas K. Owens, MD, MS, for the Clinical Efficacy Assessment Subcommittee of the American College of Physicians and the American College of Physicians/ American Pain Society Low Back Pain Guidelines Panel.

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**BlueCare/TennCareSelect**  
**ADMINISTRATIVE**  
**Reminder: NICU utilization management reviews**

Effective Feb. 1, 2012, all NICU admissions require authorization regardless of network status. All NICU requests are to be submitted by fax only. This will ensure a timely response to your NICU requests.

Submit all initial NICU requests to fax line 423-535-1861, as well as DRG threshold updates and concurrent review requests if the baby is not being managed by Alere Case Management.

Please continue to send all updates to Alere if the baby is being followed by Alere Case Management, at fax number 201-512-7126.

VSHP has up to fourteen (14) days to complete their review and respond to non-urgent requests. For questions contact us at:

- BlueCare  1-888-423-0131
- TennCareSelect  1-800-711-4104

**March quality initiative - Quitting Tobacco**

Any day is a good day to quit smoking or using other tobacco products. In March, Volunteer State Health Plan would like to encourage providers to counsel smokers and tobacco users to quit and provide them with resources to help them.

Tennessee Tobacco QuitLine is available at 1-800-QUIT-NOW (1-800-784-8669). There are also resources available for providers and members online at [http://health.state.tn.us/tobaccoquitline.htm](http://health.state.tn.us/tobaccoquitline.htm).

Let’s not wait until the Great American Smoke Out to make this a healthy goal for our members.

**March is National Colorectal Cancer Awareness Month. This is a good time to remind your patients age 50 to 75 years old to have this important screening.**

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**BlueAdvantage**  
**ADMINISTRATIVE**  
**2011 Medicare Health Outcome Survey Results Are In**

Every year, The Centers of Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to participate in the annual Medicare Health Outcomes Survey (HOS). This survey allows CMS to measure and trend certain aspects of quality among Medicare Advantage health plans, like BlueAdvantage. This measurement, in turn, allows Medicare beneficiaries to compare the quality ratings of their health plan with those of other prospective plans.

The treatment you provide to Medicare Advantage subscribers is critical to the success of a Medicare Advantage health plan. Measures such as improving or maintaining physical health, improving or maintaining mental health, monitoring physical activity, improving bladder control, and reducing the risk of falling are all measures that impact the quality outcomes of a Medicare Advantage health plan.

Quality scores for most of these measures are lower than anticipated for the BlueAdvantage plan. The following measures have been identified as needing to be addressed with your Medicare Advantage patients at the appropriate interval:

- Discuss and advise physical activity, at least every 12 months
- Discuss and treat urinary incontinence, at least every 6 months
- Discuss and manage fall risk, at least every 12 months

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Correct coding of bevacizumab (Avastin®) for intravitreal injection

Bevacizumab is supplied from 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.

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.

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

Cover Tennessee

New explanation code created for corrected bills *

Effective April 1, 2012, for 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 April 1, 2012, these claims have been returned to the provider on the front-end with no EX code. Corrected claim billing guidelines may be found in the Blue Cross Blue Shield of Tennessee Provider Administration Manual available on the company web site at <BlueCross BlueShield of Tennessee Provider Administration Manual>.

Note: Applies to CoverTN, AccessTN, CoverKids and HealthyTN Babies

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