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 policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the “Upcoming Medical Policies” link.

Effective April 11, 2013

- Aqueous Shunts and Stents for Glaucoma
- Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Other Diseases Associated with High Bone Turnover
- Stereotactic Radiosurgery of Central Nervous System Lesions
- Enhanced External Counterpulsation (EECP)
- Myoelectric Prosthetic Components for the Upper Limb
- Implantable Cardiowerter Defibrillator for the Prevention of Sudden Death
- Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension

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

ADMINISTRATIVE

Reminder: Electronic Funds Transfer (EFT) requirement

As previously communicated, effective April 1, 2013, all network providers will be required to receive payments electronically via the Electronic Funds Transfer (EFT) process. This is a network participation requirement that must be met by April 1, so if your facility or practice is not currently enrolled in EFT, please do so today. Complete the EFT enrollment form, available at <http://www.bcbst.com/providers/forms/EFT_Enrollment.pdf> and fax along with a voided check to (423) 535-3066 or (423) 535-7523, or mail to:

BlueCross BlueShield of Tennessee
ATTN: Provider Information Dept. CH 2.4
1 Cameron Hill Circle
Chattanooga, TN. 37402

BlueCross is glad to work with your organization to address specific needs or unique challenges that could make it difficult to meet this requirement.


Note: Please ensure that all providers in your practice or group have also registered to participate in the EFT process.

Change to prior authorization requirement for emergency room observation stays*

Effective April 1, 2013, prior authorization for 23-hour observation stays through the emergency room will no longer be required for commercial members. Observation for 23-hour observation stays*

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Claim inquiry resources

Claim reporting tool

For your convenience, many online tools are available in BlueAccess to assist with daily administrative tasks, such as verifying current claims status at BCBS.

One such tool is our Claim Acknowledgement for Electronic Submission (CARES) EDI claim reporting tool. With the industry transition to the ANSI 5010 277 Claim Acknowledgement (277CA) standard for initial claim status, BCBS recognized the need to develop a tool to assist providers in dealing with the change in a user-friendly format. This resource provides capabilities such as:

- Accepted / Rejected claim reports
- Line-of-Business specific searches
- Subscriber ID searches
- Report exporting

Any provider who submits claims electronically via a clearinghouse, billing agency, vendor, or directly from their practice management software can use this tool to verify whether claims have been accepted or rejected. Data is available one business day after initial processing. To access the tool, login to BlueAccess and click “More…” under the heading titled “EDI Transactions Tools & Services”. Then click the link named “Claims Acknowledgement Reports for Electronic Submissions (Version 5010).”

Additional information about tools available in BlueAccess is available on the company website at <https://www.bcbst.com/secure/providers/index.shtml>. Provider service units are also available to assist you; please reference their contact information at the end of this newsletter for specific service line information.

If you encounter a complex issue that cannot be resolved through the website or provider service units, your Network Manager remains available to assist you. If your inquiry is still not resolved to your...
Corrected Bill, Incomplete Claim, or Reconsideration?

Each has its own purpose and process.

**Corrected Bill** (Electronic submission is the preferred method for filing corrected bills.)

Corrected bills are claims that have been **processed** (Providers receive a Remittance Advice that includes the claim) and were paid incorrectly because of an error or omission on the claim. A true corrected bill includes additional/changed dates of service, codes, units, and/or charges that were **not** filed on the original claim. Corrected bills must be submitted within two (2) years of the end of the year the claim was originally submitted. For example, if a claim was filed on 2/15/13, any corrected bill must be submitted by 12/31/15.

**Incomplete Claim**

These are claims that do not conform to the billing guidelines. These claims have **NOT** been processed and will be returned to the Provider. If a claim is rejected or returned and has not been processed, that claim should be resubmitted as an original submission once the information causing the reject or return has been corrected. Providers should correct the error(s) and resubmit the claim as a new claim on a **new** claim form. **DO NOT MARK “CORRECTED CLAIM” ON THE NEW CLAIM.** Correcting the error(s) and resubmitting a new claim form will help ensure quicker turnaround.

**Reconsideration**

A reconsideration can be submitted by a provider or member to request additional review when an adverse determination is issued by BlueCross. Claims that are audited are subject to the Provider Dispute Resolution Process and should **not** be filed as corrected bills.

Additional guidelines on information found in this article are available in the BlueCross BlueShield of Tennessee Provider Administration Manual located on the Provider Page on the company websites, [www.bcbs.com](http://www.bcbs.com) and [www.vshptn.com](http://www.vshptn.com), and at [http://www.bcbs.com/providers/ecomm/bcbst_5010/5010_Corrected_Claims.pdf](http://www.bcbs.com/providers/ecomm/bcbst_5010/5010_Corrected_Claims.pdf).

Focus on preventive screenings

VSHP and Cover Tennessee conduct several activities focused to increase patient awareness:

- Automated telephone calls are made to patients with directed reminders, educating members on the importance of screenings for cervical cancer, breast cancer and Chlamydia in addition to other preventive screenings.

- Women receive a health card during their birthday month with information on pap tests and mammography, and are encouraged to discuss being tested with their health care provider.

- Newsletter articles educating on the importance of all preventive testing supporting clinical practice guidelines and therefore improving the members quality of life.

Blue Cross and Blue Shield Association expands Blue Distinction program

The Blue Cross and Blue Shield Association (BCBSA) recently announced the expansion of its Blue Distinction designation program to include specific designations for quality and quality plus cost-efficient specialty care, and another designation for high-performing Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).

Blue Distinction Centers for Specialty Care® now includes new cost-efficiency measures, as well as more robust quality measures focused on improved patient health and safety. Building on the success of the other Blue Distinction designations, The Blues® are continuing to expand the program to include a primary care focused designation – Blue Distinction Total CareSM which will designate PCMHs and ACOs that meet nationally consistent criteria for quality, efficiency, and patient experience.

Blue Distinction Centers+ are awarded to facilities for their expertise and cost efficiency in delivering specialty care. Only those facilities that first meet Blue Distinction’s nationally established, objective quality measures will be considered for designation as Blue Distinction Centers+.

Since 2006, consumers, medical providers and employers have relied on this program to identify hospitals delivering quality care in bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacements, spine surgery, and
**BlueCross BlueShield of Tennessee, Inc. (BCBST)**

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**ADMINISTRATIVE (Cont’d)**

Blue Cross and Blue Shield Association expands Blue Distinction program (Cont’d)

transplants. The program is part of The Blues efforts to collaborate with physicians and medical facilities to improve the overall quality and safety of specialty care.

For a complete listing of Blue Distinction Centers for Spine Surgery and Blue Distinction Centers for Knee and Hip Replacement, or for more information on all designated Blue Distinction Centers, please go to www.bcbs.com/bluedistinction or call 1-800-810-BLUE.

**Reminder: DME prior authorization requirements**

BlueCross administers both fully insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements, as well as benefit coverages, may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.

Prior authorization for DME is required for fully insured arrangements for DME purchase, rental or repairs greater than $500. Prior authorization requests may be faxed to 1-866-558-0789 or by calling the Provider Service line at 1-800-924-7141.

Information that must be submitted with the claim and/or prior authorization request can be found in the BlueCross BlueShield of Tennessee Provider Administration Manual available on the company website, www.bcbs.com.

**BlueCare/TennCareSelect**

**ADMINISTRATIVE**

Provider dispute form updated

The Provider Dispute Form has been updated to include additional fields for

- BlueCare/TennCareSelect Member Level
- Reconsideration to specify whether the information being submitted is for administrative disputes or utilization management for medical necessity disputes. The updated form is located on the company website at [http://www.bcbs.com/providers/forms/GO-553-122005.pdf](http://www.bcbs.com/providers/forms/GO-553-122005.pdf).

**Maternal and newborn health program**

Effective April 1, 2013, services previously provided by Alere® Women’s and Children’s Health L.L.C. will be transitioned to our VSHP Maternal and Newborn Health program. The VSHP program provides the management and support of healthy and high risk maternity members and provides support for babies admitted to the NICU/Special Care Nursery through the first year of life. VSHP will continue to include the Medela Breast Pump program to support mothers with babies in the NICU/Special Care Nursery.

**Reminder: Clinical information required for prior authorization requests**

Providers requesting prior authorization must submit clinical information to show medical necessity for the service. This includes DME providers or other servicing providers submitting on behalf of the ordering medical doctor. In order to expedite your request, please include the medical records from the ordering provider.


**Vaccine administration codes update**

Effective Jan. 1, 2013, in compliance with CMS’ National Correct Coding Initiative, office visit codes filed with vaccine administration codes 90471, 90472, 90473, or 90474 are being considered a bundled service. The explanation code you will see on claim denials is N01 (Subset Procedure Disallow).

When a significantly separate identifiable service is performed on the same day in addition to the administration of the vaccine, a modifier 25 may be appended to the office visit code. The member’s medical record must contain documentation of the services provided. Use of Modifier 25 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement.

**UPDATE: Extension of timeframe for authorization process for therapy**

In the February BlueAlert, VSHP announced that effective April 1, 2013, VSHP would require a prior authorization for therapy services performed in the school. This date will be moved to June 1, 2013.

In order for TennCare covered services to be approved for payment in the schools, VSHP must receive a copy of the child’s Individualized Educational Plan (IEP) and Release of Information/Parental Consent. After receipt of the information, VSHP will either accept the IEP and treat it as a request for services to which VSHP will respond within 14 days (prior authorization process) OR, if not accepted, assist in making an appointment to have the child evaluated. VSHP will also send a copy of the IEP related information to the PCP and notify the designated school contact of the disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery, etc.).

**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 the claim will be on file. Once the Medicaid number is received and your information updated, the claims may be paid.

*These changes will be included in the appropriate 1Q or 2Q 2013 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.*
CHOICES

ADMINISTRATIVE

Provider appeal procedures

Everyone knows about their right to remain silent, but some are not as well versed when it comes to their right to request reconsideration or an appeal regarding an adverse decision. An adverse decision is the denial, delay, termination, suspension or reduction of a covered Medicaid service. VSHP has guidelines to assist you with the Provider Dispute Resolution Procedure (PDRP) in the provider administration manuals located on the company websites www.vshptn.com and www.bcbst.com.

A provider or provider representative may request reconsideration or an appeal of any adverse decision.

Providers may submit a reconsideration request for administrative inquiries for review of non-clinical information related to rendered services, such as claims adjustments. Since these inquiries are claims-oriented in nature, providers may submit an administrative inquiry by calling the CHOICES Provider Service Line at 1-888-747-8955 or by sending the request in writing to:

CHOICES
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37402-0002

If you are not satisfied after exhausting the above process, you may submit a written appeal within 30 days of receiving a response to the inquiry/reconsideration. Actions to resolve a dispute pursuant to the Dispute Resolution Procedure must be initiated within two (2) years from the end of the year in which the event causing the dispute occurred.

In addition to the above processes, providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which is available to providers to resolve claims denied in whole or in part by VSHP. Instructions for initiating this process are available in the VSHP Provider Administration Manual.

BlueAdvantage®

ADMINISTRATIVE

Reminder: Change to prior authorization requirement for musculoskeletal program

As previously communicated, select musculoskeletal 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 Jan. 1, 2013, prior authorization is required for the following chiropractic codes (BlueAdvantage members only) through the BCBST Musculoskeletal Program administered by Triad Healthcare:

- 98940
- 98941
- 98942

Prior authorization requests can be submitted by fax to 1-800-520-8045 or via BlueAccess, BCBST’s secure area on its website, www.bcbst.com.

For questions contact BlueAdvantage Provider Service†.

BlueCard®

ADMINISTRATIVE

Reminder: Automatic crossover for all Medicare claims

All claims will be automatically submitted to the secondary payer

All Blue Plans will crossover Medicare claims for services covered under Medigap and Medicare Supplemental products. This results in automatic claims submission of Medicare claims to the Blue secondary payer, and reduces or eliminates the need for the provider’s office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide.

Providers can learn more about the Medicare crossover process by visiting the company website at <http://www.bcbst.com/providers/bluecard/IPP_es_BlueCard_ProvideFAQ.pdf>.

*These changes will be included in the appropriate 1Q 2013 provider administration manual update. Until then, please use this communication to update your provider administration manual.

†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, 8 a.m. to 5:15 p.m. (ET)

BlueCare 1-800-468-9736
TennCareSelect 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: ebusineessupport@bcbst.com
Monday – Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)