of Tennessee

JANUARY 2021

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

COVID-19 Resources for Your Practice

We know you're working hard to deliver care to your patients during the ongoing COVID-19 emergency, and we wanted to share some resources you may find useful.

Professional and government organizations, including the **American Academy of Family Physicians**, **American College of Obstetrics and Gynecology**, and **Tennessee Department of Health**, continue to offer information about COVID-19 on their websites. Resources include clinical and practice management guidance.

If you have questions about your patients' benefits or would like to learn more about our COVID-19 response, please visit **BCBSTupdates.com** or contact your Provider Network Manager.

We're Here to Support You

With surges of COVID-19 cases, we want to help you continue focus on providing care to our members. This isn't a comprehensive list of BlueCross actions we've taken to help (such as encouraging our members to schedule telehealth visits and the community-serving efforts of our foundation), but rather items we know are relevant to hospital operations:

- We're creating a streamlined prior authorization process for Commercial members with a COVID-19 diagnosis admitted through the emergency department. In these cases, we won't require supplemental clinical information for prior authorizations. This waiver will be in effect through March 31, 2021. We reserve the right to audit after the pandemic, if necessary.
- We've waived prior authorization requirements for all levels of post-acute care and transfers, as we did in April. This waiver is in effect through March 31, 2021, at which time we'll reevaluate the policy. As before, we request notification within 24 hours, or one business day, following any related facility transfers in order for our clinical staff to assist our members and their families, and to meet our contractual obligations with plan sponsors.
- We support the "hospital at home" program included in Governor Lee's Executive Order 68. We'll work with any hospital that has met the CMS criteria to implement the program.
- We're allowing flexibility to charge inpatient rates in the emergency department or other units where patients may need to be housed, based on intensity of service.
- We've reduced the burden of credentialing during this difficult time. While it's critical we have accurate rosters of providers to load into our claims system to expedite payments, BlueCross is adhering to Executive Orders and NCQA guidance related to licensure, extending time for re-credentialing, relaxing EFT requirements, providing for expedited credentialing and enrollment, and, where necessary, willing to accept the bare minimum information required from hospitals to ensure member safety (i.e., current license and NPBD report).

Join Us for a Virtual Health Information Technology (HIT) Program

Are you interested in Health Information Technology (HIT)? Then, please join us for a special virtual Health Information Technology Accelerator Program starting **Jan. 25, 2021.**

The Tennessee Chapter of the Healthcare and Information Management Systems Society (HIMSS) and the Center for Executive Education are offering a 14-week certification and acceleration program to healthcare information technology (HIT) professionals across Tennessee.

HIT professionals lead the training, covering best practices, real-world challenges and the future of health care and technology. The 14-week course starts Jan. 25 and meets every Monday night from 6:30 to 9:30 p.m. ET. The cost of the program is $2,495, and attendees will receive HIT certification when they've completed the program.

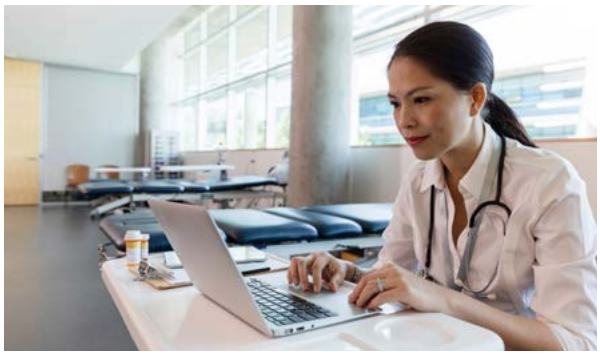
Registration is open until Jan. 25, the day of the first meeting. However, space is limited, so we encourage you to reserve your spot as soon as possible. Participants can dial into the teleconferences from a home or work computer. For more details about the classes, check out the **Spring 2021 Class Schedule**.

If you have additional questions about the program, please visit **tnhimss.org/education/hit-accelerator-program/** or contact **Erica Eubank**.

If you have questions about payment, please contact **Tiffany Madigan**, Executive Director at TN HIMSS.

Submit Provider Changes With Availity®

We've moved away from the PDF/paper Provider Change Form to a new, easy-to-use online format for submitting provider changes in the BlueCross payer space at **Availity.com**. If you or your staff handle enrollments or provider changes within your practice but haven't registered, please take a few minutes to sign up with Availity. As of Jan. 1, 2021, we're no longer accepting PDF versions of the Provider Change Form, all changes must be submitted through Availity.



Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so please take a moment to review your next renewal date. A current license tops our list of required provider credentials and we're obligated to terminate providers from our network when their licenses expire. Providers who want to rejoin the network following termination due to license expiration will have to reapply and go through the credentialing process again. It's also important to note that any claims submitted by an unlicensed provider will be denied.

Understanding Our Members' Rights and Responsibilities

We periodically remind members of their rights and responsibilities. These reminders make it easier for our members to access quality medical care and additional services. These reminders also help us comply with regulatory and accreditation requirements. For your convenience, we publish our current member rights and responsibilities in our **Provider Administration Manuals**.

Member ID Number Prefix Reminder

When submitting claims, please make sure the Member ID number is exactly as it appears on the Member ID card, including the prefix. We use prefixes to identify the member's coverage, obtain health plan contract information and route claims to the correct Home Plan through the BlueCard and Inter-Plan programs. Please note that as of Oct. 1, 2020, we're rejecting claims with incomplete Member ID numbers.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter.

You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the Network Verification at Availity.com. Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review.

The Network Verification form, in the Provider Enrollment, Updates and Changes tile, is in the BlueCross payer space on Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification Form until we can move all providers to this new process.

If you have questions, please contact our Provider Service line at 1-800-924-7141 and follow the prompts for Contracting and Credentialing.

Network Effective Dates Dependent on Receipt of Provider Information

We work hard to make the provider enrollment process fast and efficient. Please submit all new provider information as promptly as possible, so we can deliver the earliest effective dates for your new providers. We can't enroll providers in a new practice until we have the information necessary to make our system updates. This includes the addition of providers to an existing group. Network effective dates are based on when the individual provider is enrolled with BlueCross, not necessarily when the provider starts working at your practice or group.

Update to Non-Physician Practitioner Copay Amounts Delayed

During a recent system review, we found that our systems didn't always assign the appropriate member copay for primary care or specialist services when the services were rendered by a nurse practitioner or physician assistant. Member copays for covered services provided by nurse practitioners or physician assistants should be consistent with the specialty type of their respective supervising physician and based on the type of provider (i.e., primary care or specialist) where the services were provided. We made system updates to correct this.

In the October issue of BlueAlert, we stated that we would implement these updates starting Jan. 1, 2021, and would base member copays for all lines of business (excluding Federal Employee Program members and BlueCard) on whether the nurse practitioner or physician assistant is supervised and the services are provided by a primary care physician or specialist. Since then, we've made the decision to delay this implementation date. We'll share more information on the new date in future issues of BlueAlert.

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Commercial Plans Adding Codes to High-Tech Imaging Prior Authorization Program in March

Beginning **March 1, 2021**, the following CPT® codes will be added and require prior authorization through eviCore's Hi-Tech Imaging Program:

0633T 0634T 0635T 0636T 0637T 0638T 71271

Fourth Quarter PAM Introduction Section Contains Outdated Information

The introduction section in the fourth quarter edition of the Commercial Provider Administration Manual (PAM) shows outdated member benefits for 2020 instead of 2021 for On and Off Marketplace Plans. We'll publish the 2021 first quarter edition of the PAM with the updated information. If you have any questions, please contact Provider Network Services at 1-800-924-7141.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Document Each Required Part of a TennCare Kids Exam

TennCare Kids' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have seven key components:

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests
- Immunizations
- Health education/anticipatory guidance

When your BlueCare Tennessee patients visit your office for their well-child checkup, please document all seven required parts of the exam, as well as assessments of their nutrition and physical activity. Claims submitted for EPSDT visits must match your patients' medical records and contain codes for all parts, including the physical exam, vaccines, lab tests, and hearing, vision, milestone and depression screenings. Additionally, your patients' medical records should match the EPSDT record you send to us and include all care given during the exam.

If you're unable to complete a checkup because a patient is uncooperative, deferred or refused any part of the exam, please be sure to include this information in the patient's medical record.

For more information about the required components of TennCare Kids' EPSDT exams and medical record documentation requirements, please visit our **TennCare Kids provider page**.

Prior Authorization Requirements for Durable Medical Equipment

All durable medical equipment (DME) supplies that cost more than $200◊ require prior authorization, but it's not required for most DME under $200. Apnea monitors, breast pumps◊ and nebulizer rentals also don't require prior authorization, regardless of cost.

DME codes and supplies that do require prior authorization (regardless of cost) are listed below:

- Exclusions specified by TennCare (per TennCare Rules)
- Miscellaneous DME codes
- All hospital beds, mattresses and accessories codes
- Continuous glucose monitor transmitter and receiver
- Insulin pumps
- Prosthetics and accessories
- Wheelchairs and accessories
- All repairs and replacements
- Labor charges
- Brand-name incontinence products and quantity amounts over 200
- All formula
- Hip-knee-ankle-foot orthotics, ankle-foot orthotics and multiple piece braces
- Equipment rentals (except for nebulizer, breast pump and apnea monitor rentals)

If you have questions about these prior authorization requirements, please contact your Provider Network Manager.

◊**Please note:** CoverKids benefits don't include oral formula or breast pump rentals.

Hospice Claims Must Meet Certain Guidelines for Payment

Hospice care is a covered benefit for members by the Social Security Act, but all care must meet certain guidelines for payment including the following:

- Member's provider develops plan of treatment
- Hospice services provider must be Medicare Hospice certified to deliver hospice care
- Claims must document medical necessity of days billed, services coded at the appropriate level and/or billed according to recognized utilization standards

All claims payments are subject to post-payment audit and recoupment if they don't meet requirements outlined in the **Medicare Benefit Policy Manual**.

Medical Appeals Process Change for CoverKids Members

On Jan. 1, 2021, the Division of TennCare consolidated CoverKids into the TennCare Contractor Risk Agreement. CoverKids members are now assigned to one of the three TennCare managed care organizations.

As part of this change, CoverKids members or their authorized representatives should file member medical appeals directly to the Division of TennCare at **tn.gov**. If you're filing a member medical appeal on behalf of a member, please submit a signed Appointment of Representative (AOR) Form with your appeal, if an AOR form isn't already on file with the Division of TennCare.

Also, please note that Continuation of Benefits isn't applicable for CoverKids during the member medical appeals process.

If you have questions, please contact your Provider Network Manager or see the **BlueCare Tennessee Provider Administration Manual**.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ , BlueEssential (HMO/SNP)℠ ad BlueCare Plus plans unless stated otherwise.

In-Home Screenings Available for Your Patients Reminder

The relationship between you and your patients who are BlueCross BlueShield of Tennessee Medicare Advantage plan members is instrumental in making sure they get certain preventive screenings you recommend. We understand it may be difficult to get patients into your office or for them to get follow-up testing. That's why we work with vendors who provide certain in-home preventive screenings. The following in-home test kits and preventive screenings are available for our BlueAdvantage, BlueEssential and BlueCare Plus/BlueCare Plus Choice plan members:

- HbA1c testing
- Urine microalbumin screening
- iFOBT/FIT test
- Bone mineral density testing
- Diabetic retinal eye exam
- Peripheral artery disease testing
- Comprehensive history and physical exam

For more information or to arrange certain in-home preventive screenings for your patients who are BlueCross BlueShield of Tennessee Medicare Advantage plan members, please contact your local Medicare Advantage provider outreach consultant.

Provider Assessment Form Reimbursement Returns to Regular Schedule

In 2021, you'll again be eligible to receive reimbursement for completing a Provider Assessment Form (PAF) for your patients who are enrolled in BlueAdvantage or BlueEssential MA plans. The 2021 PAF reimbursement will return to the regular schedule outlined below:

- **$225** for dates of service between Jan. 1 and June 30, 2021
- **$175** for dates of service between July 1 and Dec. 31, 2021

To be reimbursed, please upload the completed PAF to the Quality Care Rewards application in Availity or fax a completed PAF to 1-877-922-2963. Please use CPT® code 96160 to file a claim for PAF submission. The completed PAF should also be included in your patient's medical record. You don't need to wait 365 days between PAF submissions as the benefit is each calendar year. For more information about the PAF, please visit the **Quality section on our provider website**. As a reminder, PAF forms are now able to be completed via a telehealth (audio and video) visit with your patient.

COVID-19 Vaccination Coverage Through 2021

Consistent with coverage by CMS for beneficiaries under Original Medicare, coverage of a COVID-19 vaccine and its administration will be covered under Part B benefits for members enrolled in BlueAdvantage, BlueEssential and BlueCare Plus.

High-Tech Imaging Process for Prior Authorizations

As a reminder, high-tech imaging prior authorization requests for BlueAdvantage, BlueEssential and BlueCare Plus may be submitted online through Availity by launching the **Prior Authorization Submission / Review Application** and then selecting the **NIA Magellan** link. If you'd like to schedule prior authorization training, please contact your eBusiness Marketing Consultant. Please note that NIA Magellan is a different vendor than the high-tech imaging vendor used for Commercial members.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

New Tool Supports NDC and J-Code Claim Filing

Effective Jan. 1, 2021, for all lines of business, claims with provider-administered drug charges must include the valid NDC code. Claims submitted without an NDC will be rejected. Claims submitted with an invalid combination of HCPCS and NDC will result in the line item being denied. We've launched the RC Claim Assist tool to help you validate NDC and HCPCS combinations and dosages with unit conversions to file medical and pharmacy claims. Simply log in to Availity and go to Payer Spaces, Resources tab, RC Claim Assist. You may be asked to register as a new user, but you won't incur any additional charges.

Changes to Commercial Plan Prior Authorizations

As of **Jan. 1, 2021**, the following drugs have transitioned from Magellan RX to our prior authorization list:

Tecartus	Brineura	Givlaari
Kymriah	Luxturna	Vyondys 53
Yescarta	Zolgensma	
Spinraza	Exondys 51	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity and clicking **Patient Registration**, then **Eligibility and Benefits Inquiry**. You may submit authorization requests through Availity, fax to Commercial Utilization Management at **1-866-558-0789** or call **1-800-924-7141**.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at 1-800-924-7141 and follow the prompts for option 1.

Revised Evaluation & Management Current Procedural Terminology (CPT®) Codes for Commercial Claims

The American Medical Association recently announced changes to CPT® codes for Evaluation & Management services effective Jan. 1, 2021. These changes include:

- Removal of code 99201
- Revisions to the description for codes 99202-99215
- Addition of code 99417

Providers are responsible for ensuring codes billed are valid for the date of service. CPT® codes, updates and resources can be obtained from the **American Medical Association**. There are no Relative Value Units (RVU) or reimbursement changes to existing or revised Evaluation & Management CPT® codes.

Reimbursement for newly established Evaluation & Management codes will be set pursuant to the applicable agreements, fee schedules, and our Provider Administration Manuals.

CMS Releases New Flu Vaccine Codes for 2020/2021

CMS has released the following payment allowances and codes for flu vaccines during the 2020/2021 flu season.

Code	Labeler Name	Vaccine Name	Payment Allowance	Effective Dates
90653	Seqirus	Fluad (2020/2021)	$59.529	8/01/2020 – 07/31/2021
90694	Seqirus	Fluad Quadrivalent (2020/2021)	$61.000	8/01/2020 – 07/31/2021
90662	Sanofi Pasteur	Fluzone High-Dose Quadrivalent (2020/2021)	$ 60.982	8/05/2020 – 07/31/2021
90672	MedImmune	FluMist Quadrivalent (2020/2021)	$26.876	8/12/2020 – 07/31/2021
90674	Seqirus	Flucelvax Quadrivalent (2020/2021) (Pres Free)	$29.228	8/06/2020 – 07/31/2021
90682	Sanofi Pasteur	Flublok Quadrivalent (2020/2021)	$60.982	8/01/2020 – 07/31/2021
90685	Sanofi Pasteur Seqirus	Fluzone Quadrivalent 0.25ml (2020/2021) (Pres Free) Afluria Quadrivalent 0.25ml (2020/2021) (Pres Free)	$21.129	8/01/2020 – 07/31/2021
90686	GlaxoSmithKline Sanofi Pasteur Seqirus	Fluarix Quadrivalent (2020/2021) (Pres free) Flulaval Quadrivalent (2020/2021) (Pres Free) Fluzone Quadrivalent (2020/2021) (Pres Free) Afluria Quadrivalent (2020/2021) (Press Free)	$19.581	8/01/2020 – 07/31/2021

Code	Labeler Name	Vaccine Name	Payment Allowance	Effective Dates
90687	Sanofi Pasteur Seqirus	Fluzone Quadrivalent 0.25ml (2020/2021) Afluria Quadrivalent 0.25ml (2020/2021)	$9.584	8/01/2020 – 07/31/2021
90688	Sanofi Pasteur Seqirus	Fluzone Quadrivalent (2020/2021) Afluria Quadrivalent (2020/2021)	$19.168	8/01/2020 – 07/31/2021
90756	Seqirus	Flucelvax Quadrivalent (2020/2021)	$27.695	8/06/2020 – 07/31/2021

This year, in light of COVID-19, it's even more important to educate patients about the safety and effectiveness of the flu vaccine. Talk with your patients about the escalated importance of getting the flu vaccine.

Dental and Vision

This information applies to all lines of business unless stated otherwise.

Eligibility and Benefits Enhancement for Dental in Availity®

We've recently updated Eligibility and Benefits to enhance dental benefit coverage. The updates for Dental include clearer benefit descriptions, comments and categories. Please use the Feedback option to tell us what you think.

Dental Cosmetic Orthodontic Processing Guidelines

Effective Jan. 1, 2021, Commercial orthodontic claims filed with dates of service of Jan. 1, 2021, and after, will be reimbursed based on your network status and group's reimbursement option. Dental Preferred Providers agree to accept reimbursement according to the terms of their provider contract with BlueCross. Find more information in the Balance Billing section of your BlueCross BlueShield of Tennessee Provider Administration Manual.

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

Medicare Advantage 2021 Quality Program Measures Reminder

As of Jan. 1, 2021, Medicare Advantage has an updated list of quality measures included in the Quality+ Partnerships 2021 program. The updated quality program removes two previously included HEDIS® measures (Comprehensive Diabetes Care – Medical Attention for Nephropathy and Disease-modifying Anti-rheumatic Drug Therapy for Rheumatoid Arthritis) and introduces two new member experience survey measures from the Consumer Assessment of Healthcare Systems and Providers (CAHPS®) and the Health Outcomes Survey (HOS). The 2021 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Comprehensive Diabetes Care (CDC) - HbA1c Control <9%	HEDIS®	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS®	3
Breast Cancer Screening (BCS)	HEDIS®	1
Colorectal Cancer Screening (COL)	HEDIS®	1
Comprehensive Diabetes Care (CDC) - Eye Exam	HEDIS®	1
Controlling High Blood Pressure (CBP)	HEDIS®	1
Medication Reconciliation Post-Discharge (MRP)	HEDIS®	1
Member Survey Experience - CAHPS	CMS Member Survey	1
Member Survey Experience - HOS	CMS Member Survey	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS®	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS®	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1

For more information about the new program year measures, please contact your local Medicare Advantage Provider Quality Outreach consultant. Your consultant will also be reaching out with more details around the two new member experience measures.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Availity Online

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

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If you have questions about a patient's BlueCross BlueShield of Tennessee plan benefits or would like to learn more about our COVID-19 response, please visit **BCBSTupdates.com** or contact your Provider Network Manager.

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Get Important Messages and Announcements by Email

Would you like to get important email messages that apply to you? Simply update your **Contact Preferences** from our Payer Spaces on **Availity®** and opt-in to make email your preferred communication method for each of these communication types:

- **Contracting –** Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies
- **Credentialing –** Information about your credentialing status
- **Network Operations –** Updates about network enrollment and your listing in the BlueCross Provider Directory
- **Network Updates –** General business announcements, newsletter updates and surveys
- **Quality and Clinical Information –** Notifications of available clinical data, performance and payment reporting for our value-based programs, the Quality Care Quarterly newsletter, and annual updates to Commercial BlueCross performance ratings
- **Financial Updates –** Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items

Once logged in to BlueCross Payer Spaces on **Availity**:

1. Select the **Contact Preferences & Communication Viewer** tile.
2. Choose your **Contact Type**, and then your **Organization** (based on tax ID).
3. Verify your **Provider Name** and **NPI**; then click **Submit**. (If you notice multiple provider names in the left pane, choose the ones you want to update, and update them in the right pane.)
4. Follow the remaining cues including checking the email **Opt In** box and making sure email is the first option in the Communication Preference list on the right-hand side. When finished, click **Save & Submit**. (You can apply the same updated contact details to other Contact Types by checking the **Contact Type** boxes – or the **Select All** box, which automatically checks all Contact Types you have access to.)

In some cases, you may find it takes time to receive these messages through your newly specified email, and you may temporarily receive them as you did before. If this causes concern, please visit our **Provider Service page** where you can find links to our Enrollment and Technical Support teams.

If you have questions or need help with Availity, please visit Availity.com or contact our eBusiness Service team at (423) 535-5717 (option 2).

HEDIS® MY2020 Medical Record Requests to Begin Soon

Each year, we're required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA uses these measures to determine whether members received the care and screenings they needed, and if the care improved their health.

You may soon receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well-child visits.

If you need help submitting your records using any of the following methods, please call us at **(423) 535-3187**.

- Remote access to your electronic medical records
- Secure email
- Fax
- On-site collection
- Our web-based portal

HEDIS® is a registered trademark of NCQA.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless stated otherwise.

Every In-Person Visit is an Opportunity for a Well-Child Checkup

When patients visit your office this winter for acute or other types of care, consider checking their medical records to see if they're up to date on preventive care before their appointment. Sometimes, the only chance you have to perform a well-child exam is when patients visit your office because of an illness or other need. So, TennCare Kids' screening guidelines allow you to receive reimbursement for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups performed at the same time as in-person visits for acute or other types of care.

According to the Tennessee Chapter of the American Academy of Pediatrics (TNAAP), you can bill for both a sick and well visit on the same day if the following criteria are met:

- You may report an additional evaluation/management service if you find a significant problem on the same day as a wellness check that requires you to provide care beyond the workup of a normal preventive visit. Please attach a Modifier-25 to the code for the additional E/M service when submitting the claim.
- Your documentation for the visit should reflect the extra work done during the appointment for the problem. There doesn't need to be a separate note, but documentation should clearly reflect a separate problem.

For more information about EPSDT exams, please visit our **TennCare Kids Tool Kit**. You can also find free TNAAP EPSDT and coding resources at **TNAAP.org**.

Special Considerations During the COVID-19 Emergency

Due to the ongoing COVID-19 public health emergency, the Division of TennCare has extended its telehealth guidelines until March 31, 2021. You can read the Division of TennCare memo about well-child care here.

Note: The information in this article doesn't apply to CoverKids.

Medicare Advantage and BlueCare Plus Tennessee

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans.

COVID-19 Vaccine Available for At-Risk Seniors

The Tennessee Department of Health updated their COVID-19 Vaccination Plan to include age-based criteria simultaneously with front-line and essential workers. Almost every county in Tennessee is now offering vaccination to those over age 75, with Davidson and Shelby Counties being notable exceptions. Those who are 65 and older can receive the vaccination in the coming month according to the current immunization plan.

You're encouraged to discuss the COVID-19 vaccine with all BlueAdvantage, BlueEssential and BlueCare Plus plan members ages 65 and older because they generally are at a higher risk. The vaccine is available with no member cost share. As a reminder, COVID-19 vaccinations are reimbursed

through Original Medicare plan for calendar year 2021. There is no cost to the member. This includes Medicare Advantage plan members. Please file COVID-19 vaccine and administration claims directly to Original Medicare through the Tennessee MAC (Palmetto GBA) for all Tennessee BlueAdvantage, BlueEssential and BlueCare Plus plan members.

Please note that during the early phase of vaccine deployment, vaccinations across Tennessee are available through county health departments and approved facilities. Please consult the Tennessee Department of Health website for times and locations or COVID-19 vaccine by county.

Medicare Outpatient Notice Required for Observation Patients

Hospitals and critical access hospitals are required to provide a Medicare Outpatient Observation Notice (MOON) to all Medicare beneficiaries, including BlueAdvantage, BlueEssential and BlueCare Plus plan members. The notice lets Medicare beneficiaries know they're receiving outpatient observation services and aren't inpatients of the hospital.

You can find the **beneficiary notice and accompanying instructions** online. The MOON is a CMS requirement for any member who receives observation services as an outpatient for more than 24 hours.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Opioid Prescription Changes Affect Medicare Advantage Plans

As a reminder, the Centers for Medicare and Medicaid Services (CMS) changed their opioid prescribing guidelines effective Jan. 1, 2019, and these apply to all BlueAdvantage, BlueEssential and BlueCare Plus plans. The changes include the following restrictions:

- Prescriptions are limited to a total of 90 morphine milligram equivalent (MME*) per day when two or more prescribers contribute to the opioid prescriptions
- Members who don't regularly take an opioid prescription are limited to seven days for their initial fill
- Prescriptions are limited to a total of 200 MME per day
- Concurrent use of long-acting opioids
- Concurrent use of opioids and benzodiazepines

Note: These prescriptions will reject at point-of-sale, but the pharmacist may be able to override these rejections in certain situations. If not, you'll need to request a coverage determination if the member needs to continue the medication as prescribed.

More details about the CMS changes are available at their website.

Prior authorization is also required by our Medicare Advantage prescription drug plans for all long-acting opioid medications. And all opioids have quantity limit restrictions.

- **2021 BlueAdvantage formulary**
- **2021 BlueEssential formulary**
- **2021 BlueCare Plus formulary**
- **2021 BlueAdvantage, BlueEssential and BlueCare Plus prior authorization criteria**

To request prior authorization or coverage determination, please call or fax us at:

BlueAdvantage: 1-800-831-2583 or fax (423) 591-9514

BlueEssential: 1-800-851-2583 or fax (423) 591-9514

BlueCare Plus: 1-800-299-1407 or fax (423) 591-9514

*MME represents a drug's potency equivalent to a dose of morphine

Commercial Prior Authorization Criteria

We've published the prior authorization **prescription drug criteria** for the commercial line of business on **bcbst.com**. Please bookmark the link for easy reference.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at 1-800-924-7141 and follow the prompts for option 1.

Use Correct Modifier for Durable Medical Equipment (DME) Purchase and Rental Requests (RR)

When submitting authorization requests for DME, please make sure requests are submitted with the correct modifier for RR instead of purchase (NU). **All items with Medicare-capped rental requirements should be submitted with the RR rental modifier.** We've seen instances where the authorization request is submitted with an NU modifier, but the claim is submitted with an RR modifier. Also be sure that requests are submitted with the same left, right or bilateral modifier that will be submitted with the claim. You can find a list of all items that are considered capped rentals at CMS.gov. Incorrectly submitting authorization and claim requests with inappropriate modifiers could result in payment delay or claim denials.

Front-End Institutional Claims Processing Change

At the direction of the Division of TennCare, we'll soon be updating our front-end institutional claims processing rules for BlueCare, TennCare*Select*, BlueCare Plus and CoverKids. Once the rules take effect, the Type of Bills listed below must be submitted with the corresponding Patient Status codes. Claims will be returned unprocessed if they don't include the correct Type of Bill and Patient Status combinations:

- If Type of Bill 111, 211, 114 or 214 (including the frequency code) is submitted on a claim, then the Patient Status on the claim must be 01-07, 20, 21, 43, 50, 51, 61, 62, 63, 64, 65, 66, 69, 70 or 81-95.
- If Type of Bill 112, 113, 212, or 213 (including the frequency code) is submitted on a claim, then the Patient Status on the claim must be 30.

We're currently working with TennCare to determine an effective date for this update. We'll share more information closer to the implementation date.

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

Providing Appropriate Screenings and Services for Older Adults

Your 2021 Quality+ Partnerships program includes a Care for Older Adults (COA) measure. Reported by Special Needs Plans (SNP) and Medicare-Medicaid Plans (MMP) only, the Care for Older Adults measure helps make sure older adults enrolled in these plans receive appropriate screenings and services. If you have SNP plan members, please make sure the following services below are completed each year:

- Medication review
- Functional status assessment
- Pain assessment

For specific information on each of these services, please refer to your 2021 Quality+ Partnerships Program Information Guide, located **here** or contact your local provider Quality Outreach Consultant.

THCII Episodes of Care Program Reports Available This Month

Quarterbacks participating in the Episodes of Care Program will receive their 2021 Interim Performance Reports for our Medicaid and Commercial lines of business on February 18. Please log in to Availity.com to review your reports.

If you have trouble accessing your reports in Availity, please call (423) 535-5717 and choose option 2, or email **eBusiness_Service@bcbst.com** for assistance.

Simple Tips to Improve Quality Care for Patients

When patients are trying to understand medical conditions and recommended treatments, they can sometimes feel overwhelmed by the information they're receiving. This can sometimes affect whether their treatment is successful. Here are some easy tips that can help you make sure your patients are getting the information they need.

1. **Explain things in ways that are easy to understand.** When talking with patients about a medical condition or treatment plan, try to avoid medical jargon. Consider using shared decision-making tools to help patients learn more about their conditions and options for treatment.
2. **Make eye contact with your patients, and spend time listening carefully to them.** Ask your patients or their caregivers if they have concerns, as well as questions. The National Institutes of Health (NIH) recommends asking open-ended questions that require patients to reveal more than a simple yes or no. Additionally, talk with them about the care they receive from other providers to make sure they understand all of the information they're receiving about their treatment plan.
3. **Be as respectful as possible about patients' thoughts and beliefs and try to continue conversations at the next visit if they refuse care.** For example, if parents don't want their child to receive a needed vaccination, work with them to find one action item that you can agree upon, like scheduling a follow-up appointment.
4. **Use the teach-back method, which involves asking patients to explain what they need to do in their own words.** According to the NIH, this technique lets you see if patients need additional information or if they understand the information you presented.

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This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Availity Online

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

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Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

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MARCH 2021

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BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and network providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

COVID-19 Resources for Your Practice

We know you're working hard to deliver care to your patients who are BlueCross BlueShield of Tennessee plan members during the ongoing COVID-19 emergency, and we wanted to share some resources you may find useful.

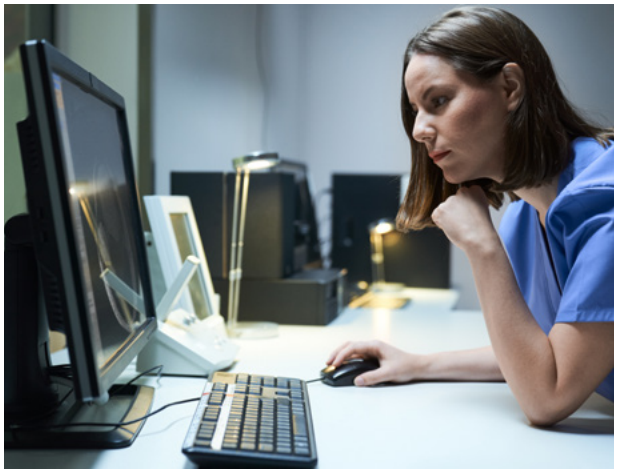
Professional and government organizations, including the **American Academy of Family Physicians**, **American College of Obstetrics and Gynecology**, and **Tennessee Department of Health**, continue to offer information about COVID-19 on their websites. Resources include clinical and practice management guidance.

If you have questions about a patient's BlueCross BlueShield of Tennessee plan benefits or would like to learn more about our COVID-19 response, please visit **BCBSTupdates.com** or contact your Provider Network Manager.

Potential Fraud Alert – Third-Party Fax Requests

We've been made aware that some members are receiving medications, medical supplies and equipment without requesting or needing these items. We believe these cases are occurring because third-party companies are soliciting information from members and faxing authorization requests to their providers. In many cases, these fax forms are pre-filled and look like legitimate requests. Office staff may not know when these requests are an attempt to get approval for prescriptions or equipment that the member doesn't need or expect, so it's important to look for these tell-tale signs:

- The request comes from an out-of-state pharmacy or durable medical equipment company
- The form is pre-filled with the SIG and asks for a high number of quantities or refills
- The request lists a range of possible conditions the member may or may not have



When you receive these requests, we encourage you to contact your patients to verify if they've asked for the medications, medical supplies or equipment. If you suspect you've received a request that may be fraudulent, please contact our Confidential Compliance Hotline at 1-888-343-4221 or e-mail us at **ComplianceHotline@bcbst.com**.

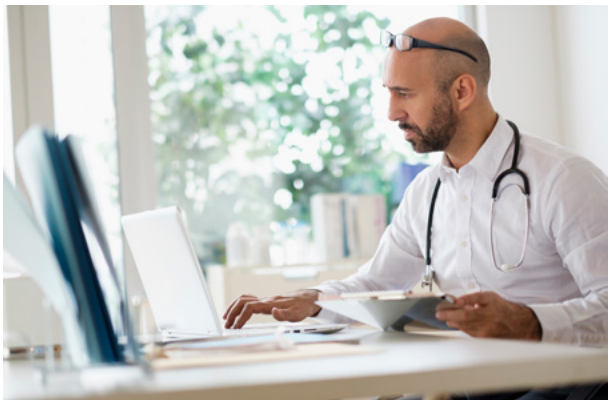
Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Changes to Musculoskeletal (MSK) Program Prior Authorization for Commercial Plans

Beginning May 1, 2021, the following codes will be added to the MSK Prior Authorization List and will require prior authorization for members with the MSK Program Benefit:

20930	0098T	0165T	0221T	0275T	S2112
20985	0163T	0219T	0222T	G0289	S2118
22850	0164T	0220T	0274T	J7330	S2348
22852					



BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Explore the Differences between EPSDT- and HEDIS®-Compliant Well-Child Exams

TennCare Kids' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have reporting criteria and eligibility requirements that differ from the well-child visit performance measures included in the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). Here's some information to help you brush up on the basics for each.

EPSDT Visits

Children and adolescents enrolled in BlueCare or TennCareSelect are eligible for TennCare Kids exams from birth until their 21st birthday. The schedule for EPSDT exams follows the American Academy of Pediatrics periodicity schedule.

The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year. Patients are eligible as long as they've had BlueCare Tennessee coverage for 90 continuous days at some point during the fiscal year.

HEDIS® Quality Measures

The NCQA recently released several updates to the measures for well-child care. Two performance measures apply to well-child checkups: Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV).

These measures determine if children and adolescents receive the appropriate number of well-child visits during the measurement year for their age.

- W30 has two reported rates, which evaluate whether children get the correct number of well-child visits before age 15 months and between ages 15-30 months.
- WCV evaluates the rate of children and adolescents between ages 3 and 21 who receive an annual well-visit during the measurement year.

The measurement year for HEDIS begins Jan. 1 and ends Dec. 31. Children must be enrolled in their health plan for the entire calendar year to be included in a primary care provider's patient population. However, the measures allow one gap in coverage of up to 45 days.

For more information about EPSDT exams and coding EPSDT visits, please visit our TennCare Kids Tool Kit.

Note: This article doesn't apply to CoverKids members.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Coordinating Services for Your School-Age Patients

BlueCare Tennessee can help coordinate medically necessary in-school covered services (including physical, speech, occupational and behavioral health therapies) for our members that are age 20 and younger. In addition to a provider's order for services, the Division of TennCare requires that children and young adults receiving school-based services have an individualized education program (IEP) including that service, as well as a signed parental consent form.

Please note, schools are no longer required to submit students' IEPs prior to delivering these services. However, BlueCare Tennessee is required to conduct regular post-payment sample audits of claims for these services and will request documents including IEPs to support the medical necessity of the school-based services we reimburse.

For more information about the requirements for school-based services, please see the **BlueCare Tennessee Provider Administration Manual**.

Fax Number Update for Prior Authorization Requests

Please fax all prior authorization requests for BlueCare, TennCareSelect or CoverKids members to 1-800-292-5311. Previously, a separate fax number was used for CoverKids members, but this number will no longer be in service beginning April 1, 2021.

You may also submit prior authorization requests in Availity®. If you have questions about using Availity, please call (423) 535-5717 and choose option 2.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO/SNP)℠ plans unless specifically identified below.

Digital Care Management Programs Available

BlueAdvantage and BlueCare Plus members have access to digital care management programs designed to engage and support plan members in managing their chronic conditions. CareTN is a free mobile app that offers on-the-go access to care management programs. Like our telephonic care management, CareTN provides one-on-one messaging with a BlueCross nurse, social worker, pharmacist and dietitian. Members need a smart device to download and use the app. Some features of the app include medication lists with reminders, goal setting with progress monitoring, appointment reminders and access to a CMS-approved health library with articles and videos. Plan members may self-enroll using the code *medhelpwell* or by calling 1-800-611-3489 to get help from one of our nurse care managers.

Screen Patients for Fall Risk and Urinary Incontinence

Your interaction with patients who are BlueAdvantage or BlueEssential MA plan members may have a direct impact on their response to the Health Outcomes Survey (HOS). Consider incorporating some simple techniques into your daily interactions may help provide a better experience, help drive better health outcomes and possibly lead to better BlueAdvantage and BlueEssential MA plan member retention:

- Screen for urinary incontinence and discuss treatment options if positive
- Recommend treatment options no matter the frequency or severity of the bladder control problem
- Discuss balance problems, falls, difficulty walking and other fall risk factors
- Recommend using assistive devices like a walker or cane if appropriate
- Check standing, sitting and reclining blood pressures
- Recommend a physical therapy or exercise program if appropriate
- Perform bone density screenings, especially for at-risk patients
- Consider having home health perform a home safety assessment to look for fall risks

For more information on the HOS survey, please visit the Quality Care Initiatives section on provider.bcbst.com.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

New Provider Education WebEx Presentations

Two updated presentations were added to the BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series in Availity. The presentations provide an overview of the BlueCross Medicare Advantage quality program and an in-depth review of the measures in the 2021 program.

These educational opportunities can help improve your performance in the BlueCross Medicare Advantage Provider Quality+ Partnerships program. Topics include medication reconciliation, Provider Assessment Forms, the risk adjustment process, member survey measures and more.

To access the presentations after logging in to Availity, choose **BlueCross BlueShield of Tennessee** within **Payer Spaces** and then select **Resources**. On the Resources page you'll see a list of all the WebEx presentations.

Opportunity for Frailty Exclusions

The Centers for Medicare & Medicaid Services (CMS) allows your patients who are BlueAdvantage, BlueEssential and BlueCare Plus members to be excluded from some quality measures when they have specific advanced illness and/or frailty diagnoses. Exclusions to these measures are made because the HEDIS definition includes services that may not benefit older adults with advanced illness that limits their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes often aren't captured during routine office visits. Annual wellness exams offer a yearly opportunity to address gaps in care as well as possible exclusions. Coding eligible frailty conditions during the current year qualifies the plan member for exclusions related to frailty and/or advanced illness.

Common frailty conditions that exist in the senior population include:

- History of falling (Z91.81)
- Weakness (R53.1)
- Muscle weakness (M62.81)
- Other malaise (R53.81)
- Other fatigue (R53.83)
- Difficulty in walking (R26.2)

For more information and codes related to exclusions for advanced illness and frailty, please refer to our **Guide to Advanced Illness and Frailty Exclusions**.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

New Tool Supports NDC and J-Code Claim Filing

Effective Jan. 1, 2021, for all lines of business, claims with provider-administered drug charges must include the valid NDC code. Claims submitted without an NDC will be rejected. Claims submitted with an invalid combination of HCPCS and NDC will result in the line item being denied.

We offer the RC Claim Assist tool to help you validate NDC and HCPCS combinations and dosages with unit conversions to file medical and pharmacy claims. Simply log in to Availity and go to BlueCross BlueShield of Tennessee Payer Spaces, Resources tab, RC Claim Assist. You may be asked to register as a new user, but you won't incur any additional charges.

Prior Authorization and 90-Day Supply Benefits for BlueCare Tennessee Members

The TennCare pharmacy benefit manager (PBM) allows prescribers and providers caring for BlueCare and TennCareSelect members to bypass prior authorization requirements for certain medications when patients have specific medical conditions. You can view the specific medications and corresponding diagnosis codes on the **Appropriate Diagnosis for PA Bypass List**.

To bypass authorization requirements, pharmacists must submit the claim with both a Diagnosis Code Qualifier of "02," representing the ICD-10 code (Field #492-WE), and an appropriate Diagnosis Code (Field #492-DO). To reduce processing delays, please include the applicable diagnosis code (ICD-10 code) on written prescriptions for inclusion on the electronic pharmacy claim.

If you'd like to review the list of preferred medications and the clinical criteria for prescribing each, please visit the **TennCare PBM**. If you have questions about prior authorization requirements, please email **tnrxeducation@optum.com**.

Refresh Your Knowledge about the 90-Day Supply Benefit

In April 2020, the TennCare Pharmacy Program announced temporary pharmacy benefits enhancements due to the COVID-19 pandemic, including a 90-day supply benefit. Your patients enrolled in BlueCare or TennCare*Select* can get 90-day supplies of maintenance medications on the TennCare **Auto-Exempt** and **Attestation** lists.

If you have questions, please call the PBM Support Center at 1-866-424-5520. For more information and updates about the TennCare Pharmacy Program's COVID-19-related benefit enhancements, please visit **BCBSTupdates.com** or **tn.gov/tenncare**.

Tips for Coding Professionals

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Quality Care Rewards

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Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality+ Partnerships Program for BlueAdvantage, BlueCare Plus and Blue Essential plans offer enhanced reimbursement to providers who achieved quality scores of 4 Stars and above with coding accuracy during the 2020 measurement period (Jan. 1 through Dec. 31, 2020).

Stars ratings, based on last year's performance, may affect reimbursement rates for provider's who participate in this program starting April 1, 2021. Impacted participating providers will receive a rate adjustment notification letter and a rate attachment with the new fee schedule by April 1. Impacted participating provider's contract amendment will include information about your base rate, the quality escalator and total earning potential.

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CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

21PED1052529 (02/21)

APRIL 2021

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

COVID-19 Updates

During the COVID-19 emergency, we're making changes to help our members and providers stay safe. Please visit the Provider FAQs at **BCBSTupdates.com** for up-to-the minute guidelines on treating our members.

INSIDE THIS ISSUE

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COVID-19 Resources for Your Practice

We know you're working hard to deliver care to your patients during the ongoing COVID-19 emergency, and we wanted to share some resources you may find useful. Professional and government organizations, including the **American Academy of Family Physicians**, **American College of Obstetrics and Gynecology**, and **Tennessee Department of Health**, continue to offer information about COVID-19 on their websites. Resources include clinical and practice management guidance. If you have questions about your patients' benefits or would like to learn more about our COVID-19 response, please visit **BCBSTupdates.com** or contact your Provider Network Manager.

in Governor Lee's Executive Order 68. We'll work with any hospital that has met the CMS criteria to implement the program.

- We're allowing flexibility to charge inpatient rates in the emergency department or other units where patients may need to be housed, based on intensity of service.
- We've reduced the burden of credentialing during this difficult time. While it's critical we have accurate rosters of providers to load into our claims system to expedite payments, BlueCross is adhering to Executive Orders and NCQA guidance related to licensure, extending time for re-credentialing, relaxing EFT requirements, providing for expedited credentialing and enrollment, and, where necessary, willing to accept the bare minimum information required from hospitals to ensure member safety (i.e., current license and NPDB report).

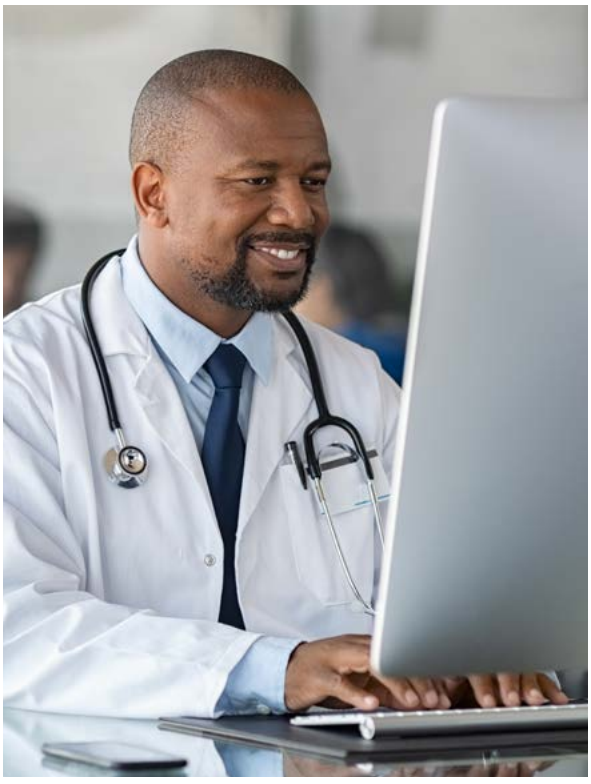
Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so if you're not sure when to renew your license, please take a look. A current license tops our list of required provider credentials and we're obligated to terminate providers from our network when their licenses expire. Providers who want to rejoin the network following termination due to license expiration will have to reapply and go through the credentialing process again. It's also important to note that any claims submitted by an unlicensed provider will be denied.

Update to Non-Physician Practitioner Copay Amounts

Earlier, we wrote about a systems issue which didn't allow us to assign the appropriate member copay for primary care or specialist services when the services were rendered by a nurse practitioner or physician assistant. Member copays for covered services provided by these providers should be consistent with the specialty type of their supervising physician and the provider type (i.e., primary care or specialist) where the services were provided.

As mentioned in our January issue of BlueAlert, we corrected this issue in our system but would need to delay implementation. Starting July 1, 2021, we'll begin to implement these updates. Please know we will base member copays for all lines of business (excluding Federal Employee Program and BlueCard) on whether the nurse practitioner or physician assistant is supervised and the services are provided by a primary care physician or specialist. Please look for complete billing guidelines in the next update of your **Provider Administration Manual**.



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BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information on the CAQH platform and complete network verification at Availity.com. Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review.

The new Network Verification Form is located in the BlueCross payer space in Availity behind the Provider Enrollment, Updates and Changes tile. For your convenience, the application allows most provider groups to easily review multiple practitioners at once. For the time being, ancillaries and facilities will continue to receive the paper Data Verification Form until we can migrate all providers to this new process. If you have questions, please contact our Provider Service line at **1-800-924-7141** and follow the prompts to Contracting and Credentialing.

All Blue Workshop Scheduled for Aug. 3, 2021

This year's All Blue Workshop will be a half-day, live-streaming event. Please mark your calendars and save the date for Tuesday, Aug. 3. You can choose to attend the morning or afternoon virtual session, where we'll discuss the latest news about topics that are important to you and your practice. Please check upcoming issues of BlueAlert for registration information and more details.

Commercial

This information applies to Blue Network P℠ and Blue Network S℠ unless stated otherwise.

Timely Filing Reminder

We're sharing a friendly reminder that the BlueCross timely filing period for our Commercial line of business is within six months from the date of service for physicians, and six months from the date of discharge for facilities. We can make an exception if you have documented evidence that the member didn't give you their BlueCross insurance information at the time of their appointment or discharge. If this occurs, the timely filing provision begins when you receive the member's insurance information.

Examples of documented evidence include:

- A signed and dated document from the member showing when you received their insurance information
- A note in the member's records showing when you received the member's information

Please note that this may be subject to member benefits. If you have questions, please refer to your **BlueCross Provider Administration Manual** or call our Provider Service line at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. ET.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Stay Up to Date on the BlueCare Tennessee Provider Appeals Process

If you disagree with the way we've processed a claim, you may use our claims reconsideration and appeal process to request a second look. To help make sure reconsideration and appeal requests are processed quickly and correctly, we've put together a few reminders to help with submission. Please note that the below process differs from the process used for utilization management or clinical authorization appeals.

Level 1: Reconsideration – Reconsideration requests must be received within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration by calling us or filling out the **Provider Reconsideration Form**. Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or multiple claims. Please include any supporting medical records as needed.

Please note that you must file a request for reconsideration before submitting an appeal, unless your request is related to a non-compliance denial.

Step 2: Appeal – An appeal must be received in writing with **all supporting medical records** within 60 days of the date of the initial denial notification. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each form should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeal process, please see the **BlueCare Tennessee Provider Administration Manual**.

Save the Date: Virtual EPSDT Coding Workshop

Please join us May 13, 2021, for a virtual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coding workshop featuring Janet Sutton, program manager for the Tennessee Chapter of the American Academy of Pediatrics.

The hour-long workshop is scheduled for 1 p.m. Eastern, noon Central and will cover:

- An overview of EPSDT
- EPSDT Documentation Requirements
- 2021 Coding Updates
- BlueCare Tennessee Resources

Register Today

To sign up, please email **CommunityEngagement@bcbst.com** and provide the following:

- Your name
- Your email address
- The name of your practice
- How many from your office plan to attend

After we receive your email, we'll send you a confirmation and calendar invitation with a link to join the workshop.

Well-Child Care Builds a Foundation for Lifelong Health

All children and teens need well-child care, including regular screenings and vaccinations. Children with special health needs often require extra care and visits to specialists and their primary care providers. Even though you may see these patients frequently for ongoing care, they still need well-child checkups.

Your patients under age 21 are eligible for TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams on the same schedule recommended by the American Academy of Pediatrics. Consider using your electronic health record system or our Quality Care Rewards application to see which patients are due for well-child care, and then contact families to schedule an appointment. If families are unable to bring their children for an in-person visit due to the ongoing COVID-19 emergency, you can complete certain components of the visit using telehealth and follow up with an in-person visit once the public health emergency ends. The Division of TennCare has extended its current telehealth policies until June 30, 2021. You can read more about these policies **here**.

For more information about delivering well-child care and the components of an EPSDT exam, please see our **TennCare Kids Tool Kit**.

Join Us for a Workshop on Coping with Grief

Support is key to helping people deal with loss. On May 7, 2021, join us for "Good Grief: Helping Clients Cope with Loss," a virtual workshop led by Mark Sanders, LCSW, CADC, an international speaker, trainer and consultant in the behavioral health field.

We're hosting the event in collaboration with the Tennessee Association of Alcohol, Drug and Other Addiction Services (TAADAS), and we encourage BlueCare Tennessee behavioral health providers to attend. The three-hour session will begin at 10 a.m. Eastern, 9 a.m. Central, and cover many aspects of understanding grief, including:

- The wide range of losses people grieve
- How to use the five models of grief recovery while working with patients
- 15 strategies to help people deal with loss

Space is Limited

Registration is required, and continuing education units are available to those who participate. Limited spots are available, so please register by April 15. You can register by sending an email to **communityengagement2@bcbst.com**. When you send your email, please let us know:

- Your name
- Your email address
- The name of your practice
- How many from your office plan to attend

If more than one person from your practice is registering, please include the name and email address for each person. This way, we can send everyone their own access link to the workshop and CEUs afterward. As we pass the one-year mark of the ongoing COVID-19 emergency, we must recognize the grief and loss that many families are experiencing. We hope you can attend this important event.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-DSNP)℠ plans.

New Modifier for Denied Predetermination Process

Effective July 1, 2021, you may submit modifier "GU" for services after you receive a denied predetermination (authorization request before services are rendered) for a BlueAdvantage or BlueEssential plan member. This will allow us to apply the appropriate member cost share if they ultimately have the service performed. Please make sure the member is aware of their out of pocket costs for the service. When submitting the claim, include the denied predetermination letter if possible to avoid delays in processing. If you have questions, please contact our Provider Service team at **1-800-924-7141**.

Prior Authorization Required for Home Health Services

As a reminder, **all** home health services require prior authorization. However, the initial evaluation for therapies don't require prior authorization when billed with the correct revenue code. If treatment is started on the same day of the evaluation, the authorization request should reflect that date as your care start date.

Administrative approvals are given on initial request to help make sure that your patient gets needed services more quickly and that you have enough time to get the supporting clinical documentation for ongoing care. Approvals are provided as follows:

- Home health skilled nursing: up to 13 visits over a 60-day period (this includes the initial evaluation visit)
- Home health speech therapy: up to six visits over a 60-day period
- Home health occupational and physical therapy: up to 12 visits over a 60-day period

You may request prior authorization by logging in to the BlueCross payer space in Availity or by calling **1-800-924-7141**. Please refer to the **Provider Administration Manual** for proper billing codes and procedures for Home Health initial evaluations.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Screen Patients for Fall Risk and Urinary Incontinence

Your interaction with patients covered by BlueAdvantage, BlueEssential or BlueCare Plus plans may have a direct impact on their response to the annual Medicare Health Outcomes Survey (HOS). Consider adding some simple techniques into your patient care interactions to help provide a better experience and help drive better health outcomes.

- Screen for urinary incontinence and discuss treatment options if necessary
- Recommend treatment options no matter the frequency or severity of the bladder control problem
- Discuss balance problems, falls, difficulty walking and other fall risk factors
- Recommend using assistive devices like a walker or cane if appropriate
- Check standing, sitting and reclining blood pressures
- Recommend a physical therapy or exercise program if appropriate
- Perform bone density screenings, especially for at-risk patients
- Consider having home health perform a home safety assessment to look for fall risks
- Consider ordering physical therapy for urinary incontinence for pelvic floor dysfunction

For more information on the Medicare HOS survey, please visit the Quality Care Initiatives section on **provider.bcbst.com**.

Complete Medicare-Required Special Needs Plan Model of Care Training

Providers participating in the BlueCare Plus, BlueCare Plus Choice and BlueEssential special needs plans are required by Medicare to complete our Model of Care Training after initial contracting and annually thereafter. This training promotes coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**. The training typically takes less than 30 minutes.

Although the last date to complete 2021 training and be considered a compliant provider is Dec. 31, 2021, providers are encouraged to complete the training earlier in the year.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare and CoverKids Pharmacy Benefit Manager (PBM) for Important Updates

To review important notices about prescribing changes, authorization guidelines and other related items, please visit the PBM landing page for your patient's plan:

- **BlueCare and TennCareSelect**
- **CoverKids**

Step Therapy and Prior Authorization Requirements

As of April 1, 2021, we've removed the Step Therapy section for inflammatory conditions in our Commercial Preferred, Essential and Essential Plus pharmacy guidebooks. You can find all prior authorization and step requirements in the Prior Authorization Criteria located at bcbst.com. You can navigate there by going to the line menu on the top left side of the page and then clicking:

- **Use Insurance**
- **Documents & Forms**
- **Pharmacies & Prescriptions**

As always, please don't hesitate to reach out to the provider team with any questions you have.

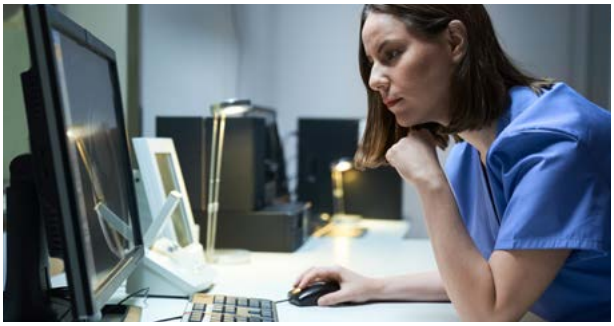
Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only. Providers are responsible for completing claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date.

If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers (option 1).



Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

2021 Commercial Episodes of Care Thresholds Now Available

The 2021 Episodes of Care program thresholds are now available online for the Commercial State Employee Health Plan and Fully Insured lines of business. To view the thresholds, please visit our **Quality Initiatives web page**.

Provider Star Ratings Now Available in Availity

The Medicare Advantage Quality+ Partnerships Program offered providers enhanced reimbursement for 4-STAR and above quality scores and coding accuracy completed during the 2020 measurement period of Jan. 1 – Dec. 31, 2020. Participating providers may view their 2020 Star rating in Availity by accessing the Quality Care Rewards application and clicking on their 2020 Medicare Advantage scorecard. The rating is located at the top of the scorecard.

Star ratings, as calculated by the previous year's performance, impacted each provider's current reimbursement rates, which are effective April 1, 2021. Providers should refer to the rate attachment provided with their rate adjustment notification letters mailed at the end of March to see their new fee schedules.

Contract amendments contain information about their base rate, the quality escalator and total earning potential.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
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21PED1072951 (03/21)

MAY 2021

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Publication Date and Schedule to Match for All Provider Administration Manuals

We're making a small change that will allow us to align the publishing schedule of all three versions of the Provider Administration Manual (PAM). In name only, we'll skip the third quarter versions of the Commercial and BlueCare Tennessee PAMs and publish both as the fourth quarter editions (the Q3 PAM becomes the Q4 PAM). As a result of this one-time change, the Q4 editions of the Commercial, BlueCare Tennessee and BlueCare Plus PAMs will publish Oct. 1, 2021, and all three will publish with the same date on the first day of each quarter going forward.

All Blue Workshop Scheduled for Aug. 3, 2021

This year's All Blue Workshop will be a half-day, live-streaming event. Please mark your calendars and save the date for Tuesday, Aug. 3. You can choose to attend the morning or afternoon virtual session, where we'll discuss the latest news about topics that are important to you and your practice. Please check upcoming issues of BlueAlert for registration information and more details.

Commercial

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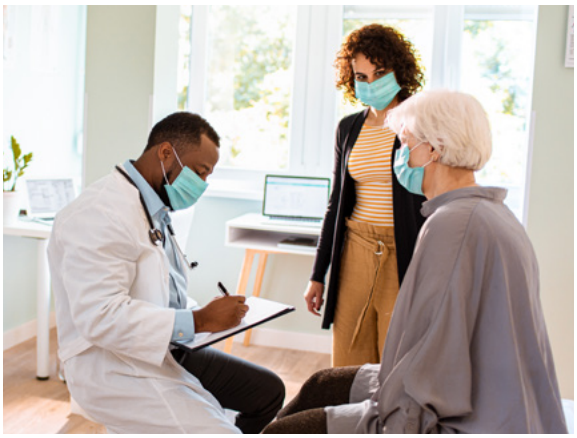
Anesthesiology Services Update

We wanted to let you know we're making some changes to how we calculate time for anesthesiology services. We measure anesthesiology time in minutes and then convert it to fractional time units. In the past, we rounded up anesthesia time units to the next whole unit. For example, 1.11 units were rounded up to 2 units. Effective July 1, 2021, we'll start rounding up anesthesia time units to the nearest tenth to better align with industry standards. For example:

- 1.41 units will be rounded up to 1.5 units
- 1.61 units will be rounded up to 1.7 units
- 1.91 units will be rounded up to 2 units



Please note that anesthesia time does not apply to Daily Hospital Management Services. This change also applies to BlueCare Tennessee. For more information, please refer to your **Provider Administration Manual**.

Timely Filing Reminder

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Examples of documented evidence include:

- A signed and dated document from the member showing when you received their insurance information
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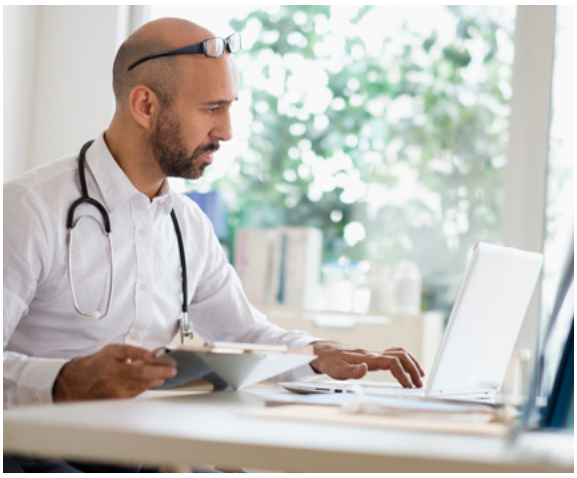

Neonatal Abstinence Syndrome (NAS) Resources Now Online

The Division of TennCare recently shared two educational resources for providers and facilities that administer medication-assisted therapy:

- TennCare's Opioid Strategy
- Neonatal Abstinence Syndrome: Education Material for Medication-Assisted Treatment (MAT) Providers

You can find links to both resources on the **Provider Tools and Resources page of bluecare.bcbst.com** under the **Behavioral Health** header.

Assess Your Patients' Vision During Well-Child Checkups

Vision screening is one of the seven key components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Please let your patients know that we cover vision screening through age 20, and refer them to an eye specialist if you have concerns about their vision or eye development. We cover eyeglasses that are medically necessary.

Children, teens and young adults are eligible for well-child care on the **same schedule recommended by the American Academy of Pediatrics**. For more information, please see our **TennCare Kids Provider page**.

Note: This information doesn't apply to CoverKids.

Stay Up to Date on the BlueCare Tennessee Provider Appeals Process

If you disagree with the way we've processed a claim, you may use our claims reconsideration and appeal process to request a second look. To help make sure reconsideration and appeal requests are processed quickly and correctly, we've put together a few reminders to help with submission. Please note that the below process differs from the process used for utilization management or clinical authorization appeals.

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Please note that you must file a request for reconsideration before submitting an appeal unless your request is related to a non-compliance denial.

Step 2: Appeal – An appeal must be received in writing with **all supporting medical records** within 60 days of the date of the initial denial notification. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each form should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeal process, please see the **BlueCare Tennessee Provider Administration Manual**.

Save the Date: Virtual EPSDT Coding Workshop

It's almost time for our virtual EPSDT workshop scheduled for May 13, 2021. Please join us for the workshop, which will feature Janet Sutton, program manager for the Tennessee Chapter of the American Academy of Pediatrics.

The event is scheduled for noon to 2 p.m. CT (1-3 p.m. ET) and will cover:

- An overview of EPSDT
- EPSDT Documentation Requirements
- COVID-19 Vaccine Coding
- BlueCare Tennessee Resources

Register Today

To sign up, please send an email to **CommunityEngagement@bcbst.com**. We'll need to know:

- Your name
- Your email address
- The name of your practice
- How many from your office plan to attend

Once we receive your email, we'll send you a confirmation and calendar invitation with a link to join the workshop.

To allow plenty of time for discussion and questions, we've extended the time of the workshop one hour. Our goal is to provide the most useful, timely information, so we've changed one of the topics to focus on coding for COVID-19 vaccines, instead of 2021 EPSDT coding updates.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ plans.

Care Plans Available in the Quality Care Rewards Application in Availity

While you've been receiving personalized care plans for your patients who are BlueEssential plan members through the mail, we want you to know they're also available in the Availity Quality Care Rewards (QCR) application. BlueEssential members also receive mailed copies of their personalized care plans, and we ask them to bring them to their health care visits for discussion and review. If you have questions or want to make any changes to a BlueEssential member's plan of care:

- Review, approve or request edits via Availity
- Call us at **1-800-611-3489 (TTY: 711)**, Monday through Friday, from 9 a.m. to 6 p.m. ET.
- Fax us at **1-800-727-0841**
- Meet with the Interdisciplinary Care Team (ICT), which we can schedule. This can take place by phone, email or video conference when the member is in your office.

Remember, you must review, sign, and return the plan of care using one of the methods outlined above prior to filing a claim for participation in an ICT Conference. The claim for the conference must include code 99366 and has a maximum allowable charge of $54.

New Modifier for Denied Predetermination Process

Effective July 1, 2021, you may submit modifier "GU" for services after you receive a denied predetermination for a BlueAdvantage or BlueEssential plan member. This will allow us to apply the appropriate member cost share if they ultimately have the service performed. Please make sure the member is aware they'll be responsible for all costs for the non-approved service. When submitting the claim, include the denied predetermination letter, if possible, to avoid delays in processing. If you have questions, please contact our Provider Service team at **1-800-924-7141**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Continuous Glucose Monitors Covered Under Part B with Prior Authorization

If you have patients who are BlueAdvantage, BlueEssential, BlueCare Plus or BlueCare Plus Choice plan members and who need continuous glucose monitors (Dexcom G5, Dexcom G6, Abbott Freestyle Libre 10-day and 14-day systems), they're covered under the medical benefits of the member's BlueAdvantage, BlueEssential, BlueCare Plus or BlueCare Plus Choice plan. But you must get prior authorization for the device and meet Medicare medical necessity criteria for continuous glucose monitors (CGMs). Please note that to be covered under the member's plan, these monitors and supplies should be obtained through a pharmacy and not a durable medical equipment (DME) provider. If you have questions or need more details, please call our Provider Service line.

New Exclusions for Statin Use in Persons with Diabetes (SUPD) Star Measure

CMS announced it will implement updated measure specifications for the Statin Use in Persons with Diabetes (SUPD) star measure for the 2021 measurement year. The update adds exclusions for members diagnosed with rhabdomyolysis or myopathy; pregnancy, lactation, or fertility; liver disease; pre-diabetes; and polycystic ovary syndrome (PCOS). Please be sure to include the diagnosis code for your patient's condition on a claim where appropriate. Documentation of a statin intolerance or contraindication in the chart alone will not exclude the patient. Sample ICD-10 codes that apply to the new exclusions are noted below:

G72.0	Drug-induced myopathy
G72.89	Other specified myopathies
G72.9	Myopathy, unspecified
M60.80	Other myositis, unspecified site
M60.9	Myositis, unspecified
M62.82	Rhabdomyolysis
T46.6X5A	Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter

Riabni Added to Step Therapy List for Part B Drugs

Effective May 1, 2021, we'll add Riabni to our Step Therapy list for Part B drugs. This will affect members who are new to therapy. You can find our Part B Step Therapy guide on provider.bcbst.com by navigating to documents and forms and clicking the **Part B Step Therapy Provider Reference Guide**. Or **click here** to access the guide.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Tips for Coding Professionals

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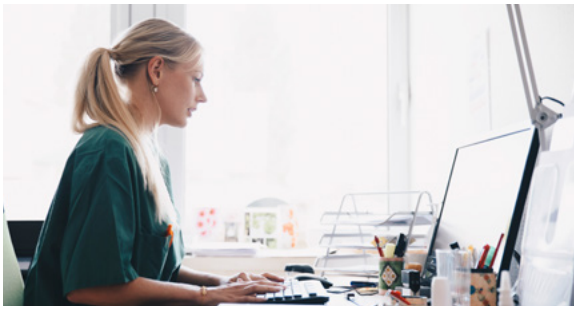

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at 1-800-924-7141 and follow the prompts for providers (option 1).

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

THCII Episodes of Care Program Reports Available This Month

On May 20, 2021, new Episodes of Care quarterly reports for Medicaid and Commercial lines of business will be available to Quarterbacks participating in the Episodes of Care Program. Quarterbacks can view their reports on Availity.

If you're a Quarterback having trouble accessing your report, please call eBusiness Support at **(423) 535-5717** and press option 2 or email **eBusiness_Service@bcbst.com** for assistance.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

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Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

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Featuring "Touchtone" or "Voice Activated" Responses

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CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
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21PED1099900 (4/21)

JUNE 2021

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

Updates to Change of Ownership or Control Process

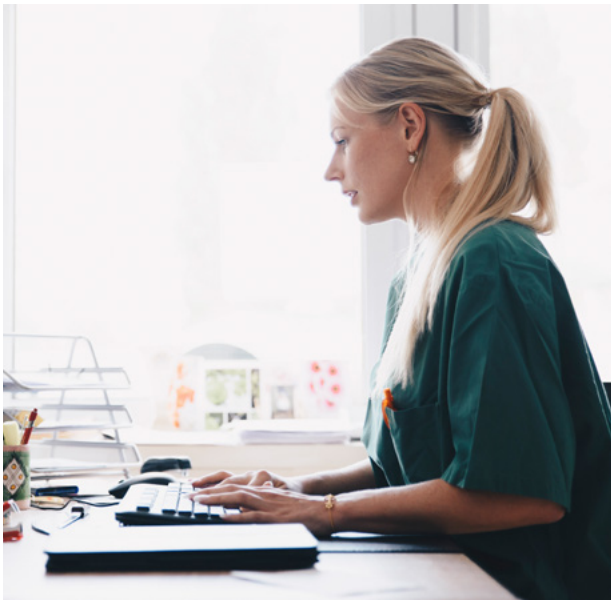
We want to let you know we're updating our Change of Ownership or Control (CHOWOC) process, effective Sept. 1, 2021. This update impacts facilities, ancillary providers and medical groups with a change in ownership or control. If this happens, you'll need to send us a completed Change of Ownership Notification form at least 60 calendar days before the change. Please note that failure to send us the form within this time frame may impact your reimbursement rates and claims payments. More information about CHOWOC updates will be available in future issues of BlueAlert.

INSIDE THIS ISSUE

Update to Non-Physician Practitioner Copay Amounts

Earlier, we wrote about a systems issue which didn't allow us to assign the appropriate member copay for primary care or specialist services when the services were rendered by a nurse practitioner or physician assistant. Member copays for covered services given by these providers should be consistent with the specialty type of their supervising physician and the provider type (i.e., primary care or specialist) where the services were provided.

As mentioned in our January BlueAlert, we corrected this issue in our system but we'll need to delay implementation. Starting July 1, 2021, we'll begin implementing these updates. Please look for complete billing guidelines in the next update of your **Provider Administration Manual**.



Register for the 2021 All Blue Workshop

Registration is now open for this year's All Blue Workshop. Click **here** to sign up for the half-day, live-streaming event set for Tuesday, Aug. 3, or visit the All Blue Workshop page on **provider.bcbst.com**. You can choose to attend either the morning or afternoon virtual session. Space is limited to 500 attendees per session, so please be sure to register soon. For more information, contact your Provider Network Manager.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Provider Stability Act Alert: An Important Update About PAM and Medical Policy Change Notifications

Effective July 1, 2021, we'll no longer mail notifications about upcoming changes to our Commercial Provider Administration Manual (PAM) or medical policies. We will, however, continue to provide these notices through email communications in accordance with the **Provider Stability Act**.

If you'd like to continue receiving these notices by email, please register your preferred "Contracting" email address under the contact preference tile in **Availity**. Otherwise, you may miss out on these important notifications.

As always, you can find the following updates 60 days before they take effect on our provider site at **provider.bcbst.com**:

- **Medical Policies**
- **Provider Administration Manuals**
- **Coding Changes**

For now, we'll continue to mail notices about fee schedule changes if you haven't registered to receive them by email. If you have questions, please call 1-800-924-7141 and follow the prompts to Contracting and Credentialing.

Prior Authorization Updates

With the onset of the COVID-19 emergency, we implemented temporary policies to help providers focus on taking care of our members. This included waiving or streamlining prior authorization processes. Now that COVID-19 vaccines are more widely available, we're reverting to our standard prior authorization policies for our Commercial line of business, effective June 1, 2021.

As a result, the following temporary prior authorizations are no longer in effect after May 31, 2021:

- Waivers for prior authorization requirements for the treatment of coronavirus or admission to post-acute care facilities (SNF, IRF, LTACH)
- Streamlined prior authorization processes for members with a COVID-19 diagnosis admitted through the ER

In April, we shared this information on the **BCBSTupdates** site. If you have questions, please contact your Provider Network Manager.

Changes to Prior Authorization for Commercial Plans ONLY

Our Commercial line of business will use the **Provider Administered Specialty Pharmacy Products** list to communicate any changes on the prior authorization process for provider-administered specialty pharmacy. Please keep monitoring the list monthly and following the instructions for submitting authorizations. Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity and clicking **Patient Registration**, then **Eligibility and Benefits Inquiry**.

Anesthesiology Services Update

We wanted to let you know we're making some changes to how we calculate time for anesthesiology services. We measure anesthesiology time in minutes and then convert it to fractional time units. In the past, we rounded up anesthesia time units to the next whole unit. For example, 1.11 units were rounded up to 2 units. Effective July 1, 2021, we'll start rounding up anesthesia time units to the nearest tenth to better align with industry standards. For example:

- 1.41 units will be rounded up to 1.5 units
- 1.61 units will be rounded up to 1.7 units
- 1.91 units will be rounded up to 2 units

Please note that anesthesia time does not apply to Daily Hospital Management Services. This change also applies to BlueCare Tennessee. For more information, please refer to your **Provider Administration Manual**.

Process InstaMed Prepaid MasterCard Payments Before They Expire – No Additional Fees

Last year, we partnered with InstaMed to launch a convenient online bill pay tool for members. This tool allows member to conveniently review claims and pay providers through their BlueCross account.

Depending on your level of participation, InstaMed sends the member's payment electronically or by mail. Electronic payments are made as soon as the next day. Mailed payments, which include a pre-paid credit card, arrive within seven to 10 business days.

We've learned that some providers aren't processing their mailed InstaMed payments on time, which means they aren't getting paid and their patients have to work harder to pay them a second time. If your office needs help processing your InstaMed payments, please contact InstaMed at **support@instamed.com** or (866) 467-8263. **Please note, you don't need to create an InstaMed account to process payments from members.**

Payment processing for each pre-paid credit card is handled like a normal credit card payment. You won't be charged additional fees to cash or deposit your payment (outside of typical credit card processing fees).

If you already have an InstaMed account, there's nothing you need to do. However, if you want to **register for** or upgrade your account, please visit **InstaMed's provider website**.

BlueCare Tennessee

This information applies to BlueCare SM, TennCareSelect and CoverKids SM plans unless stated otherwise.

Benefit Change for Oral Caffeine Citrate Solution

Effective June 1, 2021, oral caffeine citrate solution is covered exclusively through the patient's medical benefit, rather than the pharmacy benefit. The Division of TennCare made this change due to the close monitoring required during treatment with this drug.

This policy change affects these National Drug Codes and drug concentrations, which are billed with HCPCS J8499:

National Drug Code	Drug Name
25021060203	**Caffeine Citrate Solution 60mg/3mL**
51754050103	**Caffeine Citrate Solution 60mg/3mL**
51754050303	**Caffeine Citrate Solution 60mg/3mL**
72485011010	**Caffeine Citrate Solution 60mg/3mL**
63323040601	**Caffeine Citrate Solution 20mg/mL**
63323040603	**Caffeine Citrate Solution 20mg/mL**

We're updating the **Provider Administration Manual** with this information. If you have questions, please call the Provider Service line for your patient's plan.

Best Practices for Helping Families Stay Up to Date with Well-Child Care

Well-child care is essential for good health, but it's not always easy to keep children on track with their Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Consider these tips to make scheduling easier for your patients — and your team:

- Schedule a full year of visits for newborns during their first visit. This not only helps new parents stay on track with upcoming visits, but also keeps a plan of care in place if a visit is missed. Children covered by BlueCare Tennessee are eligible for well-care visits on the **same schedule recommended by the American Academy of Pediatrics**.
- For children 2 years and older, schedule the next well-child exam at the end of each appointment.
- Make the most of your patient reminder tools, such as letters, text messages and reports.
- Consider offering extended or alternate office hours to make it easier for families to keep appointments. Some practices have found that offering appointments in the evenings or on weekends helps more kids and teens get their well-child checkups. If you're interested in adjusting your hours, ask your patients' parents and caregivers what times are most convenient for them.

Note: This article doesn't apply to CoverKids.

Provider Subcontracting Rules Reminder

Providers who participate in the BlueCare and TennCare*Select* networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior agreement, claims for services provided by the subcontractor could be denied and previous payments could be subject to recoupment. An example of unapproved subcontracting would be antigen therapy.

Network providers can't subcontract with a vendor to prepare antigen therapy and submit claims indicating the antigen therapies were prepared by the provider. For more information about subcontracting requirements, please see the **BlueCare Tennessee Provider Administration Manual**.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ plans.

New Text Reminders for Appointments

We're now texting BlueAdvantage plan members reminders for upcoming appointments through our Outreach and Retention team. When we schedule wellness appointments with them, they can receive reminders for those appointments through SMS text. These texts contain the name and location of the provider's office as well as the date and time of the appointment. BlueAdvantage plan members are also provided with the phone number for the office in case their appointment needs to be rescheduled. These text reminders started in early April, and it is expected that attendance at provider events and appointments will increase with this enhancement to existing processes. As we continue to work closely with providers across the state in 2021, we know that improvements like text reminders will be beneficial for members, providers and the health plan.

New Modifier for Denied Predetermination Process

Effective Aug. 1, 2021, you may submit modifier "GU" for services after you receive a denied predetermination (authorization request before services are rendered) for a BlueAdvantage or BlueEssential plan member. This allows us to apply the appropriate member cost-share if they ultimately have the service performed. Please make sure the member is aware of their out-of-pocket costs for the service. When submitting the claim, include the denied predetermination letter, if possible, to avoid delays in processing. If you have questions, please contact our Provider Service team at 1-800-924-7141.

Post-Acute Care Support

BlueAdvantage and BlueEssential plan members have a dedicated post-acute care team of nurses ready to help them transition to the next level of care. For these members, please include the following discharge setting information along with your clinical data for all SNF, IRF and LTACH submissions to get the best support possible after discharge:

- Type of residence
- Number of home levels
- Number of stairs to enter the home and within the home (including number of rails)
- Who lives in the home
- Driving status
- Support system
- Any known resources (CHOICES, home health, caregivers)
- What DME they have and what is needed, including ramps
- Discharge plan, including if a CHOICES pre-admission evaluation (PAE) was initiated

The post-acute care team will conduct an in-depth review of the member's needs, support network, social determinants of health, and care environment. The team coordinates with Medicare Advantage providers, Medicare Advantage and facility case managers and/or social workers to provide the best opportunity for optimal recovery.

Authorization Updates in Availity

Availity now has two new authorization updates for your Medicare Advantage patients. Providers now have the ability to submit authorizations for longer home health date spans, which extends the time frame from 30 days up to 60 days. Providers can also request authorizations for acupuncture services under the outpatient forms section.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

In-Home Screening Reminders Available for Your Patients

The relationship between you and your patients is instrumental in making sure they get certain preventive screenings you recommend. We understand it may be difficult to get patients into your office or for them to get follow-up testing. That's why we work with vendors who provide certain in-home preventive screenings. The following in-home test kits and preventive screenings are available for our BlueAdvantage, BlueEssential and BlueCare Plus/BlueCare Plus Choice plan members:

- HbA1c testing
- Urine microalbumin screening
- iFOBT/FIT test
- Bone mineral density testing
- Diabetic retinal eye exam
- Peripheral artery disease testing
- Comprehensive history and physical exam

For more information or to arrange certain in-home preventive screenings for your patients who are our Medicare Advantage plan members, please contact your local Medicare Advantage provider outreach consultant.

Reduce the Risk of Falling

The Centers for Medicare & Medicaid Services (CMS) is increasingly focused on quality of life for Medicare recipients. The **Health Outcomes Survey** is used by CMS to measure member experience and self-reported outcomes annually. As an example, your patients are asked to respond to questions related to one important measure: **Reducing the Risk of Falling**. By incorporating some important tips, you can help provide your patients with a better experience, help them achieve better health outcomes, and maintain their interest in staying with your practice. These tips include:

- Promoting exercise, physical therapy, strengthening and balance activities.
- Reviewing medications for any that increase fall risk.
- Suggesting the use of a cane or walker.
- Discussing home safety tips or offering a home checklist to review for trip hazards, installing handrails and using nightlights.
- Recommending hearing/vision tests, if indicated.

More information is available in the **New Patient Survey Measures** presentation in Availity. To access the presentation, choose BlueCross BlueShield of Tennessee within **Payer Spaces** and then select **Resources**.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS annual survey is used by CMS to evaluate care and services provided to Medicare Advantage plan members. Care coordination is one specific category in which plan members are asked to respond to questions. Below are some care coordination tips that may help your patients who are Medicare Advantage plan members have a better experience:

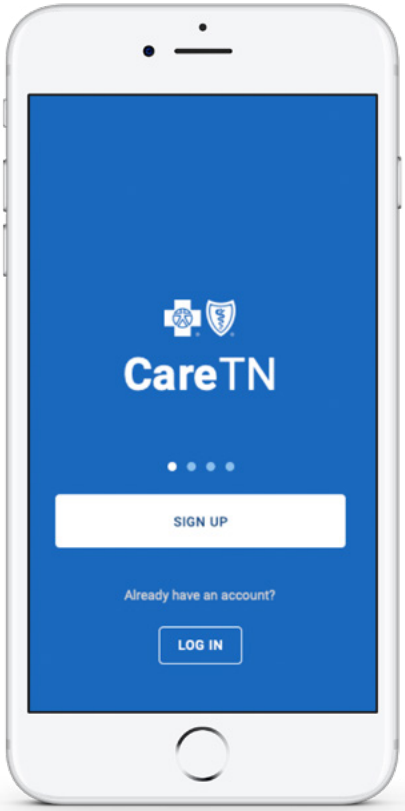
- Consider establishing a system to follow-up on diagnostic or lab test results to include time frames to communicate results and educate patients on when and how they'll receive results.
- Educate patients on why they are being referred to a specialist, and consider having your staff help coordinate scheduling referrals and transferring records.
- Incorporate time frames into reminder systems for follow up with patients who have been referred to a specialist, and with specialists to obtain reports or visit summaries.
- If you know patients received specialty care, discuss their visit and the treatment plan they received at their next clinic or telehealth visit.

Free CareTN Mobile App

BlueAdvantage, BlueEssential and BlueCare Plus plan members can manage their health by working with a care management team using the free CareTN app. Members can take self-guided courses on 30+ conditions and have access to a care management team that includes a nurse, social worker, pharmacist and dietitian through a chat feature inside the app.

When members check in, they can read articles related to specific health management topics. Some features include medication lists with reminders, goal setting with progress monitoring, appointment reminders and access to a CMS-approved health library with additional articles and videos. Members need a smart device to download and use the app. They may self-enroll or call to get help from one of our nurse care managers:

- **BlueAdvantage and BlueEssential**
  (code *medhelpwell*) 1-800-611-3489
- **BlueCare Plus**
  (code *bcphelpwell*) 1-877-715-9503



Risk Adjustment Medical Records Return and Coding

Our Medicare Advantage Risk Adjustment team began requesting copies of members' medical records in May. You may have received a request letter directly from BlueCross or from our vendor partner, CIOX Health. If you received a request for records, please follow the instructions in your packet and submit the records as quickly as possible. Also, remember that including all diagnosis codes, while submitting claims, reduces the number of records needed. Frequently overlooked diagnoses include: angina, arrhythmias, congestive heart failure, COPD, depression, diabetes, morbid obesity, rheumatoid arthritis, substance abuse and vascular diseases. Please include all ICD-10 codes for conditions that are present on your claims regardless of the reason for the visit.

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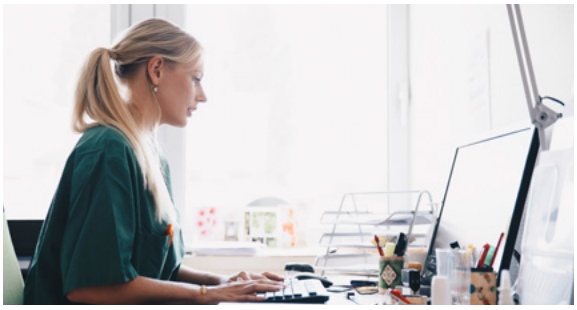

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21PED1142456 (5/21)

JULY 2021

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Coming Soon! Changes to Claims Status Inquiry*

Checking a claims status is easier than ever. You can check the status of a claim by using one of our many self-service options:

Electronic Data Interchange (EDI)

- Electronic Remittance Advice (ERA) (HIPAA X12 835) – When a claim is finalized, the claim status will be available via 835 ERA transactions that can be used to post claim results into your billing system. If you don't already receive ERAs, you can enroll at CAQH **EnrollHub®**.
- Blue CORE (HIPAA X12 276/277) – You can work with your vendor to connect with us to get a claim status in real time without exiting your system workflow.

INSIDE THIS ISSUE

Availity®

- Remittance Advice – The same ERAs that you receive for posting are available within Availity's Remittance Viewer. To view the status of claims in your remits, log in to Availity and select "Claims & Payments Remittance Viewer." If you want to view your legacy remit, select "Payer Spaces" and click on the "Print/View Remittance Advice" tile.
- Claim Status – To check the status of a claim using Availity, log in to Availity and select the "Claims & Payments" tab, then click "Claims Status."

Automated Claims Status option

- Call the appropriate Provider Service Line and choose the option for automated Claims Status.

Our customer service representatives are providing claims status verbally through the Provider Service line but soon, you'll be required to use one of the self-service options to obtain status of claims. Once you've obtained status of the claim using one of the above methods, our customer service representatives are still available to assist with specific questions you may have about a claim payment or denial. Please note when you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number.

If you have questions or need assistance with Availity or EDI, you can contact eBusiness Service at 423-535-5717, option 2. If you'd like training on Availity, contact your eBusiness Regional Marketing Consultant.

Updates to Change of Ownership or Control Process

As we mentioned in the June BlueAlert, we're updating our Change of Ownership or Control (CHOWOC) process, effective Sept. 1, 2021. This update impacts facilities, ancillary providers and medical groups with a change in ownership or control. If this happens, you'll need to send us a completed Change of Ownership Notification form at least 60 calendar days before the change. Please note that failure to send us the form within this time frame may impact your reimbursement rates and claims payments. For more information about the updated CHOWOC process, please see your **Provider Administration Manual**.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView® as our source for provider information, especially location-specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information on the CAQH platform and complete network verification using Availity. Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review.

The new Network Verification Form is located in the BlueCross payer space in Availity behind the "Provider Enrollment, Updates and Changes" tile. For your convenience, the application allows most provider groups to easily review multiple practitioners at once. For the time being, ancillaries and facilities will continue to receive the paper Data Verification Form until we can migrate all providers to this new process. If you have questions, please contact our Provider Service line at 1-800-924-7141 and follow the prompts to Contracting and Credentialing.

Update to Non-Physician Practitioner Copay Amounts

Earlier, we wrote about a systems issue which didn't allow us to assign the appropriate member copay for primary care or specialist services when the services were rendered by a nurse practitioner or physician assistant. Member copays for covered services given by these providers should be consistent with the specialty type of their supervising physician and the provider type (i.e., primary care or specialist) where the services were provided.

As mentioned in our January BlueAlert, we corrected this issue in our system but would need to delay implementation. Starting Oct. 1, 2021, we'll begin to implement these updates. Please look for complete billing guidelines in your **Provider Administration Manual**.

Register for the 2021 All Blue Workshop

Registration is now open for this year's All Blue Workshop. Click **here** to sign up for the half-day, live-streaming event set for Tuesday, Aug. 3, or visit the **All Blue Workshop page**. You can choose to attend either the morning or afternoon virtual session. Space is limited to 500 attendees per session, so please be sure to register soon. For more information, contact your Provider Network Manager.

Publication Date and Schedule to Match for All Provider Administration Manuals

We're making a small change that will allow us to align the publishing schedule of all three versions of the Provider Administration Manual. In name only, we'll skip the third quarter versions of the Commercial and BlueCare Tennessee Provider Administration Manual and publish both as the fourth quarter editions (the Q3 manual becomes Q4). As a result of this one-time change, the Q4 editions of the Commercial, BlueCare Tennessee and BlueCare Plus Provider Administration Manuals will publish Oct. 1, 2021, and all three will publish with the same date on the first day of each quarter going forward.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Commercial BlueCross PCP Performance Ratings to be Refreshed Soon

In January 2020, we introduced a Commercial BlueCross Performance rating in our online provider directory for Commercial primary care providers in Networks P℠ and S℠ to help our members make more informed health care decisions. We're now entering our second annual refresh cycle for this rating.

Notifications for this refresh cycle will be sent to the email address listed under the Contract contact type in Payer Spaces through Availity, along with instructions on how to locate the refreshed ratings in the Quality Care Rewards (QCR) application prior to publication in the online provider directory this fall. If an email is not loaded or valid, a physical letter will be mailed to the practice instead, with the same message.

For questions on how to update an email address in Availity, please contact eBusiness Technical Support at (423) 535-5717 option 2, or **eBusiness_service@bcbst.com**.

Changes to Commercial Plan Prior Authorizations

Beginning Oct. 1, 2021, some Commercial members will require prior authorization for lab-based sleep studies. Home-based sleep studies for Commercial members don't require a prior authorization.

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity and clicking "Patient Registration," then "Eligibility and Benefits Inquiry." You may submit authorization requests through Availity, by faxing them to Commercial Utilization Management at 1-866-558-0789, or by calling our Provider Service Line at 1-800-924-7141.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so if you're not sure when to renew your license, please take a look. A current license tops our list of required provider credentials and network participation criteria, and we're obligated to terminate providers from our network when their licenses expire. Providers who want to rejoin the network following termination due to license expiration will have to reapply and go through the credentialing process again. It's also important to note that any claims submitted by an unlicensed provider will be denied.

Anesthesiology Services Reminder

We wanted to let you know we're making some changes to how we calculate time for anesthesiology services. We measure anesthesiology time in minutes and then convert it to fractional time units. In the past, we rounded up anesthesia time units to the next whole unit. For example, 1.11 units were rounded up to 2 units. As of July 1, 2021, we're rounding up anesthesia time units to the nearest tenth to better align with industry standards. For example:

- 1.41 units will be rounded up to 1.5 units
- 1.61 units will be rounded up to 1.7 units
- 1.91 units will be rounded up to 2 units

Please note that anesthesia time doesn't apply to Daily Hospital Management Services. For more information, please refer to your **Provider Administration Manual**. **This change also applies to BlueCare Tennessee.**

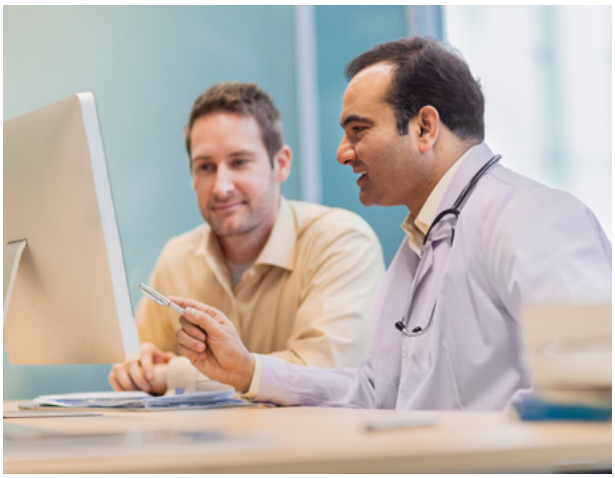
Changes to Musculoskeletal (MSK) Program Prior Authorizations

Beginning Sept. 1, the following codes will require prior authorization for those members with the MSK program benefit:

27437 28446 29828 64625

The following codes will be removed from the MSK prior authorization list effective Sept. 1:

22100	22103	22114	22819	62326	62367
22101	22110	22116	62324	62327	62368
22102	22112	22818	62325	62365	L8695



BlueCare Tennessee

This information applies to BlueCare SM, TennCareSelect and CoverKids SM plans unless stated otherwise.

Changes to BlueCare Tennessee and CoverKids Observation Room Guidelines

Beginning Aug. 1, 2021, BlueCare Tennessee and CoverKids will allow for up to 48 hours of observation services that are medically necessary and appropriate. Currently, we allow up to 36 hours of observation.

Observation services should be billed on a CMS-1450 claim form using revenue code 0762. When submitting ANSI 837 electronic claims, please use the institutional format. Services are reimbursed in one-hour increments, and each number of service (form locator 46) should be equal to one hour in observation. (For example, one hour equals one unit, two hours equals two units, etc.)

This chart outlines certain scenarios and sample revenue codes to use. Please note that hours billed in excess of 48 hours won't be allowed.

Revenue Code (RC)	Type of Service	HCPCS/CPT® Code	Allowed
0729	Other Labor Room/Delivery	N/A	Allowed at an hourly rate per contract not to exceed 48 hours
0762	Observation Room	N/A	Allowed at an hourly rate per contract not to exceed 48 hours
0769	Other Specialty Services	N/A	Allowed at an hourly rate per contract not to exceed 48 hours

For more information, please see the **BlueCare Tennessee Provider Administration Manual**.

Prior Authorization and 90-Day Supply Benefits for BlueCare Tennessee Members

The TennCare pharmacy benefit manager allows prescribers and providers caring for TennCare members to bypass prior authorization requirements for certain medications when patients have specific medical conditions. You can view the specific medications and corresponding diagnosis codes on the **Appropriate Diagnosis for PA Bypass List**.

To bypass authorization requirements, pharmacists must submit the claim with both a Diagnosis Code Qualifier of "02," representing the ICD-10 code (Field #492-WE), and an appropriate Diagnosis Code (Field #492-DO). To reduce processing delays, please include the applicable diagnosis code (ICD-10 code) on written prescriptions for inclusion on the electronic pharmacy claim.

If you'd like to review the list of preferred medications and the clinical criteria for prescribing each, please visit the **landing page for the TennCare PBM**. If you have questions about prior authorization requirements, please email **tnrxeducation@optum.com**.

Refresh Your Knowledge about the 90-Day Supply Benefit: In April 2020, the TennCare Pharmacy Program announced temporary pharmacy benefits enhancements due to the COVID-19 pandemic, including a 90-day supply benefit. Your patients can get 90-day supplies of maintenance medications on the TennCare **Auto-Exempt** and **Attestation** lists.

If you have questions, please call the Pharmacy Benefits Management Support Center at 1-866-424-5520. For more information and updates about the TennCare Pharmacy Program's COVID-19-related benefit enhancements, please visit **BCBSTupdates.com** or **tn.gov/tenncare**.

Non-Emergency Medical Transportation (NEMT) Through Southeastrans

As a reminder, your BlueCare or TennCareSelect patients who need NEMT for TennCare-approved services can use Southeastrans for transportation. You can access the **online scheduling portal** to schedule travel. If you don't already have an account, you'll need to speak with a Southeastrans representative to request one. Please note you may be required to complete an online application to access the portal.

TennCare*Select*	1-866-473-7565
BlueCare	1-855-735-4660

BlueCare Tennessee and CoverKids Readmission Policy Update

Effective Aug. 1, 2021, claims for patients who are readmitted to a Diagnosis Related Group (DRG) or per diem facility won't be eligible for multiple payments. We define a readmission as a preventable, unplanned admission occurring within 30 days after a hospital discharge to the same facility for a complication of the original hospital stay or admission resulting from a modifiable cause. The updated policy applies to all readmissions, except those listed in the **BlueCare Tennessee Provider Administration Manual**.

Please note: Payment guidelines are based on each provider's contract, as well as retrospective claims review and recovery. Some examples of readmissions that may not be approved for claims payment include:

- Acute myocardial infarction (AMI)
- Heart failure
- Pneumonia
- Respiratory admissions, e.g., chronic obstructive pulmonary disease (COPD)
- Complications from surgical procedures

For more information about this policy change, please see the **BlueCare Tennessee Provider Administration Manual**.

After-Hours Prior Authorization for Urgent Behavioral Health Care

When calling for behavioral health prior authorization after hours, the BlueCare Tennessee vendor can provide prior authorization for urgent behavioral health levels of care, including Psychiatric Acute Inpatient, Inpatient Detox 4.0 and Crisis Stabilization. All non-urgent levels of care will need to be pre-authorized during regular business hours. Please refer to the **Provider Administration Manual** if you need additional information.

Verify Patient Coordination of Benefits (COB) Information Through Availity

Every year, our members are required to update their COB with us. From time to time, they don't update their information on time or simply forget. When this happens, any claims you file will be denied.

If you receive a claim denial related to a patient's COB information, you can quickly verify a patient's COB, who their primary insurance provider is and if they have any secondary coverage in **Availity**. Some of the most common COB denials you'll see on your remittance advice are XCD, XCO, EOB and MED.

Tips for Coding Childhood and Adolescent Vaccines

Vaccines are a key element of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) TennCare Kids exams. Delivering vaccines on schedule not only protects your patients' health, but also lowers the risk of vaccine-preventable disease outbreaks. This is especially true for children age 2 and younger.

When administering and submitting claims for immunizations, please use the following CPT® codes:

CPT® Code	Description
90460	IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid component administered (do not report with 90471 or 90473).
+90461♦	IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered.
Codes 90460 and 90461♦ are reported when the patient is 18 years or younger and the physician or other qualified health care professional performs face-to-face vaccine counseling.	
90471	IA, one injected vaccine (do not report with 90460 or 90473)
+90472	IA, each additional injected vaccine
90473	IA by intranasal/oral route; one vaccine (do not report with 90460 or 90471)
+90474	IA by intranasal/oral route; each additional vaccine
90471-90474 are reported when the patient is over the age of 18 or when counseling is not performed.	

♦Please note: CPT® code 90461 will only be reimbursed for vaccines that aren't administered through the Vaccines for Children program.

You can view the immunization schedules for children and adolescents at **cdc.gov**. The American Academy of Pediatrics has also prepared a variety of resources, including a comprehensive **list** of all codes for commonly administered pediatric vaccines and **information** on delivering well-child care while minimizing their patients' COVID-19 exposure.

Additional resources can be found through the **Vaccines for Children (VFC) Program** and the **Tennessee Immunization Information System (TennIIS)**, offered free to providers through the Tennessee Department of Health.

Coordinating Services for Your School-Age Patients

BlueCare Tennessee can help coordinate medically necessary, in-school covered services for our members age 20 and younger. Services that may be available in a school setting include physical, speech, occupational and behavioral therapies, as well as some school medical services. We encourage providers to fax orders for these services to schools as soon as possible during the summer to avoid delays in care when the school year begins.

In addition to a provider's order, the Division of TennCare requires that children and young adults receiving school-based services have an individualized education program (IEP) including that service, as well as a signed parental consent form. Schools aren't required to submit students' IEPs before delivering services. However, BlueCare Tennessee is required to conduct regular post-payment sample audits of claims for these services and will request documents, including IEPs to support the medical necessity of the school-based services we reimburse.

Please note: TennCare doesn't require an IEP for school-based behavioral health services for these services to be reimbursed.

For more information about the requirements for school-based services, please see the **BlueCare Tennessee Provider Administration Manual**.

Evaluation and Management Service Billing Guidance for Therapy Providers Reminder

According to CMS guidelines for evaluation and management (E&M) services, it's inappropriate for speech, physical and occupational therapists to bill E&M services. These guidelines require therapists to submit services, including evaluations, with the appropriate code listed in the Special Otorhinolaryngologic or Physical Medicine and Rehabilitation sections.

Therapy claims that bill E&M services are subject to post-payment audit review and recoupment. For more information, visit **cms.gov** or see the **BlueCare Tennessee Provider Administration Manual**.

CoverKids Provides Benefits for Breast Pumps

Since Jan. 1, 2021, breast pumps have been included in patients' CoverKids benefits. Your patients with CoverKids coverage no longer need to have rentals or purchases authorized for the following codes regardless of the amount billed:

E0602 E0603 E0604

Claims filed **after** Jan. 1, 2021, will be identified and adjusted.

You'll need to prescribe a breast pump to your CoverKids patients for them to receive the benefit. Once prescribed, the patient will need to fill the prescription at a participating Durable Medical Equipment (DME) supplier. Your CoverKids patients can also receive an electric breast pump with a physician's order by completing an online form through **Medline @t Home** or **Aeroflow Breastpumps**.

If you have questions, please call the Provider Service Line at 1-800-924-7141. We're here Monday through Friday from 8 a.m. to 6 p.m. ET.

XpeDose Mini vLARC Cabinet

If you have patients with BlueCare Tennessee or CoverKids coverage, you can get a free XpeDose mini voluntary long-acting reversible contraception (vLARC) cabinet for your office. The Division of TennCare works with StellarRX to provide free equipment and installation of the system, which allows StellarRX to remotely monitor and replenish vLARC products. The system allows you to safely store medications for point-of-care use, so your patients can receive preventive and contraceptive care in one office visit.

For more information, view the TennCare flyer in the **News and Manuals** section of the BlueCare Provider site (under Announcements) or call StellarRX at (629) 335-4400.

Refer to TennCare Website for Sterilization Form Updates

Please refer to the **Miscellaneous Provider Forms** page of TennCare's website for updates to the Sterilization Consent Form instructions and FAQ document. Any recent changes made to the instructions or FAQ will be effective July 1, 2021.

BlueCare Tennessee and BlueCare Plus Tennessee

This information applies to BlueCare, TennCareSelect, CoverKids and BlueCare Plus dual-eligible special needs plans.

Fraud Alert: Postcard Disguised as Official Office for Civil Rights (OCR) Communication

You may have recently received a postcard that appears to be from the Office for Civil Rights (OCR) stating a requirement for a "Required Security Risk Assessment." This communication is from a private entity and not an OCR communication.

The link on the postcard directs you to hsaudit.org, which is a non-governmental website marketing consulting service. This postcard is not from OCR or the U.S. Department of Health and Human Services (HHS). If you've received this postcard, please disregard and recycle it.

To verify if any communication is from OCR, look for the OCR mailing or email address, which ends in @hhs.gov. Addresses for OCR's headquarters and regional offices are on the OCR website. If you have questions or concerns, please contact **OCRMail@hhs.gov**.

BlueCare Plus Tennessee

This information applies to our BlueCare Plus (D-SNP)℠, and BlueCare Plus Choice Medicare Advantage, Fully Integrated Dual Eligible special needs plans.

Patient Care and Planning Form (PACF)

Primary care physicians are eligible to receive reimbursement for completing a PACF for patients who are enrolled in a BlueCare Plus Dual Special Needs Plan. Each year, A PACF should be completed with a face-to-face or telehealth visit (both audio and video components required) for each member to document all active acute and chronic conditions and how they're assessed and managed.

PACF data may also close some quality care measure gaps and facilitate Interdisciplinary Care Team (ICT) collaboration between BlueCare Plus, the provider and member. This collaboration allows BlueCare Plus and providers to meet CMS requirements regarding annual ICT communication and provides additional reimbursement of $54 when billing CPT® codes 99366-99368. You may complete a PACF at the same time as an annual wellness visit. BlueCare Plus plan members will be eligible to receive a gift card incentive for completing their annual wellness visit.

To receive the $155 reimbursement, submit your claim with CPT® code 96160 with the visit E/M code. You may fax PACFs to (423) 591-9504 or upload them in the Quality Care Rewards tool in **Availity**. Please contact your BlueCare Plus Provider Outreach Consultant if you have questions about the Patient Assessment and Care Planning Form.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Health Outcomes Survey (HOS): Improving Bladder Control

CMS is increasingly focused on the patients' quality of life, functional health status and experience with key aspects of their care. The HOS annual survey is used by CMS to evaluate care and services provided to your patients.

Improving bladder control is one specific category in which your patients are asked to respond to questions. By incorporating some of the tips below, you can help your patients have a more positive experience, achieve better health outcomes, and improve patient retention.

- Screen all patients for urinary incontinence. If positive, discuss treatment options.
- Recommend treatment options no matter the frequency or severity of the bladder control problem.
- When you recommend certain exercises or other less conventional remedies, emphasize you're providing treatment and that patients should take your recommendations seriously.
- Note that physical therapy for pelvic health is a covered benefit for urinary incontinence (with prior authorization).

Updated Provider Education WebEx Presentations

New quality measure presentations have been added to the BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series in Availity:

- 2021 Medicare Advantage quality program new patient experience survey
- Provider Assessment Forms (PAFs)
- Care for Older Adults (COA)
- Statin Use in Persons with Diabetes (SUPD)
- Medication Reconciliation Post Discharge (MRP)
- Risk adjustment
- Quality Care Rewards (QCR) application

These presentations provide an in-depth review of each topic as it relates to this year's quality program. As a reminder, there are additional episodes on various topics such as the program overview and program measures. These presentations can serve as a resource for additional ways to enhance performance in the Medicare Advantage Provider Quality+ Partnerships program.

To access the presentations after logging in to Availity, choose BlueCross BlueShield of Tennessee within "Payer Spaces," then select "Resources." On the Resources page, you'll find a list of presentations.

Chronic Condition Coding and Morbid Obesity

When addressing your patient's chronic conditions during their annual wellness visit, don't forget to code each chronic condition including BMI values and obesity related codes. Documenting morbid obesity, BMI and their applicable codes provides a more accurate picture of the patient's health status. Morbid obesity is defined as a person who has a BMI of 40 or higher, a BMI of 35 or more with obesity-related health conditions or is 100 pounds over their ideal weight.

Accurate documentation and coding of morbid obesity requires the documentation of the BMI (40 or higher or BMI of 35 and comorbid conditions) and the condition morbid obesity. Here's a list of the BMI codes and their descriptions.

Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.2	Morbid (severe) obesity with alveolar hypoventilation
Z68.41	BMI 40.0-44.9, adult
Z68.42	BMI 45.0-49.9, adult
Z68.43	BMI 50.0-59.9, adult
Z68.44	BMI 60.0-69.9, adult
Z68.45	BMI 70 or greater, adult

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ plans.

New Modifier for Denied Predetermination Process

Effective Sept. 1, 2021, you may submit modifier "GU" for services after you receive a denied predetermination (authorization request before services are rendered) for a BlueAdvantage or BlueEssential plan member. We previously communicated the effective date as Aug. 1, but we've delayed this date to September. This allows us to apply the appropriate member cost-share if they ultimately have the service performed. Please make sure the member is aware of their out-of-pocket costs for the service. When submitting the claim, include the denied predetermination letter, if possible, to avoid delays in processing. This new process is only applicable for procedure codes eligible to be billed with modifier GU. If you have questions, please contact our Provider Service team at 1-800-924-7141.

Organ Acquisition Cost

Certified transplant centers (CTC) that submit any claims for organ acquisition costs must be accompanied by the following documents:

- **Form CMS-2252-10** (pages 162-166)
- **Worksheet D4, Parts I-IV:V Computation of Organ Acquisition Cost and Charges for Hospitals** which are Certified Transplant Centers (page 79)
- **Medicare Provider Reimbursement Manual, Part 1, Chapter 31- Organ Donation and Reimbursement**

Facility claims submitted without form CMS-2252-10, Worksheets D4, Parts I-IV will be denied. If you have questions, please contact your provider network manager.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at 1-800-924-7141 and follow the prompts for providers (option 1).

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

Reminder of Annual Health Planners for Well-Visits and Screenings

Now that COVID-19 vaccines have become widely available, more patients are visiting their health care providers in their offices. You may have noticed a surge in your own practice, and we're happy to see things move toward a state of normalcy.

As a service to our members, we send annual health planners to let them know when they're overdue for important health visits and screenings. We also know many of you reach out to your patients to let them know they're due for a visit. Now that we're in the second half of 2021, we encourage you to continue these efforts so children, teens and adults get their well-visits and screenings that proactively manage their health.

If you have questions about our quality programs or want to learn more about ways other health care providers are managing quality care for their patients, please contact us:

Program	Email	Phone
BlueCare Plus	Amy_Clements@bcbst.com	(423) 535-8225
BlueCare Tennessee	Julia_Germann@bcbst.com	(423) 290-2990
Medicare Advantage	Julie_Mason@bcbst.com	(423) 618-2562
Commercial	Patty_Howard@bcbst.com	(423) 535-7865

Division of TennCare Waiving Episodes of Care Risk-Sharing Payments

The Division of TennCare recognizes that COVID-19 continues to be an unprecedented health and economic crisis for the provider community. To help ease the economic burden, TennCare recently released a memo waiving the 2020 Episodes of Care risk-sharing payments. This means providers who owe a risk-sharing payment based on their final 2020 episode results won't have to make this payment.

Please note: Providers who earned a gain-share payment based on 2020 performance will still receive that payment from us.

Providers who participate in the Episodes of Care program can see if they have a risk- or gain-share payment by viewing their final 2020 reports. These will be available in Availity on Aug. 19, 2021.

For more information about this announcement, please see the **TennCare Memo: Waiving 2020 Episodes Risk-Sharing Payments**.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

21PED1190201 (6/21)

of Tennessee

AUGUST 2021

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

Publication Date and Schedule to Match for All Provider Administration Manuals

We're making a small change that will allow us to align the publishing schedule of all three versions of our Provider Administration Manual (PAM). In name only, we'll skip the third quarter versions of the Commercial and BlueCare Tennessee PAMs and publish both as the fourth quarter editions of the PAM (the Q3 PAM becomes the Q4 PAM). As a result of this one-time change, the fourth quarter editions of the Commercial, BlueCare Tennessee and BlueCare Plus PAMs will publish Oct. 1, 2021, and all three will publish with the same date on the first day of each quarter going forward.

INSIDE THIS ISSUE

Easier Online Confirmation Process to Replace Data Verification Form

We've steadily increased the use of CAQH ProView® as our source for provider information, especially location specific data. This helps us move away from sending you lengthy paper Data Verification Forms each quarter. You'll soon receive a letter with instructions on how to confirm the information on the CAQH platform and complete network verification using Availity®. Most items are in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review.

The new Network Verification Form is in the BlueCross payer space in Availity behind the Provider Enrollment, Updates and Changes tile. For your convenience, the application allows most provider groups to easily review multiple practitioners at once. For the time being, ancillaries and facilities will continue to receive the paper Data Verification Form until we can migrate all providers to this new process. If you have questions, please contact our Provider Service line at 1-800-924-7141 and follow the prompts to Contracting and Credentialing.

Updates to Change of Ownership or Control Process

As we mentioned in recent issues of BlueAlert, we're updating our Change of Ownership or Control (CHOWOC) process, effective Sept. 1, 2021. This update impacts facilities, ancillary providers and medical groups with a change in ownership or control. If this happens, you'll need to send us a completed Change of Ownership Notification form at least 60 calendar days before the change. Please note that failure to send us the form within this time frame may impact your reimbursement rates and claims payments. For more information about the updated CHOWOC process, please see your Provider Administration Manual.

New Approval and Predetermination Form for Federal Employee Program (FEP) Members

A new form is available for requesting predeterminations or prior approvals for FEP members. Please note, this form isn't for items that need utilization management or Magellan review. You can find the **Federal Employee Program Predetermination/ Prior Approval Request Form** on the **Documents & Forms** page under the Commercial **Authorizations & Appeals** section on our website.

TennCare Is Preparing for an EHR Adoption Environmental Scan Survey

TennCare, Tennessee's Medicaid Agency, is releasing in mid-August 2021 an Electronic Health Record (EHR) Adoption Environmental Scan Survey. As a Tennessee provider, you can help TennCare collect valuable information about the health information technology (HIT) landscape in the state. This brief survey will take 5-10 minutes to complete. You can prepare for the survey by considering these items about your EHR system: which EHR you have, how you use it, and how your organization uses it. Additionally, the survey will ask you a few questions about your organization, such as whether you're from a hospital/facility/clinic or office/practice and how many providers you are affiliated with.

We are looking for information not only from TennCare-participating providers, but all medical providers within Tennessee. TennCare intends to distribute the survey to all Tennessee providers with a current email address. Should you not receive an email from us, please go to either the TennCare or TDH websites and click the link to start the survey. Please plan to take the EHR Adoption Environmental Scan Survey and have your insight heard. Be on the lookout for future announcements regarding the survey.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Changes to Musculoskeletal (MSK) Program Prior Authorizations

Beginning **Sept. 1, 2021**, the following codes will require prior authorization for those members with the MSK program benefit:

27437 28446 29828 64625

The following codes will be removed from the MSK prior authorization list effective Sept. 1:

22100	22103	22114	22819	62326	62367
22101	22110	22116	62324	62327	62368
22102	22112	22818	62325	62365	L8695

Out of Network Request Form: Who Needs it, Why Use it, Where to Find it

The Out of Network Request form is for non-network providers based in Tennessee who don't participate in our network, as well as out-of-state providers who don't participate in BlueCard. The information you provide improves how we process your claims.

The form is moving to a digital-only format beginning **Sept. 1, 2021**, but is available online now. To access the form:

- Log in to **Availity**, select Tennessee from the state drop down, and then select the BlueCross BlueShield of Tennessee Payer Space
- Choose the **Provider Enrollment, Updates and Changes** tile
- Select the **Update Out of Network Provider Information** drop-down tab for claims purposes

For Provider Group, Institution or Organization contracting, please contact 1-800-924-7141 and follow the prompt for Contracting and Credentialing or email **Contracts_Reqs_GM@bcbst.com**.

Changes to Commercial Plan Prior Authorizations

Beginning **Oct. 1, 2021**, some Commercial members over the age of 18 will require prior authorization for lab-based sleep studies for the following codes: 95807, 95808, 95810, 95811. Home-based sleep studies for Commercial members don't require prior authorization.

You can submit authorization requests through the **Authorization Submission/Review** application tile on Availity, by faxing them to Commercial Utilization Management at 1-866-558-0789 or by calling our Provider Service Line at 1-800-924-7141.

Changes to Claims Status Inquiry Coming Soon*

Checking a claims status is easier than ever. You can check the status of a claim by using one of our many self-service options:

Electronic Data Interchange (EDI)

- Electronic Remittance Advice (ERA) (HIPAA X12 835) – When a claim is finalized, the claims status will be available via 835 ERA transactions that can be used to post claim results into your billing system. If you don't already receive ERAs, you can enroll at CAQH **EnrollHub®**.
- Blue CORE (HIPAA X12 276/277) – You can work with your vendor to connect with us to get a claims status in real time without exiting your system workflow.

Availity

- Remittance Advice – The same ERAs that you receive for posting are available within Availity's Remittance Viewer. To view the status of claims in your remits, log in to Availity and select **Claims & Payments Remittance Viewer**. If you want to view your legacy remit, select **Payer Spaces** and click on the **Print/View Remittance Advice** tile.
- Claims Status – To check the status of a claim using Availity, log in and select the **Claims & Payments** tab, then click **Claims Status**.

Automated Claims Status option

- Call the appropriate Provider Service Line and choose the option for automated Claims Status.

Our customer service representatives are providing claims status verbally through our Provider Service line. However, you'll soon be required to use one of the self-service options to find the status of claims. Once you've obtained status of the claim using one of the above methods, our customer service

representatives are still available to answer specific questions you may have about a claim payment or denial. Please note, when you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number.

If you have questions or need help with Availity or EDI, you can contact eBusiness at 423-535-5717, option 2. If you'd like training on Availity, please contact your eBusiness Regional Marketing Consultant.

* This also applies to outsourced vendors acting on the provider's behalf.

Requesting Reconsideration Status

As a reminder, the review reconsideration timeframe is 30 calendar days. We make every effort to investigate and respond to inquiries within that time. After we complete our review, we'll send you a letter with our decision. If you haven't received a letter or notification on your remittance advice within 30 days, please call our Provider Service line. You can find more information about this process in our **Provider Administration Manual**.

BlueCare Tennessee

This information applies to BlueCare [SM], TennCareSelect and CoverKids [SM] plans unless stated otherwise.

Help Your Patients Prepare for the New School Year

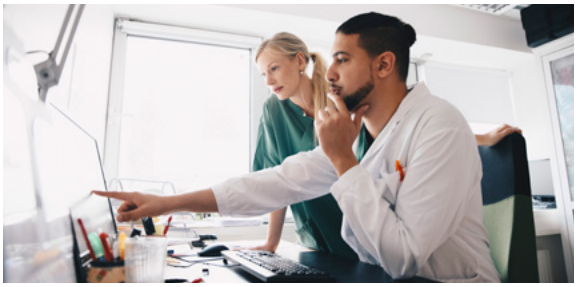
The school year will be starting soon and it's a great time to check in with your patients. Make sure they're up to date on preventive care by using the Quality Care Rewards application within Availity. This tool can help you find out which patients are past due for their checkup or any vaccines they may need for school.

It's also a popular time for many patients to schedule sports physicals. Stand-alone sports physicals and their corresponding codes aren't covered for BlueCare Tennessee members. If a patient is due for a checkup, you can convert the sports physical to a well-child exam. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams satisfy all components of sports physicals.

Updated Guidelines: Subcontracting Requirements

Providers and vendors who participate in the BlueCare and TennCareSelect networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior agreement, claims for services provided by the subcontractor may be denied, and previous payments may be subject to recoupment.

Moving forward, to request approval of all provider subcontracts, BlueCare Tennessee providers must submit the BlueCare Tennessee Provider Subcontract Request Form and signed exhibit. We're updating our website with these documents and we'll let you know when they're available.



All provider and vendor subcontractors must meet these requirements:

- All employees and subcontractors supporting the BlueCare Tennessee contract must complete **Deficit Reduction Act/Fraud, Waste and Abuse training**.
- Records of services provided by subcontractors must be kept for at least 10 years after the agreement with BlueCare Tennessee expires, unless otherwise noted in the vendor contract.
- Subcontractors must verify that employees aren't listed on the **Office of the Inspector General List of Excluded Individuals and Entities** or the **System for Award Management** databases before hiring and every month during employment.

We're updating the **BlueCare Tennessee Provider Administration Manual (PAM)** with this information. Please see the PAM for more information about subcontracting requirements.

CARES Act Home Health Order Requirements

Effective **June 15, 2021**, home health services can be ordered by any physician or other licensed health care provider treating a member who is practicing within the scope of their license. This means that nurse practitioners and physician assistants are now allowed to write orders for home health services.

The Division of TennCare made this change in response to the Coronavirus Aid, Relief and Economic Security (CARES) Act, which changed the definition of home health services. For information about how to submit a prior authorization request for home health services, please refer to your **Provider Administration Manual**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Encourage Female Patients to Have Breast Cancer Screenings

Breast cancer screening rates have seen a significant decrease over the past year with many women delaying their preventive mammograms during the COVID-19 pandemic. Patients often rely on their PCP to provide guidance for when it's safe to resume preventive care and services. With the implementation of a variety of safety protocols and rising vaccination rates, we encourage you to talk to your female patients about scheduling or re-scheduling their mammograms before the end of the year. Remember that female BlueAdvantage and BlueEssential plan members who are between 50 and 74 years of age and enrolled in our My HealthPath® incentive program are eligible to receive a $50 gift card for completing this service. Female members enrolled in a BlueCare Plus plan who are between 50 and 74 years of age are eligible to receive a $25 gift card under the BlueCare Plus plan rewards and incentives program.

Patients with Diabetes Need Statin Medication Fill

As a reminder, your patients between the ages of 40 and 75 who have filled at least two prescriptions for a medication to treat diabetes this year should also receive a prescription for a statin medication according to national guidelines.

Specifically, the Statin Use in Persons with Diabetes (SUPD) CMS quality measure looks for Medicare Advantage plan members who meet the above criteria and also receive **at least one fill** of a statin medication before the end of the year. Statin medication intensity can be written based on risk and patient-specific factors, as there's no minimum dosage requirement under the quality measure. Patients who have end-stage renal disease or are receiving hospice services are excluded from this measure.

Additionally, new exclusions were added to the measure specifications for 2021 by the Centers for Medicare & Medicaid Services (CMS). The update adds exclusions for members diagnosed with:

- Rhabdomyolysis or myopathy
- Pregnancy, lactation or fertility
- Liver disease
- Pre-diabetes
- Polycystic ovary syndrome (PCOS)

To exclude a patient, you must submit the diagnosis code for the applicable exclusion condition on the claim. Documentation of a statin intolerance or contraindication in the chart alone won't exclude the patient from this quality measure.

All generic statins are included in the BlueCross Medicare Part D drug list when filled at preferred pharmacies. Copays range from $0 - $1 for a 90-day supply depending on the member's plan type.

In-Home Screening Reminders Available for Your Patients

The relationship between you and your patients is key to making sure they get the preventive screenings you prescribe. We understand it may be sometimes difficult to get patients into your office or for them to get follow-up testing. That's why we work with vendors who provide certain in-home preventive screenings.

The following in-home test kits and preventive screenings are currently available for our BlueAdvantage, BlueEssential and BlueCare Plus/BlueCare Plus Choice plan members:

- HbA1c testing
- Urine microalbumin screening
- iFOBT/FIT test
- Bone mineral density testing
- Diabetic retinal eye exam
- Peripheral artery disease testing
- Comprehensive history and physical exam

For more information or to arrange in-home preventive screenings for your patients in our Medicare Advantage plans, please contact your local BlueCross BlueShield of Tennessee Medicare Advantage provider outreach consultant.

The Health Outcomes Survey (HOS): Physical Activity in Older Adults

The Centers for Medicare & Medicaid Services uses the annual HOS survey to evaluate care and services provided to your Medicare Advantage plan patients. Physical Activity in Older Adults is one category of questions in which your patients are asked to respond. By encouraging them to stay active you can help them have a more positive experience, attain better health outcomes, and improve patient retention.

Remind your BlueCross BlueShield of Tennessee Medicare Advantage plan patients that they have a fitness benefit that includes:

- A Silver&Fit® fitness membership, home fitness kits, workout videos, classes on Facebook and YouTube
- Videos and home kits with unique options like yoga, pilates, walking, cardio exercises, tai chi and many others
- Various levels from beginner to advanced

For more information, members can contact our customer service department at the number on the back of their insurance card.

Patients can also take advantage of local community parks.

Your patients can visit our numerous state and local parks to stay active and fit. In addition, they can visit one of our **BlueCross Healthy Places** we're building in local communities to promote human connection and healthy activity across the state.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at 1-800-924-7141 and follow the prompts for providers (option 1).

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

Comprehensive Diabetes Care — Retinal Eye Exam (DRE)

By working together, we can improve health outcomes for our members. This information provides details about the Comprehensive Diabetes Care (CDC) Star measure.

What is the measure?

The percentage of diabetic members 18-75 years old who have had an eye screening for diabetic retinal disease including:

- A **retinal or dilated eye exam by an optometrist or ophthalmologist** in 2021

  OR

- A **retinal or dilated eye exam negative for retinopathy by an optometrist or ophthalmologist** in 2020

  OR

- **Bilateral eye enucleation** anytime during the member's history through Dec. 31, 2021

Encourage and/or refer your patients to see an eye care professional for a comprehensive eye exam in 2021. PCPs should obtain and place a copy of all 2020 or 2021 eye exams with results in the member's medical record. To count 2020 exams, documentation in the medical record must clearly indicate results were negative for retinopathy. This measure may not apply to the following members anytime during the measurement year:

- Members in hospice
- Members age 66 and over who are enrolled in an institutional special needs plan or living long-term in an institution
- Members age 66 and over with frailty and advanced illness
- Members receiving palliative care

For additional information, please visit **Availity.com** or call our Provider Service line at 1-800-924-7141.

THCII Episodes of Care Program News and Updates

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available **Aug. 19, 2021**. If you're a quarterback who's having trouble accessing your Quarterly Report, please call eBusiness Support at (423) 535-5717 and press option 2 or email **eBusiness_Service@bcbst.com** for help.

Division of TennCare Waiving Risk-Share Payments

As a reminder, TennCare recently released a memo waiving the 2020 Episodes of Care risk-sharing payments. This means that providers who owe a risk-sharing payment based on their final 2020 episode results won't have to make the payment.

Please note: Providers who earned a gain-share payment based on 2020 performance will still receive that payment from us.

For more information about the risk-share payments waiver, please review the **TennCare Memo: Waiving 2020 Episodes Risk-Sharing Payments**.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

21PED1232609 (7/21)

SEPTEMBER 2021

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

New Feature Now Available: Submit Claims Through Availity®

We've made it easy for you to submit claims electronically through Availity. To do this, you'll need an Availity account with a "claims user role" and be set up as an electronic provider with us.

INSIDE THIS ISSUE

Simply follow these steps to get started submitting your claims through Availity.

1. Log in to **Availity**.
2. Click the **Claims & Payments** drop-down list.
3. Under **Claims**, select your claim type: Professional, Facility, Dental*.
4. Enter your claim information on the claim form.
5. Once you've completed the form, click "Submit."

If you need help or would like training, call your **eBusiness Regional Marketing Consultant**. If you have any technical issues, please call the eBusiness Support Team.

*Dental providers filing services that require submission of X-rays for clinical review or secondary-filed claims are advised to continue submitting claims through their current method at this time.

Publication Date and Schedule to Match for All Provider Administration Manuals

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Provider Enrollment Form Survey

We're always looking for ways to improve our systems and processes, and your input is appreciated. We've recently created a survey to ask for your feedback about our enrollment process. A link to the survey is included at the bottom of the enrollment summary after you've completed a Provider Enrollment Form. We hope you'll take a few minutes to tell us about your experience.

CAQH to Retire EnrollHub® in November, BlueCross to Name New Vendor in October

CAQH's EnrollHub tool, which BlueCross uses as our source for provider payment information, will be retired by CAQH in early November. We'll begin using a new payment configuration vendor on Nov. 1, 2021, and providers will be able to access it through Availity. Please look for more details about this change in the October BlueAlert. BlueCross will continue partnering with CAQH on the ProView® and DirectAssure products for provider enrollment and directories.

Easier Online Confirmation Process to Replace Data Verification Form

BlueCross has steadily increased the use of CAQH ProView as our source for provider information, especially location-specific data. This will help us move away from sending you lengthy paper Data Verification Forms each quarter.

You'll soon receive a letter with instructions on how to confirm the information at CAQH and complete the BlueCross Network Verification in Availity. Most of your information can be updated in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review in our portal. The Network Verification form in the **Provider Enrollment, Updates and Changes** tile, is located in the BlueCross payer space in Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to receive the paper Data Verification form until we can migrate all providers to this new process.

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New Approval and Predetermination Form for Federal Employee Program (FEP) Members

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Updates to Change of Ownership or Control Process

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Changes to Claims Status Inquiry Coming Soon*

Checking a claims status is easier than ever. Simply use one of our many self-service options:

Electronic Data Interchange (EDI)

- Electronic Remittance Advice (ERA) (HIPAA X12 835) – When a claim is finalized, the claims status will be available via 835 ERA transactions that can be used to post claim results into your billing system.
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Availity

- Remittance Advice – The same ERAs that you receive for posting are available within Availity's Remittance Viewer. To view the status of claims in your remits, log in to Availity and select **Claims & Payments Remittance Viewer**. If you want to view your legacy remit, select **Payer Spaces** and click on the **Print/View Remittance Advice** tile.
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- Call the appropriate Provider Service Line and choose the option for Automated Claims Status.

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*This also applies to outsourced vendors acting on the provider's behalf.

BlueCare Tennessee

This information applies to BlueCare [SM], TennCareSelect [SM] and CoverKids [SM] plans unless stated otherwise.

New Member ID Cards for Patients Enrolled in Department of Intellectual and Developmental Disabilities (DIDD) 1915(c) Waiver Programs

Your BlueCare patients who receive care through a DIDD 1915(c) waiver program or get support from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) will receive new Member ID cards effective **Oct. 1, 2021**. The 1915(c) waiver program and ICF/IID information will now be listed on the front of the patient's Member ID card.

What This Means for Your Patients

Beginning Oct. 1, 2021, all 1915(c) and ICF/IID services will be part of one program led by DIDD, though patient benefits aren't changing. Your BlueCare patients will still be able to receive the same care and see the same providers. For more information about this change, visit **tn.gov/didd**.

Save the Date: Tennessee Healthcare Symposium, Nov. 2-4, 2021

Mark your calendars to attend the Tennessee Healthcare Symposium for health care professionals. You'll hear from a variety of speakers and industry experts, who will present information in three informational tracks:

- Specialty Coding
- Management and Compliance
- Coding and Billing

Event registration is now open, with early bird pricing (TMA Member $149; Non-Member $199) available until Sept. 30. Regular ticket pricing begins Oct. 1 (TMA Member $199; Non-Member $249).

If you have questions, please contact Karen Baird at **(615) 460-1651** or **Karen.Baird@tnmed.org**. To learn more about the symposium, go to **tnmed.org/symposium**.

Perform All Seven Components of an EPSDT Visit

Early Periodic Screening, Diagnosis and Treatment (EPSDT) checkups should include a group of standard services. During each well-child exam, it's important to review a patient's health history, perform a complete physical exam, administer lab tests and immunizations as needed, and perform a vision and hearing screening. It's also important to perform age-appropriate developmental and behavioral screenings and provide advice to parents on how to keep their child healthy. Checkups are needed on a regular basis to monitor a child's growth and development. To provide optimal care, consider scheduling multiple routine visits in advance to help your patients stay on track.

Your patients with BlueCare Tennessee coverage are eligible for well-child exams on the same schedule recommended by the American Academy of Pediatrics (AAP). To review the Bright Futures/AAP Periodicity Chart, please see our **EPSDT Provider Booklet**, which we recently updated for 2021.

Updated Consent Form Instructions for Sterilization and Hysterectomy

The Division of TennCare has updated the Sterilization Consent Form FAQ document and instructions for completing the Consent for Sterilization Form and the Hysterectomy Acknowledgement Form. All changes were effective July 1, 2021, and links to the revised documents can be found in the **Forms** section of the **BlueCare Tennessee Provider site**.

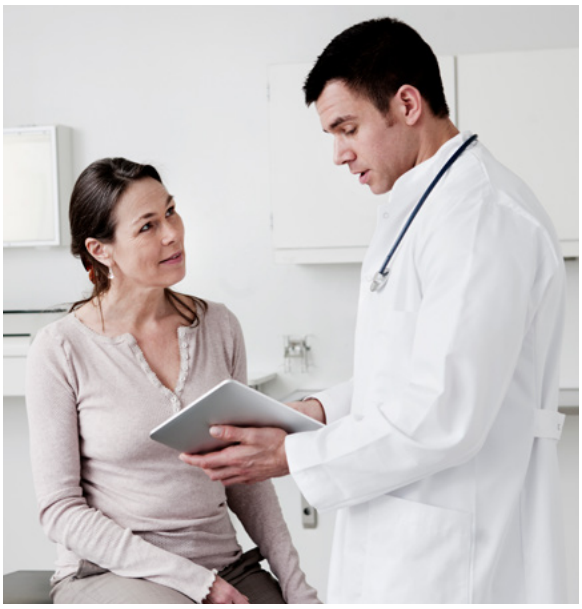
Hysterectomy Acknowledgement Form Changes

At least one section (A, B and/or C) must be completed. However, more than one section can be completed if applicable. The signature requirement is consistent with the Sterilization Consent Form instructions (a signature is a sign or mark by the patient on a document signifying knowledge, approval, acceptance and informed consent).

Updated Instructions for Completing the Sterilization Consent Form

- All fields requiring "type of operation" (fields 2, 6, 14 and 18) may be described in terms the patient uses to reflect understanding of the operation or medical terminology. Descriptions in these fields don't have to match.
- Field 15 (Signature/Date of Person Obtaining Consent and Facility Name/Address) was updated to remove the requirement to have the consent date match the patient's signature date.
- The Sterilization Consent Form FAQ document has been updated to state that "premature delivery" doesn't refer to the clinical definition of prematurity. Instead, it refers to any date prior to the estimated due date.

For more information about abortion, sterilization and hysterectomy requirements, please see the **BlueCare Tennessee Provider Administration Manual**.



Coming Soon: Abortion, Sterilization or Hysterectomy (ASH) Claims Review

In late 2021, we'll review BlueCare, TennCareSelect and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2020, and June 30, 2021.

The retrospective ASH review includes an in-depth look at documents that may not have been required at the time claims were submitted. If you submitted a claim with an ASH code between July 2020 and June 2021, we may contact you for additional records. **Note:** We may recover payment if we don't receive records within the requested time frame.

If you have questions about the ASH review or ASH claims guidelines, please see the **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

Guidance for Billing Covered Services from a School Nurse

The Division of TennCare recently developed guidelines for providing and billing in-school, covered services delivered by a school nurse. The table shows billable and non-billable services, and codes to use on claims.

You can view the guidelines in the **Tools and Resources** section of **bluecare.bcbst.com/providers**. Once on the **Tools and Resources** page, click on **Guidelines for Billing Covered Services Provided by a School Nurse**. We'll also update the **BlueCare Tennessee Provider Administration Manual** with this information.

BlueCare Plus Tennessee

This information applies to our BlueCare Plus, and BlueCare Plus Choice Medicare Advantage, Fully Integrated Dual Eligible special needs plans.

Change to BlueCare Plus PDRP Coming in October

Starting Oct. 1, 2021, the BlueCare Plus Provider Dispute Resolution Process (PDRP) will align more closely with our Medicare Advantage line of business regarding medical necessity provider appeals. We'll offer providers peer-to-peer review (for medical necessity service denials), as well as one written medical necessity provider appeal per case within BlueCare Plus. More details will be available in October's **BlueCare Plus Provider Administration Manual**. Please note that this provider appeal process is contractual and distinctly different than the Medicare Member appeal process.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Opportunity for Frailty Exclusions

The Centers for Medicare & Medicaid Services (CMS) allows exclusions from some quality measures for your patients who are BlueAdvantage, BlueEssential and BlueCare Plus members when they have specific advanced illness and/or frailty diagnoses. Exclusions to these measures are made because the HEDIS® definition includes services that may not benefit older adults with advanced illness, which limits their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes often aren't captured during routine office appointments. Annual wellness visits offer a yearly opportunity to address gaps in care, as well as possible exclusions. Coding eligible frailty conditions during the current year qualifies the member for exclusions from select quality measures related to the frailty and/or advanced illness.

Common frailty conditions that exist in the senior population include:

- History of falling (Z91.81)
- Weakness (R53.1)
- Muscle weakness (M62.81)
- Other malaise (R53.81)
- Other fatigue (R53.83)
- Difficulty in walking (R26.2)

For more information and codes related to exclusions for advanced illness and frailty, please refer to our **Guide to Advanced Illness and Frailty Exclusions**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Free CareTN Mobile App

BlueAdvantage, BlueEssential and BlueCare Plus plan members can manage their health by working with a clinical professional on our population health teams using the free CareTN app. Members can take self-guided courses on 30+ conditions and have access to a care management team that includes a nurse, social worker, pharmacist and dietitian through a chat feature inside the app.

When members check in, they can read articles related to specific health management topics. Some features include medication lists with reminders, goal setting with progress monitoring, appointment reminders and access to a CMS-approved health library with additional articles and videos. Members need a smart device to download and use the app. They may self-enroll or call to get help from one of our nurse care managers:

BlueAdvantage and BlueEssential (code *medhelpwell*) **1-800-611-3489**

BlueCare Plus (code *bcphelpwell*). **1-877-715-9503**

Risk Adjustment Medical Records Return and Coding

Our Medicare Advantage Risk Adjustment team began requesting copies of members' medical records in May. You may have received a request letter directly from BlueCross or from our vendor, CIOX Health. If you received a request for records, please follow the instructions in your packet and submit the records as quickly as possible.

Also, please remember that including all diagnosis codes, when submitting medical claims, reduces the number of records needed. Please include all actively managed ICD-10 codes for conditions that are present on your claims regardless of the reason for the visit.

Up to 12 diagnoses can be submitted on each claim form. If there are more than 12 actively managed diagnoses for a given patient, you can submit additional $0.01 claims using CPT 99499 with the additional diagnoses. Frequently overlooked diagnoses include: angina, arrhythmias, congestive heart failure, COPD, depression, diabetes, morbid obesity, rheumatoid arthritis, substance abuse and vascular diseases.

Pharmacy

This information applies to all lines of business unless stated otherwise.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

90-Day Supply of Maintenance Medications Now Permanent Benefit for BlueCare Tennessee Members

During the COVID-19 emergency, BlueCare Tennessee members with chronic conditions could obtain a 90-day supply of select maintenance medications. As of Sept. 1, 2021, medications on the 90-Day Supply List will process for 90-day supplies at the pharmacy as a permanent benefit. The TennCare provider relations team has already notified BlueCare providers, and **you can see a copy of that memo here**. You can also **find the drug list online**. If you have questions about the list, please call OptumRx, TennCare's pharmacy benefit manager, at 1-866-434-5520.

Updates to Key Online Resources

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

See the Latest and What Changes Are on the Way: Coding Updates, PAMs, Medical Policies

You can easily find the latest information and what changes are on the way for several key items that are important to providers.

- Commercial Provider Administration Manuals (60-Day Preview Version): You can access the Preview PAM 60 days before the effective date in the **Manuals, Policies & Guidelines** section at **provider.bcbst.com**.
- Medical Policy, Administrative Services Policy, Utilization Management Guideline (UMG): View upcoming BlueCross policy or guideline changes each month at **provider.bcbst.com/coverage**. If you have questions, please send an email to: **medical_policy@bcbst.com**.
- Coding Updates

Find current coding updates and pending claim edit changes 60 days before their effective date under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page.

If you have questions, please call us at **1-800-924-7141** and follow the prompts to Network Contracting and Credentialing.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

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of Tennessee

OCTOBER 2021

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

New Feature Now Available: Submit Claims Through Availity®

We've made it easy for you to submit claims electronically through Availity. To do this, you'll need an Availity account with a "claims user role" and be set up as an electronic provider with us.

INSIDE THIS ISSUE

Simply follow these steps to get started submitting your claims through Availity.

1. Log in to **Availity**.
2. Click the **Claims & Payments** drop-down list.
3. Under **Claims**, select your claim type: Professional, Facility, Dental*.
4. Enter your claim information on the claim form.
5. Once you've completed the form, click "Submit."

If you need help or would like training, call your **eBusiness Regional Marketing Consultant**. If you have any technical issues, please call the eBusiness Support Team.

*Dental providers filing services that require submission of X-rays for clinical review or secondary-filed claims are advised to continue submitting claims through their current method at this time.

CAQH to Retire EnrollHub® in November, BlueCross to Name New Vendor

CAQH's EnrollHub tool, which BlueCross uses as our source for provider payment information, will be retired by CAQH in early November. We'll begin using a new payment configuration vendor, and providers will be able to access the tool through Availity. More details about this change will be in the November BlueAlert.

We'll continue using with CAQH on the ProView® and DirectAssure products for our provider enrollment and directory efforts.

Web Authorization though Availity

If you've requested prior authorizations for behavioral health services through Availity and it's been more than one year, you'll need to create a new case and reference the previous case authorization number in the Free Form Notes section to ensure streamlined services. If you have questions or need additional training, please contact your **eBusiness Regional Marketing Consultant**.

Provider Enrollment Form Survey

We're always looking for ways to improve our systems and processes, and your input is appreciated. We've recently created a survey to ask your feedback about our provider enrollment process. A link to the survey is included at the bottom of the enrollment summary after you've completed a Provider Enrollment Form. We hope you'll take a few minutes to tell us about your experience.

Easier Online Confirmation Process to Replace Data Verification Form

We've steadily increased the use of CAQH ProView as our source for provider information, especially location-specific data. This will help us move away from sending you lengthy paper Data Verification Forms each quarter.

You'll soon receive a letter with instructions on how to confirm the information in CAQH and complete the BlueCross Network Verification on our portal in Availity. Most of your information can be updated in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review on our portal. The Network Verification form in the **Provider Enrollment, Updates and Changes** tile is located in the BlueCross payer space in Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to get the paper Data Verification Form until we can move all providers to this new process.

If you have questions, please contact Provider Service at **1-800-924-7141** and follow the prompts for Contracting and Credentialing.

Consolidated Appropriations Act Brings Changes

In December 2020, Congress signed the **Consolidated Appropriations Act (CAA)** into law. Many of the health care requirements outlined in the CAA go into effect on or after Jan. 1, 2022. While the law contains several new regulations, we wanted to update you on several new requirements. The requirements listed are based on the provisions as we currently understand them and may change with future guidance from the government.

ID Cards – Beginning on or after Jan. 1, 2022

The CAA is expanding the information available on Member ID cards. Health insurance ID cards will now be required to show:

- In-network and out-of-network deductibles
- Out-of-pocket maximum amounts
- Websites and phone numbers for members to get more information

Note: Only new cards issued or digital cards downloaded/printed on or after Jan. 1, 2022, will contain this additional information.

Provider Directory – Effective Jan. 1, 2022

The CAA requires health insurance plans to have an accurate provider directory of in-network providers. New requirements outline specific processes to:

- Verify and update the provider directory information at least every 90 days
- Update certain provider data within two business days
- Respond to requests for in-network provider information
- Establish a procedure to remove providers from our provider directory who don't validate their data

The CAA also requires providers to submit provider directory information to contracted health plans in a timely manner. New requirements outline when providers should submit their information:

- When the provider enters into a provider agreement with the health plan
- When the provider terminates their provider agreement with the health plan
- When there's a material change to their provider directory information
- At any other time, including when requested by the health plan

To meet these requirements, individual providers should continue using CAQH to validate their data. Facilities and ancillaries should continue using Data Verification Forms to validate their information. Information in CAQH must be reviewed and validated every 90 days and a response must be returned for every Data Verification Form.

If you're removed from the directory for non-compliance, you can attest your information to be added back in the directory.

No Surprises Act (NSA): Surprise Billing – Beginning on or after Jan. 1, 2022

The CAA includes new protections that prevent members from getting unexpected bills for certain emergency and ancillary services from out-of-network providers. It also outlines protections for non-emergency services provided by out-of-network providers at an in-network facility.

Under certain circumstances, the provider will be required to refund members. For example, if a provider bills a member and the cost-share is more than what's required for in-network treatment and the member pays the bill, the provider must reimburse the member for the full amount of the difference, plus interest. The interest rate will be determined later.

Other Provisions of the CAA Have Been Delayed

On Aug. 20, the federal agencies overseeing CAA implementation said they'll issue further guidance and won't enforce certain provisions until a future date. This includes:

Advance Cost Estimates for Health Care Services – Effective Date To Be Determined

The CAA requires that members be able to request cost estimates, known as advance explanation of benefits (AEOB) for upcoming health care services. These estimates will require actions by BlueCross and providers.

- Providers will need to send BlueCross a good-faith estimate of the costs. This includes billing and diagnostic codes for the scheduled care, as well as anything expected to be offered by other providers or facilities.
- We'll give our members with information on the:
  - Provider's network participation and rates
  - Member's remaining deductible and out-of-pocket balances
  - Member's expected financial responsibility (good-faith estimate)

For more information about the CAA, please click this **link**. For more information about operational changes we plan to make as a result of the law, please visit **BCBSTnews.com**.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Speech Therapy Additional Benefit Information

Many Commercial plans have limits on the conditions eligible for speech therapy. To make sure a patient is eligible for speech therapy before writing a referral, check the patient's Benefits and Eligibility on Availity. If you still have questions once you've checked our Payer Space, please use the Fast Path process (listed in Availity) to get your information by phone.

If you need help registering for Availity, call **1-800-282-4548**. For navigation help, please contact our eBusiness department at **(423) 535-5717** or call **1-800-924-7141** and press 4 for eBusiness Support.

Requesting Predetermination Status

As a reminder, our predetermination review timeframe is up to 15 calendar days but could take longer if there's a backlog. After the review is complete, we'll send you a letter with our decision. If you haven't received the notice after 15 calendar days, please call our Provider Service line at **1-800-924-7141**.

Use Self-Service Options for Claims Status Inquiry Starting Nov. 1, 2021*

In the past, our customer service representatives have provided claims status through our Provider Service line. However, starting Nov. 1, 2021, you'll be required to use one of the self-service options.

Electronic Data Interchange (EDI)

- Electronic Remittance Advice (ERA) (HIPAA X12 835) – When claims are final, their status will be available via 835 ERA transactions, which also allow you to post claim results to your billing system.
- Blue CORE (HIPAA X12 276/277) – You can work with your vendor to connect with us to get claims status in real time without exiting your system workflow.

Availity

- Remittance Advice – The same ERAs that you receive for posting are available in Availity's **Remittance Viewer**. To view the status of claims in your remittance, log in to Availity and select the **Claims & Payments Remittance Viewer**. If you want to view your legacy remittance, select the BlueCross **Payer Space** and click on the **Print/View Remittance Advice** tile.
- Claims Status – To check the status of a claim, log in and select the **Claims & Payments** tab, then click **Claims Status**. An easy way to determine status is to look for the colors associated with the claim: green is processed, yellow is pending and red means denied.

* This also applies to outsourced vendors acting on the provider's behalf.

Automated Claims Status Option

- Call the appropriate Provider Service line and choose the option for "Automated Claims Status."

After you've found the status of the claim using one of the above methods, our customer service representatives are still available to answer specific questions you may have about a claim payment or denial. Please note, when you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number. If you have questions or need help with Availity or EDI, you can contact eBusiness at **(423) 535-5717, option 2**. If you'd like training on Availity, please contact your eBusiness Regional Marketing Consultant.

Advanced Specialty Benefit Management Program Pharmacy Expansion

Starting Jan. 1, 2022, we're expanding our Advanced Specialty Benefit Management (ASBM) program to all commercial fully insured plans, both group and Marketplace. This program only affects specialty drugs administered in a provider's office or facility; not self-administered specialty drugs delivered to members' homes. The prior authorization and claim submission processes in place for members in our self-funded ASBM groups will apply to members in fully insured group and Marketplace plans. Providers who chose our TransactRx specialty drug billing option can expect to receive calendar year 2022 contracts in mid- to late-fall, just like last year.

We're sending letters in November to all members and their providers who have an open authorization for one of the affected drugs to make sure they're aware of and understand this change. If you have questions, please contact your Provider Network Manager.

Updates to Change of Ownership or Control Process

As mentioned in recent issues of BlueAlert, we've updated our Change of Ownership or Control (CHOWOC) process as of **Sept. 1, 2021**. This update impacts facilities, ancillary providers and professional groups with a change in ownership or control. If this happens, you'll need to send us a completed **Change of Ownership Notification Form** at least 60 calendar days before the change. If you don't send us the form within this time frame, your reimbursement rates and claims payments may be impacted. For more information about the updated CHOWOC process, please see your **Provider Administration Manual** or the **CHOWOC FAQs**.

Current Medical License Required to Remain in Network

Providers are responsible for maintaining their medical licenses, so please make sure you know when to renew your license. A current license is the most important requirement to maintain your credentials and network participation, and we're required to terminate providers from our network when their licenses expire. If you're removed from our networks because your license expired, you'll have to reapply and go through the full credentialing process again. Any claims submitted by an unlicensed provider will be denied.

Changes to Hi-Tech Imaging and Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Dec. 1, 2021, the following CPT® codes will be added and require prior authorization through eviCore's Hi-Tech Imaging Program:

0648T 0649T 0623T 0624T 0625T 0626T

Beginning Dec. 1, 2021, the following CPT® codes will be added and require prior authorization through eviCore's Genetic Testing Program:

0250U	0258U	0265U	0269U	0273U	0278U
0252U	0260U	0266U	0270U	0274U	0282U
0253U	0262U	0267U	0271U	0276U	G0327
0254U	0264U	0268U	0272U	0277U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity, clicking **Patient Registration** and then **Eligibility and Benefits Inquiry**. You can submit prior authorization requests through Availity by sending a fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

Changes to Commercial Plan Prior Authorizations

As of **Oct. 1, 2021**, providers will need to get prior authorization for some Commercial members over the age of 18 who are participating in lab-based sleep studies for the following codes: 95807, 95808, 95810, 95811. Home-based sleep studies for Commercial members don't require prior authorization.

You can send authorization requests through the **Authorization Submission/Review** application tile in Availity, by faxing them to Commercial Utilization Management at **1-866-558-0789**, or by calling our Provider Service line at **1-800-924-7141**.

Prior Authorization for Medical Supplies

Medical supplies* don't require prior authorization unless the supplies are related to a left ventricular assist device (LVAD) with CPT® codes Q0508 and Q0509. If you need differentiation between medical supplies and durable medical equipment (DME), or have other questions, please refer to your **Provider Administration Manual**.

* Including medical supplies costing more than $500

BlueCare Tennessee

This information applies to BlueCare [SM], TennCareSelect and CoverKids plans unless stated otherwise.

Rise in RSV Cases Prompts TennCare to Open RSV/Synagis Season Early

Based on our medical policy, Synagis injections are only approved for use during respiratory syncytial virus (RSV) season, which typically begins Nov. 1 and ends March 31 annually. This year, TennCare is extending RSV season, with a retroactive opening date of Aug. 1, 2021.

What This Means for You

Our pharmacy department updated the authorization guidelines for Synagis injections to allow for the extended season. Please request authorization for Synagis injections as you normally would during RSV season. For more information about this change, please visit **BCBSTupdates.com**.

Flu Vaccines Are More Important Than Ever

Fall signals the beginning of flu season in Tennessee. This year, in light of COVID-19, it's even more important to educate patients about the importance of the flu vaccine. Consider offering these reminders to prepare your team – and your patients:

- Schedule patients' flu vaccines in advance and send appointment reminders. The Centers for Disease Control and Prevention (CDC) recommends patients age 6 months and older get their flu shots by the end of October.
- Talk with your patients about the heightened importance of getting the flu vaccine and staying healthy during cold and flu season.
- If you have patients who will turn 6 months old toward the end of flu season, don't forget to order extra doses of the vaccine. It's often in short supply in February, March and April.
- Your patients eligible for the COVID-19 vaccine or vaccine booster can take the flu shot at the same time, according to guidance from the CDC.

Updated Guidelines: Subcontracting Requirements

As announced in the August 2021 BlueAlert, providers and vendors who participate in the BlueCare and TennCareSelect networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior agreement, claims for services provided by the subcontractor may be denied, and previous payments may be subject to recoupment.

To request approval of all provider subcontracts, BlueCare Tennessee providers must submit the BlueCare Tennessee **Provider/Vendor Subcontracting Form** and a signed exhibit. You can find both documents in the Office Administration section of our **Provider Forms** page.

All provider and vendor subcontractors must also meet these requirements:

- All employees and subcontractors supporting the BlueCare Tennessee contract must complete **Deficit Reduction Act/Fraud, Waste and Abuse training**. We recently updated this training for 2021.
- Records of services provided by subcontractors must be kept for at least 10 years after the agreement with BlueCare Tennessee expires, unless otherwise noted in the vendor contract.
- Subcontractors must verify that employees aren't listed on the **Office of the Inspector General List of Excluded Individuals and Entities** or the **System for Award Management** databases before hiring and every month during employment.

For more information about subcontracting requirements, please see the **BlueCare Tennessee Provider Administration Manual**.

Important Announcement from TennCare: Providers CARE Survey

Good health outcomes start in the communities where your patients live. Starting Oct. 8, 2021, you can take the Providers CARE Survey. The survey will ask you about your patients' needs, your experiences and learning opportunities that can support your practice.

Our goal is to help you improve your patients' health by:

C= Connecting them with community resources (like food pantries and housing help)

A= Acting for better health by teaching them about their care needs

R= Reducing differences

E= Encouraging them. Take the time to listen to your patients. Treating them with kindness and support helps them take steps they need for better health and supports them on their journey to their best life.

To fill out the survey, please visit **tn.gov/tenncare/providers/social-and-health-needs.html**. Your responses are anonymous and will be combined with information from other providers.

Enhanced Support for Providers Prescribing Opioids to BlueCare Tennessee Members

We're committed to supporting you in the continued fight against opioid use disorder, so we've developed a new solution to help you better understand your BlueCare Tennessee patients' opioid use patterns: The Provider Risk Index Score (PRISE™).

PRISE compares a provider's prescribing patterns to clinical guidelines and other providers in the BlueCare and TennCare*Select* networks who prescribe opioids and gives us actionable information about our members' opioid use. We can then use this information to work with providers who care for individuals at the highest risk of adverse opioid-related outcomes, such as overdose.

Next Steps for Network Providers

We began using PRISE in July 2021, and we'll review the data in our PRISE dashboard monthly moving forward. If you prescribe opioids, you may get a letter from us or a request to schedule a peer-to-peer meeting with one of our medical directors or our clinical pharmacist. During these meetings, a member of our clinical team will share important safety alerts and information about your patients, including:

- **Multiple Prescriber Risk:** Patients receiving opioids from multiple practices within a 90-day period
- **Polydrug Risk:** Patients prescribed opioids who are also taking a drug that may adversely interact with opioids, such as benzodiazepines or carisoprodol
- **MEDD (morphine equivalent daily dose) Risk:** Opioids prescribed at MEDDs higher than 50mg

If a member of our clinical team contacts you, we encourage you to work with them to help make sure your patients are using opioids safely.

For more information about PRISE, please see the **PRISE™: Using Artificial Intelligence to Improve Opioid Prescription Monitoring and Medication Management Across the Care Continuum** document in Availity.If you have questions, please contact your Provider Network Manager.

Stay Up to Date on the BlueCare Tennessee Provider Appeals Process

If you disagree with the way we've processed a claim, you may use our claims reconsideration and appeal process to request a second look. We've put together a few reminders to help make sure reconsideration and appeal requests are processed quickly and correctly. Please note that the below process differs from the process used for utilization management or clinical authorization appeals.

Level 1: Reconsideration – Reconsideration requests must be received within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or multiple claims. Include any supporting medical records as needed.**

Please note that you must file a request for reconsideration before submitting an appeal unless your request is related to a non-compliance denial.

Step 2: Appeal – An appeal must be received in writing with all supporting medical records within 60 days of the date of the initial denial notification. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each document should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeal process, please see the **BlueCare Tennessee Provider Administration Manual**.

Save the Date: Tennessee Healthcare Symposium, Nov. 2-4, 2021

Mark your calendars to attend the Tennessee Healthcare Symposium for health care professionals. You'll hear from a variety of speakers and industry experts, who will present information in three informational tracks:

- Specialty Coding
- Management and Compliance
- Coding and Billing

Event registration is open and regular ticket pricing will run until the start of the symposium (TMA Member $199; Non-Member $249).

If you have questions, please contact Karen Baird at **(615) 460-1651** or **Karen.Baird@tnmed.org**. To learn more about the symposium, go to **tnmed.org/symposium**.

BlueCare Plus Tennessee

This information applies to our BlueCare Plus (D-SNP)℠, and BlueCare Plus Choice Medicare Advantage, Fully Integrated Dual Eligible special needs plans.

Patient Care and Planning Form (PACF)

BlueCare Plus network participating primary care physicians are eligible to receive reimbursement for completing a PACF for members enrolled in a BlueCare Plus Dual Special Needs Plan. Each year, a PACF should be completed with a face-to-face or telehealth visit (both audio and video components required) for each member to document all active acute and chronic conditions and how they're assessed and managed.

PACF data may also close some quality care measure gaps and facilitate Interdisciplinary Care Team (ICT) collaboration between BlueCare Plus, the primary care provider and member. This supports Centers for Medicare & Medicaid Services (CMS) requirements for annual ICT communication and provides additional reimbursement of $54 when billing CPT® codes 99366-99368. You may complete a PACF at the same time as an annual wellness visit. BlueCare Plus plan members will be eligible to receive a gift card incentive for completing their annual wellness visit.

To receive a $155 reimbursement, submit your claim with CPT® code 96160 with the visit E/M code. You may fax PACFs to **(423) 591-9504** or upload them in the Quality Care Rewards tool in Availity. Please contact your BlueCare Plus Provider Outreach Consultant if you have questions about completing the PACF.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Special Needs Plan Model of Care Training

Providers participating in BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plans are contractually required to complete our Model of Care training after initial contracting and every year afterwards. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**.

Patients with Diabetes Need Statin Medication Fill

American College of Cardiology and American Heart Association guidelines state patients with diabetes should receive a statin medication to help reduce the incidence of heart disease and stroke.

One of the Centers for Medicare & Medicaid Services (CMS) star measures –Statin Use in Persons with Diabetes (SUPD) – looks at Medicare Advantage Prescription Drug plan members who are between the ages of 40 and 75 and who've filled at least two prescriptions for a medication to treat diabetes during the plan year who also receive a prescription for a statin medication. This measure doesn't include a minimum dosage requirement. Members who have end-stage renal disease or are receiving hospice services are excluded from this measure.

Additionally, new exclusions were added by CMS to the measure specifications for 2021:

M62.82	Rhabdomyolysis
G72.0	Drug-induced myopathy
G72.9	Myopathy, unspecified
K72.90	Hepatic failure, unspecified, without coma
T46.6X5A	Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs initial encounter
M60.9	Myositis, unspecified
R73.03	Pre-diabetes
E28.2	Polycystic ovary syndrome (PCOS)

For an MAPD plan member to be excluded from the measure, the treating physician must include the ICD-10 diagnosis code for the applicable exclusion condition on the claim submitted to the plan. **Documentation of a statin intolerance or contraindication in the chart alone won't exclude the member from this quality measure.**

Clinical decisions regarding whether a statin medication is appropriate are between the treating physician and their patient. Please note that when making prescribing decisions with patients who are our Medicare Advantage Prescription Drug plan members, all generic statins are included in the BlueCross Medicare Part D drug list when filled at preferred pharmacies. Copays range from $0 - $1 for a 90-day supply depending on the member's specific plan type.

Encourage Eligible Patients to Have Breast Cancer Screenings

Breast cancer screening rates have seen a significant decrease over the past year with many members delaying their preventive mammograms during the COVID-19 pandemic. Members often rely on their primary care physician to provide guidance for when it's safe to resume routine preventive care and services.

With the implementation of a variety of safety protocols and rising vaccination rates, we encourage you to talk to your patients who are our Medicare Advantage plan members about scheduling or rescheduling their screening mammograms before the end of the year. Remember that BlueAdvantage and BlueEssential plan members who are between 50 and 74 years of age and who are enrolled in our My HealthPath® incentive and rewards program are eligible to receive points redeemable for a $50 gift card for completing a screening mammogram annually. Members enrolled in a BlueCare Plus plan who are between 50 and 74 years of age and who have a screening mammogram are eligible to receive a $25 gift card under the BlueCare Plus plan rewards and incentives program annually. Please note that this measure and incentive for members is for screening mammograms only.

New Education WebEx Presentations Now Available

New quality measure presentations have been added to the BlueAdvantage, BlueEssential and BlueCare Plus provider education WebEx series in Availity:

- 2021 Medicare Advantage Quality Program Overview
- 2021 Medicare Advantage Program Measures
- Provider Assessment Forms (PAFs)
- Care for Older Adults (COA)
- Statin Use in Persons with Diabetes (SUPD)
- Medication Reconciliation Post Discharge (MRP)
- Risk adjustment
- Quality Care Rewards (QCR) application
- New Patient Survey Measures
- Advanced Illness and Frailty Exclusions

These presentations provide an in-depth review of each topic for this year's quality program. As a reminder, there are additional episodes on various topics, such as the program overview and program measures. These presentations are educational and can serve as a resource for additional ways to enhance performance in the Medicare Advantage Provider Quality+ Partnerships program.

To access the presentations after logging in to Availity, go to the **BlueCross Payer Space tab** and select **Resources**. There, you'll find a list of presentations.

Pharmacy

This information applies to all lines of business unless stated otherwise.

2022 Drug List Changes

Each year, we review our drug lists and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they may occur at any time because of market changes, such as:

- Release of new drugs to the market after Food and Drug Administration (FDA) approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links on the **Pharmacy Resources & Forms** page to view the 2022 drug list changes:

- **2022 Preferred Formulary Changes**
- **2022 Essential Formulary Changes**
- **2022 BlueAdvantage Formulary**
- **2022 BlueCare Plus Formulary**

Use National Drug Code Numbers on Claims for Drugs Only

Providers should only use national drug code (NDC) numbers on BlueCare, TennCare*Select* and CoverKids claims for provider-administered drugs. NDC numbers shouldn't be used for other line items, such as urinalysis, surgeries and administration codes.

Please be sure to include an NDC and the corresponding quantity amount on crossover claims for physician-administered drugs. To review policies about the collection of NDCs on claims for physician-administered drugs, see the **Centers for Medicare & Medicaid Services Manual System for Claims Processing** and our **BlueCare Tennessee Provider Administration Manual**.

340B Drug Pricing Program Modifier Requirements

Beginning Dec. 1, 2021, providers who have BlueCare, TennCareSelect and CoverKids patients and participate in the 340B Drug Pricing Program must include the appropriate modifier on all outpatient/office claims that include an NDC.

- **JG** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members OR
- **TB** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members (reported for informational purposes) OR
- **UD** – Drug or biological acquired with the 340B drug pricing program discount OR
- **UC** – Drug or biological acquired without the 340B drug pricing program discount

We encourage you to include the appropriate modifier on your claims that contain an NDC number as soon as possible. Outpatient/office drug claims that contain an NDC number without the appropriate modifier will be denied starting Dec. 1. While there's a list of drugs included in the 340B program, we won't be using this list when evaluating claims. We'll only review claims for the presence of an NDC number to determine if a modifier should be included.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Updates to Key Online Resources

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

'What if' and Scenario Questions

Definitive payment and coverage responses aren't possible for "what if" or scenario questions. While we strive to provide meaningful information through the Provider Administration Manuals and this newsletter, the final determination is based on review of a specific claim and the associated documentation submitted.

We can't provide exact reimbursement or instructions on how to code a service based on snippets of information. Providers are responsible for correctly coding services provided to our members. You can review the published billing and reimbursement guidelines in the **Provider Administration Manuals**.

Questions related to the interpretation of codes should be addressed with the coding organizations (e.g. AMA, CMS, etc.) and/or various medical societies/associations (e.g. ACOG, AAOS, etc.).

Submitting Unclassified or Not Otherwise Classified (NOC) Drug Codes Correctly

When billing with an NOC code for drugs, it's important to provide the necessary information for coding and reimbursement review. Incomplete or conflicting information submission will cause a reimbursement delay.

Here's what you need to provide:

- The valid/current 11-digit National Drug Code (NDC) for the drug administered, preceded by the 'N4' qualifier
- The total dosage administered, expressed in the appropriate unit of measure for the specific drug and preceded by the qualifier indicating that unit of measure (e.g., ME – milligrams, ML – milliliters, GM – grams, UN – units, F2 – international units)

Correctly Billing Drug Wastage from a Single Dose Vial (SDV)

Due to differences in adjudication systems and processes, our guidelines differ from Medicare's guidelines when billing for drug wastage from an SDV. Our guidelines indicate both the total administered dosage and wastage amount should be combined and submitted on a single line item with the appropriate JW modifier (drug/biological amount discarded/not administered to any patient). Incorrect billing for drug wastage will cause a reimbursement delay.

Providers are responsible for using the most economical packaging of the drug to achieve the required dosage with the least amount of wastage necessary. If two vials with different NDCs are utilized, the NDC of the SDV requiring wastage should be submitted along with the total dosage administered and the wastage expressed in the appropriate unit of measure for the specific drug.

You can find detailed billing guidelines in our **Provider Administration Manuals**.

Latest Information and Changes for Coding Updates, Provider Administration Manuals (PAMs) and Medical Policies

You can easily find the latest information and the changes on the way for several key items that are important to providers:

- **Commercial Provider Administration Manuals (60-Day Preview Version)** – Access the Commercial Preview PAM 60 days before the effective date in the **Manuals, Policies & Guidelines** section at **provider.bcbst.com**.
- **Medical Policies, Administrative Services Policies, Utilization Management Guidelines (UMG)** – View upcoming BlueCross policy or guideline changes at **provider.bcbst.com/coverage**. If you have questions, please send an email to: **medical_policy@bcbst.com**.
- **Coding Updates** – Find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page.

If you have questions, please call us at **1-800-924-7141** and follow the prompts to Network Contracting and Credentialing.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

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of Tennessee

NOVEMBER 2021

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

Flu Vaccines Are Still Important

This year, in light of COVID-19, it's even more important to educate patients about the importance of the flu vaccine. The US Centers for Disease Control and Prevention (CDC) recommends everyone 6 months of age and older should consider the annual flu vaccination.

INSIDE THIS ISSUE

Consider offering these reminders to prepare your team – and your patients if appropriate.

- Schedule flu vaccines in advance and send appointment reminders.
- Talk about the heightened importance of getting the flu vaccine and staying healthy during cold and flu season.
- Discuss whether getting the flu vaccine while also getting a COVID-19 initial series vaccine or CDC-recommended COVID-19 vaccine booster is appropriate.

For further guidance on flu vaccines, please refer to the **CDC's website**.

Get Important Messages and Announcements by Email

If you'd like to get important email messages that apply to you, simply update your Contact Preferences from our Payer Spaces on **Availity®** and opt in to make email your preferred communication method for each of these communication types:

- **Contracting** – Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross performance ratings
- **Credentialing** – Information about your credentialing status or credentialing appeals inquiries
- **Network Operations** – Updates about network enrollment and your listing in the BlueCross
- **Provider Directory**
- **Network Updates** – General business announcements, newsletter updates and surveys
- **Quality and Clinical Information** – Notifications of available clinical data, performance and payment reporting for our value-based programs, which alert the provider to log into the secure Quality Care Rewards application to download. Also, the Quality Care Quarterly newsletter is distributed electronically if desired.
- **Financial Updates** – Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items

After you're logged in to BlueCross Payer Spaces on **Availity**:

1. Select the **Contact Preferences & Communication Viewer** tile
2. Choose your **Contact Type** and then your **Organization** (based on tax ID)
3. Verify your **Provider Name** and **National Provider Identifier (NPI)**; then click **Submit**

   TIP: If you don't see your name from the drop-down list, you can add it through Express Entry or enter your NPI. For Contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.
4. Follow the remaining cues, including checking the email **Opt In** box and making sure email is the first option in the Communication Preference list on the right side. Then click **Save & Submit**. You can apply the same updated contact details to other **Contact Types** by checking the Contact Type boxes – or the **Select All** box, which automatically checks all Contact Types to which you have access.

In some cases, it may take time to receive these messages through your newly specified email, and you may temporarily receive them as you did before. Please visit our **Provider Service page** where you can find links to our Enrollment and Technical Support teams. If you have questions or need help with Availity, please visit Availity.com or contact our eBusiness Service team at **(423) 535-5717 (option 2)**.

New Feature Now Available: Submit Claims Through Availity

We've made it easy for you to submit claims electronically through Availity. To do this, you'll need an Availity account with a "claims user role" and be set up as an electronic provider with us.

Simply follow these steps to get started submitting your claims through Availity:

1. Log in to **Availity**.
2. Click the **Claims & Payments** drop-down list.
3. Under **Claims**, select your claim type: Professional, Facility, Dental.*
4. Enter your claim information on the claim form.
5. Once you've completed the form, click **Submit**.

If you need help or would like training, call your **eBusiness Regional Marketing Consultant**. If you have any technical issues, please call the eBusiness Service team at **(423) 535-5717 (option 2)**.

*Dental providers filing services that require submission of X-rays for clinical review or secondary-filed claims should continue submitting claims through their current method at this time.

Need Help Navigating Availity?

If you need help navigating Availity, you can find Quick Reference Guides (QRGs) for many of the applications on BlueCross Payer Spaces. Here are some examples of the many QRGs available under the **Resources** tab:

- **Authorization Submission/Review** – If you need help requesting initial authorizations through Availity, viewing the current authorization status, updating existing authorizations, or uploading medical records, you can refer to the step-by-step instructions of one of many *Authorization Submission/Review QRGs*.
- **Contact Preferences & Communication Viewer** – Learn how to update your contact information and view your important messages and documents on Availity by referencing the *Contact Preference QRG*.
- **Fee Schedule Viewer** – Use the *Fee Schedule Viewer QRG* to learn how to access your fee schedules for BlueCross contracts.
- **Provider Enrollment, Updates and Changes** – Follow the step-by-step instructions of the *Provider Enrollment, Updates and Changes QRG* to keep your provider information current by submitting provider updates and changes.
- **Quality Care Rewards (QCR)** – Use the *Quality Care Rewards QRG* to help you navigate the QCR application to review gaps and track incentives for providing quality care.

If you need help with an **Eligibility and Benefits Inquiry**, Availity's Provider Help Center has **Eligibility and Benefits training** (use training link once in Availity) with BlueCross payer-specific information including Fast Path for contacting Provider Service.

1. On the Eligibility and Benefits results page, click **Contact Payer**, and then click **Call the Payer (Fast Path)**.
2. Call the number displayed in the Fast Path window. When you speak with our customer service representative, reference the transaction ID displayed.

Note: The Fast Path transaction ID does not display for members of the BlueCard and FEP plans. In addition, the telephone number that displays for BlueCard and FEP plan members is different from the telephone number shown in the example above.

Our Regional eBusiness Marketing Consultants are here to help you manage our web-based tools and electronic processes that support your everyday business transactions. If you need additional assistance, you can call or email your regional **eBusiness Marketing Consultant** or the eBusiness technical support team.

Use Self-Service Options for Claims Status Inquiry*

In the past, our customer service representatives have provided claims status through our Provider Service line. However, as of Nov. 1, 2021, customer service will no longer provide claims status and you'll be required to use one of the self-service options.

Electronic Data Interchange (EDI)

- **Electronic Remittance Advice (ERA) (HIPAA X12 835)** – When claims are final, their status will be available via 835 ERA transactions, which also allow you to post claim results to your billing system.
- **Blue CORE (HIPAA X12 276/277)** – You can work with your vendor to connect with us to get claims status in real time without exiting your system workflow.

Availity

- **Remittance Advice** – The same ERAs that you receive for posting are available in Availity's **Remittance Viewer**. To view status, log in to Availity and select the **Claims & Payments Remittance Viewer**. If you want to see your legacy remittance, select the BlueCross **Payer Spaces** and click on the **Print/View Remittance Advice** tile.
- **Claims Status** – To check the status of a claim, log in and select the **Claims & Payments** tab, then click **Claims Status**. An easy way to check status is to look for the colors associated with the claim: green is processed, yellow is pending and red means denied.

Automated Claims Status Option

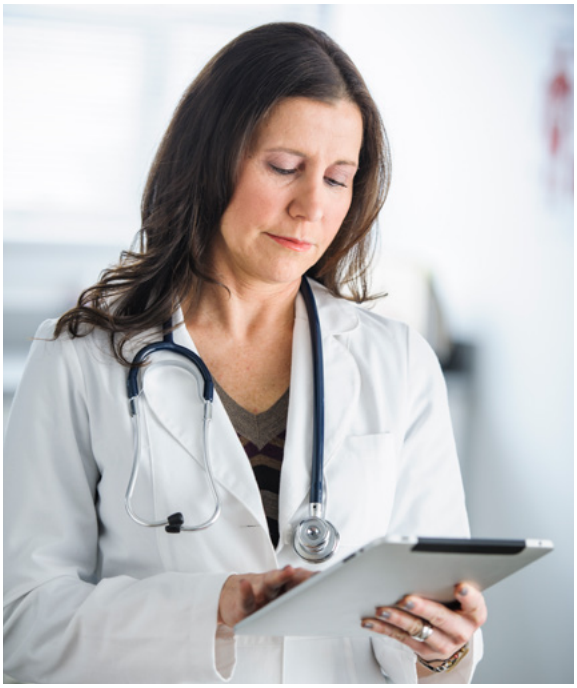
- Call the appropriate Provider Service line and choose the option for "Automated Claims Status."

After you've found the status of the claim using one of the above methods, our customer service representatives are still available to answer specific questions you may have about a claim payment or denial. Please note, when you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number. If you have questions or need help with Availity or EDI, you can contact eBusiness at **(423) 535-5717, option 2**. If you'd like training on Availity, please contact your eBusiness **Regional Marketing Consultant**.

* This also applies to outsourced vendors acting on the provider's behalf.

New Updates in Availity's Prior Authorization Tool

You can now submit authorizations for skilled nursing facilities (SNF), inpatient rehabilitation services and long-term acute care (LTACH) through Availity. You can find the **SNF and inpatient authorization request form** for all lines of business and the **commercial LTACH form** on our website. Please be sure to attach the completed form with each request you submit. If you'd like training on Availity, contact your **eBusiness Regional Marketing Consultant**.



CAQH to Retire EnrollHub® and BlueCross to Name New Vendor

CAQH's EnrollHub tool, which BlueCross uses as our source for provider payment information, will be retired by the end of the year. We expect we'll be able to share news about our new EFT/ERA tool soon, and providers will be able to access it through Availity and **provider.bcbst.com**. In the meantime, please verify your information in the CAQH EnrollHub tool until further notice.

If your information is correct in EnrollHub, you'll continue to receive payments and remittance advice as you always have. If you have questions, please contact our Network Contracts and Credentialing service team by following the prompts on our Provider Service Line, **1-800-924-7141**.

Please note, we'll continue using CAQH ProView® and DirectAssure products for our provider enrollment and directory efforts.

Easier Online Confirmation Process to Replace Data Verification Form

We've steadily increased the use of CAQH ProView as our source for provider information, especially location-specific data. This will help us move away from sending you lengthy paper Data Verification Forms each quarter. You should have already received a notice with instructions on how to confirm the information in CAQH and complete the BlueCross Network Verification on our portal in Availity. Most of your information can be updated in CAQH, but some, like patient acceptance for our networks and remittance address, still need your review on our portal.

The Network Verification form in the Provider Enrollment, Updates and Changes tile is located in the BlueCross payer space in Availity. This application allows provider groups to easily review multiple practitioners at once. Ancillaries and facilities will continue to get the paper Data Verification Form until we can move all providers to this new process.

If you have questions, please contact Provider Service at **1-800-924-7141** and follow the prompts for Contracting and Credentialing.

Provider Enrollment Form Survey

We're always looking for ways to improve our systems and processes, and your input is appreciated. We've recently created a survey to ask your feedback about our provider enrollment process. A link to the survey is included at the bottom of the enrollment summary after you've completed a Provider Enrollment Form. We hope you'll take a few minutes to tell us about your experience.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Consolidated Appropriations Act Brings Changes

In December 2020, Congress signed the **Consolidated Appropriations Act (CAA)** into law. Many of the health care requirements outlined in the CAA go into effect on or after Jan. 1, 2022. The requirements listed below are based on the provisions as we currently understand them and may change with future guidance from the government.

ID Cards – Beginning on or after Jan. 1, 2022

The CAA is expanding the information available on Member ID cards. Health insurance ID cards will now be required to show:

- In-network and out-of-network deductibles
- Out-of-pocket maximum amounts
- Websites and phone numbers for members to get more information

Note: Only new cards issued or digital cards downloaded/printed on or after Jan. 1, 2022, will contain this additional information.

Provider Directory – Effective Jan. 1, 2022

The CAA imposes new requirements on health insurance plans regarding the provider directory of in-network providers. New requirements outline specific processes to:

- Verify and update the provider directory information at least every 90 days
- Update certain provider data within two business days
- Respond to requests for in-network provider information
- Establish a procedure to remove providers from our provider directory who don't validate their data

The CAA also requires providers to submit provider directory information to contracted health plans in a timely manner. New requirements outline when providers should submit their information:

- When the provider enters into a provider agreement with the health plan
- When the provider terminates their provider agreement with the health plan
- When there's a material change to their provider directory information
- At any other time, including when requested by the health plan

To meet these requirements, individual providers should continue using CAQH to validate their data. Facilities and ancillaries should continue using Data Verification Forms to validate their information. Information in CAQH must be reviewed and validated every 90 days and a response must be returned for every Data Verification Form.

If you're removed from the directory for non-compliance, you can attest your information to be added back in the directory.

No Surprises Act (NSA): Surprise Billing – Beginning on or after Jan. 1, 2022

The CAA includes new protections that prevent members from getting unexpected bills for certain emergency and ancillary services from out-of-network providers. It also outlines protections for non-emergency services provided by out-of-network providers at an in-network facility.

Under certain circumstances, the provider will be required to refund members. For example, if a provider bills a member and the cost-share is more than what's required for in-network treatment and the member pays the bill, the provider must reimburse the member for the full amount of the difference, plus interest. The interest rate will be determined later.

Other Provisions of the CAA Have Been Delayed

On Aug. 20, 2021, the federal agencies overseeing CAA implementation said they'll issue further guidance and won't enforce certain provisions until a future date. This includes:

Advance Cost Estimates for Health Care Services – Effective Date To Be Determined

The CAA requires that members be able to request cost estimates, known as an advance explanation of benefits (AEOB) for upcoming health care services. These estimates will require actions by BlueCross and providers.

- Providers will need to send BlueCross a good faith estimate of the costs. This includes billing and diagnostic codes for the scheduled care, as well as anything expected to be offered by other providers or facilities.
- We'll give our members information on the:
  - Provider's network participation and rates
  - Member's remaining deductible and out-of-pocket balances
  - Member's expected financial responsibility (good-faith estimate)

For more information about the CAA, please click this **link**. For more information about operational changes we plan to make as a result of the law, please visit **BCBSTnews.com**.

Commercial Durable Medical Equipment (DME) Authorization Requests

Submitting authorization requests through Availity often results in an immediate response for most DME requests. When submitting web authorizations, please span dates appropriately to allow time for equipment delivery. Most Commercial plans require prior authorization for DME over $500. If the individual rental price or purchase price on DME is less than $500, authorization isn't required.

Reminders of DME that doesn't require prior authorization:

- Continuous positive airway pressure (CPAP) rental price, unless the cost is more than $500 a month per item billed
- Dressing supplies with A codes
- Continuous oxygen rental codes

The Durable Medical Equipment Quick Reference Guide is on the Payer Spaces Resources tab in Availity. If you're interested in setting up Availity training, contact your **eBusiness Regional Marketing Consultant**.

Changes to Hi-Tech Imaging and Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Dec. 1, 2021 the following CPT® codes will be added and require prior authorization through eviCore's Hi-Tech Imaging Program:

0648T 0649T 0623T 0624T 0625T 0626T

Beginning Dec. 1, 2021, the following CPT® codes will be added and require prior authorization through eviCore's Genetic Testing Program:

0250U	0258U	0265U	0269U	0273U	0278U
0252U	0260U	0266U	0270U	0274U	0282U
0253U	0262U	0267U	0271U	0276U	G0327
0254U	0264U	0268U	0272U	0277U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity, clicking **Patient Registration** and then **Eligibility and Benefits Inquiry**.

You can submit prior authorization requests through Availity by sending a fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

Advanced Specialty Benefit Management (ASBM) Program Pharmacy Expansion

Starting Jan. 1, 2022, we're expanding our ASBM program to all Commercial fully insured plans, both group and Marketplace. This program only affects specialty drugs administered in a provider's office or facility, not self-administered specialty drugs delivered to members' homes. The prior authorization and claim submission processes in place for members in our self-funded ASBM groups will apply to members in fully insured group and Marketplace plans. Providers who chose our TransactRx specialty drug billing option can expect to receive calendar-year 2022 contracts in mid- to late-fall, just like last year.

We began sending letters in November to all members and their providers who have an open authorization for one of the affected drugs to make sure they're aware of and understand this change. If you have questions, please contact your Provider Network Manager.

Anesthesiology Services Reminder

We wanted to remind you that we've made some changes to how we calculate time for anesthesiology services. We measure anesthesiology time in minutes and then convert it to fractional time units. In the past, we rounded up anesthesia time units to the next whole unit. For example, 1.11 units were rounded up to 2 units. Effective July 1, 2021, we started rounding up anesthesia time units to the nearest tenth to better align with industry standards.

For example:

- 1.41 units will be rounded up to 1.5 units
- 1.61 units will be rounded up to 1.7 units
- 1.91 units will be rounded up to 2 units

Please note that anesthesia time doesn't apply to Daily Hospital Management Services. For more information, please refer to your **Provider Administration Manual**. **This change also applies to BlueCare Tennessee.**

Updates to Change of Ownership or Control Process

As mentioned in recent issues of BlueAlert, we've updated our Change of Ownership or Control (CHOWOC) process as of Sept. 1, 2021. This update impacts facilities, ancillary providers and professional groups with a change in ownership or control. If this happens, you'll need to send us a completed **Change of Ownership Notification Form** at least 60 calendar days before the change. If you don't send us the form within this time frame, your reimbursement rates and claims payments may be impacted. For more information about the updated CHOWOC process, please see your **Provider Administration Manual** or the **CHOWOC FAQs**.

Changes to Commercial the Lab-based Sleep Study

Beginning Jan. 1, 2022, CPT® code 95805 will be added and require prior authorization through Commercial's Lab-based Sleep Study Program. Before requesting prior authorization, please verify member benefits and eligibility by logging in to Availity and clicking Patient Registration then Eligibility and Benefits Inquiry. You can submit authorization requests through the Authorization Submission/Review application tile in **Availity**, by faxing them to Commercial Utilization Management at **1-866-558-0789** or calling our Provider Service Line at **1-800-924-7141**.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless stated otherwise.

Join Us for a Virtual Webinar on Maternal Health

The Division of TennCare and the TennCare managed care organizations (MCOs) are hosting a joint maternal health webinar on Dec. 1 at 11:30 CT/12:30 ET. Topics covered during the hour-long session will include:

- Coding and reimbursement updates related to submitting pregnancy notification forms
- Updates on care management and referral
- Conducting mental health screenings with validated tools

The webinar will also cover details on each MCO's care management and maternity resources and leave time for questions and answers. We encourage all providers who serve pregnant and postpartum TennCare members and their office staff to attend.

Registration is required for this event. To sign up, **click here** to complete the registration form.

New Pilot Program for Katie Beckett Members Enrolled in TennCare*Select*

As part of the newly launched Katie Beckett program, TennCare*Select* will enroll Katie Beckett members in a pilot program to allow children with complex respiratory needs to be monitored remotely in their home. We're working with Eventa* our quality-of-care respiratory vendor, and Breathe Easy, one of our durable medical equipment providers, to conduct the program.

Children enrolled in the pilot program are monitored by Bluetooth wireless technology. Information is sent to Breathe Easy and monitored daily for alarms. Providers also receive trending reports. Metrics monitored will include oxygen saturation, end tidal CO2, pulse and respiratory rate.

Eventa will provide quality oversight of the pilot program. The goals of the program include reducing unplanned hospitalizations, promoting independence from ventilators, tracheostomies and other equipment, and most importantly, to improve the quality of life for the children and their families.

Eventa will notify pulmonary care providers whose patients qualify for the program. If Eventa contacts your office, we encourage you to work with them to enroll your patient in the program.

Note: This program doesn't apply to members with BlueCare or CoverKids coverage.

Flu Vaccine Reimbursement Update for the 2021 Flu Season

We want to make sure that flu vaccines are easily accessible for all children and teens in our state. As we did last year, we're covering flu vaccines for patients under age 19 outside of the Vaccines for Children (VFC) program. This means that if you give a flu vaccine to a child or teen covered by BlueCare Tennessee and don't participate in the VFC program, we'll reimburse you for the vaccine and the cost of delivering it.

If you aren't in the VFC program, please bill modifier 32 on the flu vaccine line item on your claims to receive payment for the vaccine when administering it to patients age 18 and younger. If you have access to the Tennessee Immunization Information System (TennIIS), please also report that you've administered the flu vaccine in the system. If you're enrolled in the VFC program, please disregard this information and continue to follow your normal process for vaccine administration.

Note: The information in this article doesn't apply to CoverKids.

Coming Soon: Chiropractic Services Coverage Expansion

Effective Jan. 1, 2022, BlueCare Tennessee will cover chiropractic services for all members, regardless of age. These services will require prior authorization, and you can use Availity to submit prior authorization requests. If you haven't signed up for Availity, please visit Availity.com to register for an account.

Important Coverage Details

When providing and billing for chiropractic services, please keep these guidelines in mind:

- You can submit the first 12 chiropractic visits to BlueCare Tennessee as notification only. These visits aren't subject to prospective medical necessity review but may be subject to retrospective review based on medical criteria.
- Any orders/requests for more than 12 chiropractic visits, including therapy continuation beyond the initial 12 visits, will require a medical necessity review. Please submit all necessary clinical information with your request. You can review the MCG Care Guidelines **here**.
- Chiropractic coverage is limited to spinal manipulation codes only (CPT® codes 98940, 98941 and 98942). Additional services won't be covered.

We're updating the **BlueCare Tennessee Provider Administration Manual** with this information. If you have questions about using Availity, please contact our eBusiness technical support team at **(423) 535-5717, option 2**, or **eBusiness_service@bcbst.com**.

Note: The information in this article doesn't apply to CoverKids.

Help Your Patients Get to Appointments

If families need transportation to and from your office, please let them know they have an option. Southeastrans offers free rides to TennCare-covered medical services and the pharmacy. Depending on their location in the state, your patients with BlueCare and TennCare*Select* coverage may qualify for a shared ride, bus pass or gas mileage reimbursement.

In most cases, our members need to schedule their transportation at least 72 hours before their appointment. If they need to travel fewer than 90 miles, they can schedule their ride by calling the Southeastrans Call Center number for their health plan:

- **BlueCare** – 1-855-735-4660
- **TennCare*Select*** – 1-866-473-7565

Those who need to travel more than 90 miles can call the number on the back of their Member ID card to request transportation. For more information about transportation benefits, please see our **EPSDT Provider Booklet** or visit **bluecare.bcbst.com** and select **Get a Ride.**

THCII Episodes of Care Program News and Updates

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available Nov. 18, 2021. If you're a quarterback who's having trouble accessing your Quarterly Report, please call **(423) 535-5717 and press option 2** or email **eBusiness_Service@bcbst.com**.

Coming Soon: 2022 Program Changes

The Division of TennCare recently released its Memorandum of 2022 Episode Changes, which outlines recommendations from the Episodes Annual Feedback Session in May 2021 and corresponding improvements that have been made for the 2022 Episodes of Care performance period. Please **review the memo of upcoming changes** so you're prepared for the coming year. We look forward to working with you to the make the 2022 performance year a success.

Important Announcement from TennCare: Providers CARE Survey

Good health outcomes start in the communities where your patients live, so we invite you to take the Providers CARE Survey. The CARE survey will ask you about the needs of your patients, your experiences, and learning opportunities that can assist your practice team.

Our goal is to help you improve your patients' health by:

C = Connecting them with community resources (like food pantries and housing help);

A = Acting for better health by teaching them about their care needs;

R = Reducing differences; and

E = Encouraging them. Take the time to listen to your patients. Treating them with kindness and support can help them take the steps they need for better health, and it supports them on their journey to their best life.

To fill out the survey, please visit **https://www.tn.gov/tenncare/providers/social-and-health-needs.html**. Your answers will not have your name on them and will be combined with information from other providers.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO C-SNP)℠ plans.

BlueEssential (HMO C-SNP)℠ Closure Update

BlueEssential (HMO SNP)℠ will not be offered in 2022. Launched as a chronic special needs plan for individuals with diabetes in 2020 with cardiovascular disease added in 2021, it included a limited network with key hospitals, primary care providers, and specialist groups in Chattanooga, Jackson, Knoxville, Memphis, Nashville and the Tri-Cities (30 Tennessee counties).

Please contact your Medicare Advantage Provider Quality Outreach Consultant if you have questions about this plan. Current C-SNP members have options to enroll in our PPO plan during the Annual Enrollment Period from Oct. 15 to Dec 7, 2021.

Update to the 2022 Provider Assessment Form (PAF) Program

On Jan. 1, 2022, Medicare Advantage will change our existing PAF program, providing two options for PAF submission:

- **Electronic PAF:** A new, brief, hierarchical chronic condition (HCC)-focused PAF is in the Quality Care Rewards (QCR) application in Availity®. You can complete it in the QCR application, export it for completion and upload it to the QCR, or fax it.
- **Non-Standard PAF:** Providers/groups that have an approved non-standard PAF with BlueCross in 2021 may continue to submit these assessments for 2022 either by uploading it into the QCR or by fax.
- **Please note the current PAF form will be retired and not accepted after Dec. 31, 2021.**

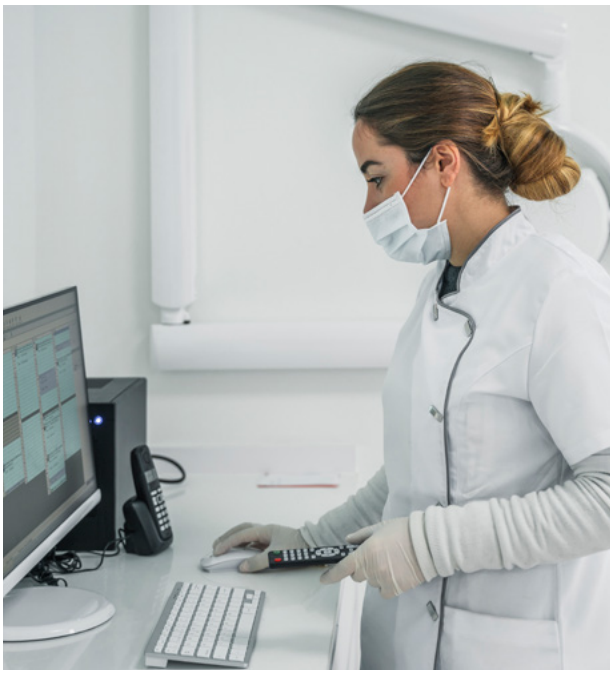
Providers will submit the **appropriate CPT®** code once per calendar year after the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code – as a face-to-face visit is still required for PAF documentation. No modifier is needed.

- **Electronic PAF:** CPT code **96161** (new code beginning in 2022)
- **Approved Non-Standard PAF:** CPT code **96160**

Reimbursement for completion of a PAF will be based on the PAF submission option outlined above.

- **Electronic PAF: $225** Jan. 1 through Dec. 31
- **Non-Standard PAF: $100** Jan. 1 through Dec. 31

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information about these PAF program updates.



High Tech Imaging Authorization Update

Effective Jan. 1, 2022, the authorization date span for High Tech Imaging will be reduced from 90 days to 60 days. Authorization requests will only be approved to reflect a 60-day timeframe.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Special Needs Plan Model of Care Training

Providers participating in BlueCare Plus, BlueCare Plus Choice, and BlueEssential special needs plans are contractually required to complete our Model of Care training after initial contracting and every year afterwards. This training highlights how coordinated care for our members with complex, chronic or catastrophic health care needs can lead to better health outcomes. The training is a requirement from CMS.
You can access the online self-study training and attestation by **clicking here**.

Pharmacy

This information applies to all lines of business unless stated otherwise.

New Pharmacy Benefits Manager Coming in 2022

Beginning Jan. 1, 2022, we're changing our pharmacy benefits manager from Express Scripts to CVS Caremark (CVS).

Although this change should have little-to-no impact on your day-to-day operations, we wanted to highlight some key points:

- We'll continue managing our formularies and notify you of major changes in BlueAlert.
- Our **2022 formularies** are online.
- More than 66,000 pharmacies are included in our national pharmacy network, so member disruption will be minimal. We'll notify members whose pharmacy won't be in-network as of Jan 1, 2022.
- Please send all mail order prescriptions to CVS Caremark. Current mail order refills will be automatically moved to CVS. The only step members will need to take is to update their payment information by calling:

  Commercial mail order **1-844-740-0604**

  Medicare mail order **1-844-740-0602**

- Continue submitting prior authorizations through Availity.
- We'll provide two years of pharmacy claims to CVS for seamless utilization review.
- You can check your patients' pharmacy benefits; see utilization management requirements and point-of-care costs in real-time through the e-prescribing workflow.
- CVS will oversee certain clinical programs. You may get communications from CVS Caremark on behalf of BlueCross members.

Members will receive new ID cards next month. Our Member and Provider Service phone numbers will remain the same. If you have any questions, please contact your Provider Network Manager.

New Prior Authorization and Quantity Limits for Ivermectin (Stromectol) Tablets

Ivermectin (Stromectol) tablets are FDA-approved to treat certain parasitic infections. With an exponential rise in off-label ivermectin prescriptions to prevent and treat COVID-19, the American Medical Association (AMA), American Pharmacists Association (APhA) and American Society of Health-System Pharmacists (ASHP) have released statements against prescribing this off-label drug.

The FDA hasn't granted emergency use authorization for ivermectin to prevent or treat COVID-19, so we're requiring prior authorization for ivermectin (Stromectol) tablets for our Commercial Preferred Formulary as of Nov 1. It also has a quantity limit of 12 tablets every 75 days. If you have questions, please call our Provider Service line at **1-800-924-7141**.

Reminder for Electronic Prior Authorizations (EPA) Submissions

When submitting EPAs for Commercial members with pharmacy coverage, please use CoverMyMeds in Availity or CoverMyMeds.com. Be sure to use the BlueCross BlueShield of Tennessee form. If you use the "Renew PA" button, you'll need to select the appropriate BlueCross form instead of the Express Scripts (ESI) form. We can't process claims submitted on the ESIform, and using it will cause additional delays. Continue submitting EPAs for provider-administered specialty drugs directly to Magellan Rx. If you have questions, please call our Provider Service line at **1-800-924-7141**.

340B Drug Pricing Program Modifier Requirements

Beginning Dec. 1, 2021, providers who have BlueCare, TennCare*Select* and CoverKids patients who participate in the 340B Drug Pricing Program must include the appropriate modifier on all outpatient/office claim lines that include a National Drug Code (NDC) number.

- **JG** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members **OR**
- **TB** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members (reported for informational purposes) **OR**
- **UD** – Drug or biological acquired with the 340B drug pricing program discount **OR**
- **UC** – Drug or biological acquired without the 340B drug pricing program discount

We encourage you to include the appropriate modifier on your claim lines that contain an NDC number as soon as possible. Outpatient/office drug claim lines that contain an NDC number without the appropriate modifier will be denied starting Dec. 1. While there's a list of drugs included in the 340B program, we won't be using this list when evaluating claims. We'll only review claim lines for the presence of an NDC number to determine if a modifier should be included.

Updates to Key Online Resources

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Latest Information and Changes for Coding Updates, Provider Administration Manuals (PAMs) and Medical Policies

You can easily find the latest information and the changes on the way for several key items that are important to providers:

- **Commercial Provider Administration Manuals (60-Day Preview Version)** – Access the Commercial Preview PAM 60 days before the effective date in the **Manuals, Policies & Guidelines** section at **provider.bcbst.com**.
- **Medical Policies, Administrative Services Policies, Utilization Management Guidelines (UMG)** – View upcoming BlueCross policy or guideline changes at **provider.bcbst.com/coverage**. If you have questions, please send an email to: **medical_policy@bcbst.com**.
- **Coding Updates** – Find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page.

If you have questions, please call us at **1-800-924-7141** and follow the prompts to Network Contracting and Credentialing.

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

Medicare Advantage 2022 Quality Program Measures

Beginning Jan. 1, 2022, Medicare Advantage will make changes to these quality measures included in the Quality+ Partnerships program:

- Controlling Blood Pressure (CBP) will move to a three-weight measure
- The Member Experience CAHPS and HOS measures will move to two-weight measures
- Medication Reconciliation Post-Discharge (MRP) will be one of four components included in a new Transitions of Care measure

2022 Program Year Measures (in order of weight)	Source	Weight
Comprehensive Diabetes Care (CDC) - HbA1c Control <9%	HEDIS	3
Controlling High Blood Pressure (CBP)	HEDIS	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS	3
Member Experience – CAHPS	CMS Member Survey	2
Member Experience – HOS	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Comprehensive Diabetes Care (CDC) - Eye Exam	HEDIS	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Transitions of Care (TRC)	HEDIS	1

If you have questions about the 2022 measures, contact your Medicare Advantage Provider Quality Outreach Consultant.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

21PED1411600 (10/21)

DECEMBER 2021

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

COVID-19 Updates

Throughout the COVID-19 pandemic, we've made changes to help our members and providers stay safe. Please continue to visit the Provider FAQs at **BCBSTupdates.com** for up-to-date guidelines on how we have updated our policies to help you care for our members.

INSIDE THIS ISSUE

News About Upcoming Telehealth Updates

During the pandemic, we greatly expanded our telehealth coverage so providers could continue providing quality care to our members. We're deeply invested in supporting telehealth and will broadly cover many telehealth services even after this public health emergency has passed. We're also reviewing codes to make sure we don't cover services that need to take place in a provider's office and will start denying inaccurate telehealth claims beginning Jan. 1, 2022. We've been monitoring claims over time, and a small number (fewer than .01%) appear to have been billed incorrectly so far. We don't believe these changes will affect many providers.

Some examples of telehealth claims mistakenly received that we'll deny:

- Comprehensive physical exams
- Urinalysis
- Eye exams or X-rays
- Vaccinations

Please continue to visit our telehealth section at **bcbstupdates.com** for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

Submit Secondary Claims Through Availity® for Faster Payment

Are you still submitting printed copies of your explanation of benefits (EOBs) for secondary claims? Did you know if you include your primary EOB payment data with your claim electronically, your claim will be processed quicker? Billing secondary claims online will reduce manual pending claims and help processing times.

We've made it easy for you to submit claims electronically through Availity. To do this, you'll need an Availity account with a "Claims" user role and be set up as an electronic provider with us.

Simply follow these steps to get started submitting your claims:

1. Log in to **Availity**.
2. Click the **Claims & Payments** drop-down list.
3. Under **Claims**, select your claim type (Professional, Facility or Dental*).
4. Enter your claim information on the claim form.
5. Once you've completed the form, click **Submit**.

If you need help or would like training, you can use the **Submitting Secondary Claims Electronically** guide or call your **eBusiness Regional Marketing Consultant**. If you have any technical issues, please call the eBusiness Service team at **(423) 535-5717 (option 2)**.

* Dental providers filing services that require submission of X-rays for clinical review or secondary-filed claims should continue submitting claims through their current method at this time.

Self-Service Options Available for Claims Status Inquiry*

To find the status of your claims, please use one of the following self-service options:

Electronic Data Interchange (EDI)

- **Electronic Remittance Advice (ERA) (HIPAA X12 835)** – When claims are final, their status will be available via 835 ERA transactions, which also allow you to post claim results to your billing system.
- **Blue CORE (HIPAA X12 276/277)** – You can work with your vendor to connect with us to get claims status in real time without exiting your system workflow.

Availity

- **Remittance Advice** – The same ERAs that you receive for posting are available in Availity's **Remittance Viewer**. To view the status, log in to Availity and select the **Claims & Payments Remittance Viewer**. If you want to see your legacy remittance, select the BlueCross **Payer Spaces** and click on the **Print/View Remittance Advice** tile.
- **Claims Status** – To check the status of a claim, log in and select the **Claims & Payments** tab, then click **Claims Status**. An easy way to check status is to look for the colors associated with the claim: green is processed, yellow is pending and red means denied.

Automated Claims Status Option

- Call the appropriate Provider Service line (phone numbers are on the last page of this newsletter) and choose the option for **Automated Claims Status**.

After you've found the status of the claim using one of the above methods, our customer service representatives are still available to answer specific questions you may have about a claim payment or denial. Please note, when you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number. If you have questions or need help with Availity or EDI, you can contact eBusiness at **(423) 535-5717, option 2**. If you'd like training on Availity, please contact your **eBusiness Regional Marketing Consultant**.

* This also applies to outsourced vendors acting on a provider's behalf.

BlueCross to Stop Accepting Provider Change Information by Email

Earlier, we posted news that we'd soon require all providers to use CAQH ProView for all updates to provider directory information, including office locations, hours, hospital affiliations and contact numbers. Starting Jan. 1, 2022, we'll return emails for requests to update provider data information and attach instructions on how to complete the process using CAQH ProView.

If you'd like to make updates to your information, please visit our BCBST Payer Space on Availity, and then click the **Provider Enrollment, Updates and Changes** tile. You can also update your information by logging into the **CAQH ProView application** directly. For more information, please call **1-800-924-7141** and follow the prompts to our Network Contracts and Credentialing team.

BlueCross Now Using Change Healthcare for EFT/ERA Enrollment

BlueCross is transitioning to a new source for provider payment information. In the past, we used CAQH's EnrollHub® but CAQH is retiring this tool. As of Dec. 2, 2021, you'll be able to submit Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) changes and enrollments through **Change Healthcare's Payer Enrollment Services** portal, which is accessible through Availity® and **provider.bcbst.com**.

If your information is correct in EnrollHub, you'll continue receiving payments and remittance advice as you always have. If you have questions, please call our Network Contracts and Credentialing service team by following the prompts on our Provider Service Line at **1-800-924-7141**.

Please note, we'll continue using CAQH ProView® for our provider enrollment, credentialing and directory efforts.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Feb. 1, 2022, CPT® code 0208U will no longer require prior authorization through eviCore's Genetic Testing Program. However, the following codes were added and will need prior authorization:

0285U	0290U	0296U	81349
0286U	0291U	0297U	81523
0287U	0292U	0298U	
0288U	0293U	0299U	
0289U	0294U	0300U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity** and clicking **Patient Registration**, then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity. You can also fax eviCore at **1-888-693-3210** or call them at **1-888-693-3211**.

Anesthesiology Services Reminder

We wanted to remind you that we've made some changes to how we calculate time for anesthesiology services. In the past, we rounded up anesthesia time units to the next whole unit. For example, 1.11 units were rounded up to 2 units. Effective July 1, 2021, we started rounding up anesthesia time units to the nearest tenth to better align with industry standards.

For example, we round:

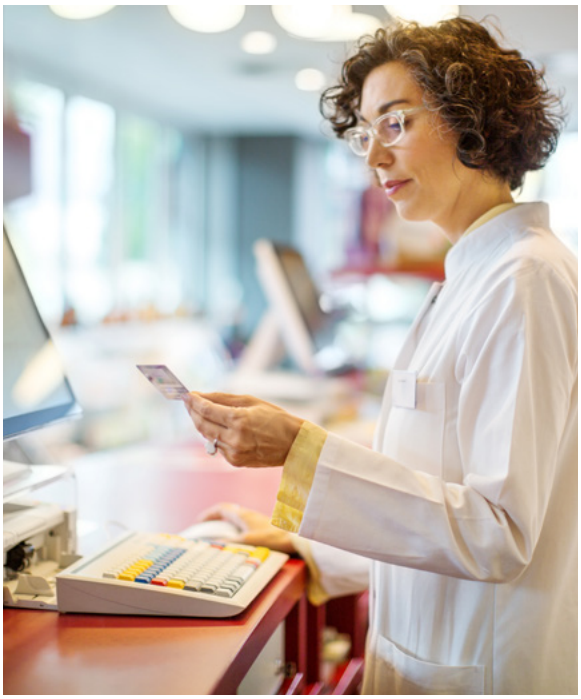
- 1.41 units up to 1.5 units
- 1.91 units up to 2 units
- 1.61 units up to 1.7 units

Please note that anesthesia time doesn't apply to Daily Hospital Management Services. For more details, please refer to your **Provider Administration Manual**. **This change also applies to BlueCare Tennessee.**

Speech Therapy Additional Benefit Information

Please use the Fast Path option in Availity for benefits and eligibility. Many Commercial plans have limitations on what conditions are eligible for speech therapy. Make sure your patient is eligible for speech therapy prior to services being rendered.

If you need help registering for Availity, call **1-800-282-4548**. For navigation help, please contact our eBusiness department at **(423) 535-5717** or call **1-800-924-7141** and follow the prompts to eBusiness Support.



Advanced Specialty Benefit Management (ASBM) Program Pharmacy Expansion

Starting Jan. 1, 2022, we're expanding our ASBM program to all Commercial fully insured plans, both group and Marketplace. This program only affects specialty drugs administered in a provider's office or facility, not self-administered specialty drugs delivered to members' homes. The prior authorization and claim submission processes in place for members in our self-funded ASBM groups will apply to members in fully insured group and Marketplace plans. Providers who chose our TransactRx specialty drug billing option can expect to receive calendar-year 2022 contracts in mid- to late-fall, just like last year.

We began sending letters in November to all members and their providers who have an open authorization for one of the affected drugs to make sure they're aware of and understand this change. If you have questions, please contact your Provider Network Manager.

Changes to Commercial Prior Authorization Requirements

Beginning Feb. 1, 2022, CPT® codes 53430, C1813 and C2622 will require prior authorization. CPT® codes 57295, 57296 and 57426 will no longer require prior authorization. These CPT® codes are for Gender Reassignment and only require prior authorization when being billed with the gender reassignment diagnosis codes.

You can submit authorization requests through the **Authorization Submission/Review application** tile in Availity, by faxing them to Commercial Utilization Management at **1-866-558-0789** or calling our Provider Service Line at **1-800-924-7141**.

Member Telephone Numbers Needed for Online Utilization Management Authorizations

When submitting utilization management authorizations through the Provider Authorization Tool in Availity, please make sure to add the member's telephone number in the **Patient Phone** field. Although this isn't a required field, including a telephone number for the member helps our Case Management team with any needed outreach or member care services. If you have questions, please call the Provider Service Line at **1-800-924-7141**.

Changes to Commercial the Lab-based Sleep Study

Beginning Jan. 1, 2022, CPT® code 95805 will be added and require prior authorization through Commercial's Lab-based Sleep Study Program. Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity** and clicking **Patient Registration** then **Eligibility** and **Benefits Inquiry**. You can submit authorization requests through the **Authorization Submission/Review** application tile in Availity, by faxing them to Commercial Utilization Management at **1-866-558-0789** or calling our Provider Service Line at **1-800-924-7141**.

Consolidated Appropriations Act Requirements Beginning Jan. 1, 2022

Many of the health care requirements outlined in the **Consolidated Appropriations Act (CAA)** go into effect on or after Jan. 1, 2022. The requirements listed below are based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

One of the provisions of the CAA requires that health insurance companies and group health plans (groups) include new information on member ID cards. Beginning Jan. 1, 2022, you may start seeing health insurance ID cards with this additional information. However, only new cards issued or digital cards downloaded/printed on or after Jan. 1, 2022, will include this additional information:

- In-network and out-of-network (OON) deductibles
- Out-of-pocket maximum amounts
- Websites and phone numbers for members to get more information

Below are two sample cards for typical plans – a preferred provider organization (PPO) plan and a high-deductible health plan (HDHP) with in-network and out-of-network benefits. Actual cards may differ based on plan specifics.

Sample PPO Card

Sample HDHP Card

Provider Directory

FAQs issued in August indicated that federal agencies will be issuing regulations to fully implement this provision, but not until after Jan. 1, 2022. In the meantime, we're working toward implementing the requirements as we best understand them. New requirements outline specific processes to:

- Verify and update provider directory information at least every 90 days (name, address, phone number, specialty and digital contact information).
- Update certain provider data within two business days.
- Respond to requests for in-network provider information.
- Establish a procedure to remove providers from our provider directory who don't validate their data.

Beginning Jan. 1, 2022, the CAA also requires providers to submit provider directory information to contracted health plans in a timely manner. New requirements outline when providers should submit their information:

- When the provider enters into or terminates their provider agreement with the health plan
- When there's a material change to their provider directory information
- At any other time, including when requested by the health plan

To meet these requirements, individual providers should continue using CAQH to validate their data. Facilities and ancillaries should continue using Data Verification Forms. Information in CAQH must be reviewed and validated every 90 days and a response must be returned for every Data Verification Form.

If you're removed from the directory for non-compliance, you can attest your information to be added back in the directory.

Surprise Billing Protections

Beginning Jan. 1, 2022, the CAA includes new protections that prohibit OON providers from billing members for more than their cost-share in:

- Emergency services received at an OON hospital emergency department or independent freestanding emergency department
- Non-emergency services received from an OON provider at an in-network facility, except non-ancillary services, when the member receives notice of and agrees to treatment by the OON provider and balance billing
- OON air ambulance if the services would've been covered if provided by an in-network air ambulance provider

Delayed Enforcement of Advance Cost Estimates for Health Care Services – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies overseeing CAA implementation issued **FAQs** addressing several provisions of the law and won't enforce certain provisions until a future date. This includes the advanced explanation of benefits (AEOB).

As a reminder, the AEOB cost estimates will require actions by BlueCross and providers:

- You'll need to send BlueCross a good faith estimate of the costs. This includes billing and diagnostic codes for the scheduled care, as well as anything expected to be offered by other providers or facilities.
- We'll give our members information on the:
  - Provider's network participation and rates
  - Member's remaining deductible and out-of-pocket balances
  - Member's expected financial responsibility (good-faith estimate)

The FAQs indicate that the federal agencies plan to issue regulations to fully implement this provision, including establishing appropriate data transfer standards. For more information about the CAA, please click this **link**.

BlueCare Tennessee

This information applies to BlueCare [SM], TennCareSelect and CoverKids plans unless stated otherwise.

Emergency Room Benefit Update

Effective Jan. 1, 2022, the emergency room copay will decrease from $10 to $8.20 for BlueCare Tennessee members with incomes at/or between 100-199% of the federal poverty level. BlueCare members will only pay this copay if they aren't admitted to the hospital.

Maternity Care Updates Beginning Jan. 1

Beginning Jan. 1, 2022, coding changes will take effect for postpartum care. According to the American College of Obstetricians and Gynecologists (ACOG), every mother should be screened at least once for depression and anxiety during the perinatal period using a standardized validated tool. In response to ACOG's recommendations, TennCare is making changes to its model of postpartum care. The following applies for all deliveries (liveborn and non-liveborn) and all risk categories. The length of the postpartum period will be increased to 84 days.

Maternity Care Management Form (formerly Pregnancy Notification Form)

- Code 0500F should be billed with one of these CPT® codes: 99202-99205, 99211-99215.
- We'll no longer use CPT® code 99201.
- The additional reimbursement for submitting the form will increase from $10 to $25.

Postpartum visit for uncomplicated, routine care

- Code 0503F should be billed with CPT® code 59430.
- We'll allow for reimbursement of two claims and payments during the 84-day postpartum period.
- The additional payment for completing these visits will increase from $10 to $75 per visit.

Mental health screening with validated tool

- Bill CPT® 96160 with a TH modifier to show you completed this service.
- You'll receive an additional reimbursement of $28.35 for performing this screening.
- No specific diagnosis code is required for payment.

Process Reminder: Submitting Provider Appeals for Payment Disputes

When disputing a provider payment, please follow the Provider Dispute Resolution Procedure in the **BlueCare Tennessee Provider Administration Manual**. If you've filed a provider payment (non-specialty pharmacy) dispute reconsideration and aren't satisfied with the response, please send appeal requests to BlueCare Tennessee, **not** the Division of TennCare.

To file a payment dispute appeal, please complete the **Provider Appeal Form** and fax it to (**423) 535-1959** or mail it to:

BlueCare Tennessee/
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste. 0039
Chattanooga, TN 37402

For more detailed information about our appeal and reconsideration process, please see the **BlueCare Tennessee Provider Administration Manual**.

Mileage Reimbursement for BlueCare Tennessee Members

We contract with Southeastrans to handle non-emergency medical transportation to and from covered TennCare services. Depending on a member's location, transportation options may include a shared ride service, bus pass or mileage reimbursement.

Mileage reimbursement is a convenient option for members who have access to a vehicle or a friend/relative willing to drive them to their appointment. Members who choose mileage reimbursement will receive a form that you'll need to sign confirming they visited your office. They'll then send the form to Southeastrans, which will reimburse them for the cost of fuel.

Scheduling transportation

All transportation requests should be made at least 72 hours (three calendar days) before the appointment. Your patients who need to travel less than 90 miles can contact Southeastrans at the appropriate number below to schedule their transportation:

BlueCare. **1-855-735-4660**

TennCareSelect **1-866-473-7565**

If your patient needs to travel more than 90 miles, please ask them to call the **Customer Service line** for their plan:

BlueCare. **1-800-468-9698**

TennCareSelect **1-800-263-5479**

Our Utilization Management department will review the request and may help the member find a closer provider, if applicable, to reduce travel time and distance.

For more information about these transportation benefits, please visit **bluecare.bcbst.com** and select **Get a Ride**.

Note: These transportation benefits don't apply to CoverKids members.

Be on the Lookout for Southeastrans Information Requests

When BlueCare and TennCareSelect members use Southeastrans, the carrier conducts regular pre- and post-trip audits to make sure the transportation is only for covered services and the visits go as scheduled. As part of these audits, Southeastrans may call your office to verify your patients' appointments. This is a normal part of Southeastrans' process, and you may release the requested information.

Note: The information in this article doesn't apply to CoverKids.

Resources to Support Pediatric Care

We want to support you as you continue to welcome families back to your office and encourage well-child care. You can find a variety of resources about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams on the Provider pages of **bluecare.bcbst.com**:

1. **BlueCare Tennessee Provider Administration Manual (PAM)** – Our PAM is updated quarterly and provides comprehensive information about your BlueCare Tennessee patients' benefits.
2. **TennCare Kids Tool Kit** – Our TennCare Kids Tool Kit contains information about the TennCare Kids program and links to resources, such as our EPSDT Provider Booklet and reference materials for patient outreach.

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) also offers guidance about delivering well-child care, including EPSDT visits and coding. For more information, visit **tnaap.org**.

Be on the Lookout for More Opportunities to Connect in 2022

Next year, we'll be hosting focus groups for providers in certain areas of the state. The goal of these sessions will be to get feedback on barriers that may be preventing kids from getting needed care and share information on how we can work together to improve EPSDT screening rates.

We'll be meeting with providers in **Giles, Lawrence, Perry, Lewis and Wayne counties** on **Jan. 7 from 9:30 to 11 a.m. CT (10:30 a.m. to 12 p.m. EST)** and with providers from **Obian, Gibson, Lake, Crockett and Dyer counties** on **Jan. 18 from 12 to 1:30 p.m. CT (1 to 2:30 p.m. EST)**. Providers in these areas will receive more information about the focus groups soon. If you're a provider in one of these counties and would like to learn more or register to attend, please email **CommunityEngagement@bcbst.com**.

Note: The information in this article doesn't apply to CoverKids.

Ownership Disclosure Reporting for BlueCare Tennessee Providers

All contracted and non-contracted providers, groups and facilities who participate in the BlueCare and TennCareSelect networks and/or receive TennCare funds must comply with federal ownership disclosure requirements. These requirements also apply to referring, ordering and prescribing providers who serve TennCare members, even if they don't participate in our networks.

According to the guidelines, providers must submit routine disclosures during initial contracting and at least every three years afterward. You may need to submit a disclosure sooner than three years if:

- You renew your contract
- Information on the disclosure form changes
- There's a change of ownership

In cases of change of ownership, the revised disclosure must be submitted within 35 business days.

To satisfy these requirements, we encourage you to update your TennCare provider profile any time there are changes to your practice's office manager or others with an ownership stake in your practice. This includes updating your information if someone associated with your practice is convicted of a crime. To change the information in your provider profile, visit **tn.gov/tenncare/providers/provider-registration.html**

Review Your Updated Episodes of Care Reports in Availity

We want to make sure you have the information you need to succeed in the Episodes of Care program, so we recently made a significant enhancement to your quarterly reports.

All Excel reports have been combined into one workbook, which contains both included and excluded episodes. We hope this improvement makes it easier for you to access, review and download your reports. If you have questions about using Availity, please call **(423) 535-5717** and press option 2 or email **eBusiness_Service@bcbst.com**.

Free Shared Decision-Making Tools in Availity

Shared decision-making (SDM) is a model of two-way communication that involves providers and patients discussing health care options with evidence-based information, the provider's knowledge, and the patient's preferences. Please take a moment to access your free SDM tools, or printable handouts, in Availity. These guides may be helpful for OB/GYN providers when discussing a higher risk of complications during childbirth or orthopedic providers when discussing joint pain.

SDM aids on the Availity portal include:

- Pregnancy: Your Birth Options After Cesarean
- Pregnancy: Birth Options if Your Baby is Getting Too Big
- Hip Osteoarthritis: Is it Time to Think About Surgery?
- Knee Osteoarthritis: Is it Time to Think About Surgery?

To use these resources, simply log in to Availity and go to the **BlueCross Payer Space**. From there, choose the **Resources** tab and click the link to show all resources. Select the SDM tool you want to view, and it will open in a new browser tab for you to review with your patient and/or print. If you have questions about using the Availity portal, please call your **eBusiness Regional Marketing Consultant**.

Important Announcement from TennCare: Providers CARE Survey

Good health outcomes start in the communities where your patients live, so we invite you to take the Providers CARE Survey. The CARE survey will ask you about the needs of your patients, your experiences, and learning opportunities that can assist your practice team.

Our goal is to help you improve your patients' health by:

C = Connecting them with community resources (like food pantries and housing help)

A = Acting for better health by teaching them about their care needs

R = Reducing differences

E = Encouraging them. Take the time to listen to your patients. Treating them with kindness and support can help them take the steps they need for better health.

To fill out the survey, please visit **tn.gov/tenncare/providers/social-and-health-needs.html**. Your answers won't have your name on them and will be combined with information from other providers.

Benefit Changes for Formula and Incontinence Supplies

Formula and incontinence supplies are now covered retroactively (as of Jan. 1, 2021) for CoverKids members. Authorization requirements and limits apply, which you can learn more about on the next page.

Formula Coverage

Food supplements and substitutes including formulas are now covered. This includes parenteral nutrition formulas, enteral nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat phenylketonuria for members age 21 and older. Oral liquid nutrition may also be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight and physically incapable of consuming a sufficient food intake.

All enteral and oral formula requires authorization except for total parenteral nutrition.

Incontinence Supplies Coverage

Incontinence supplies are covered exclusively through Medline and have a limit of 200 per month. Requests for brand name products and supplies over 200 per month require authorization. Incontinence supplies (diapers/liners/under pads) not needed for a medical condition aren't covered for children age three and younger. For more information on incontinence supplies, contact Medline:

Phone: **1-877-853-7558**

Fax: **1-866-557-2737**

Email: **BlueCareTennessee@medline.com**

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ plans.

BlueEssential (HMO C-SNP)℠ Closure Update

BlueEssential (HMO C-SNP)℠ won't be offered in 2022. It was launched as a chronic special needs plan for individuals with diabetes in 2020 and expanded to those with cardiovascular disease in 2021. The plan included a limited network with key hospitals, primary care providers, and specialist groups in Chattanooga, Jackson, Knoxville, Memphis, Nashville and the Tri-Cities (30 Tennessee counties).

Please contact your Medicare Advantage Provider Quality Outreach Consultant if you have questions about this plan. Current C-SNP members have options to enroll in our PPO plan during the Annual Enrollment Period until Dec. 7, 2021.

Update to the 2022 Provider Assessment Form (PAF) Program

On Jan. 1, 2022, Medicare Advantage will change our existing PAF program, providing two options for PAF submission:

- **Electronic PAF:** A new, brief, hierarchical chronic condition (HCC)-focused PAF is in the Quality Care Rewards (QCR) application in Availity. You can complete it in the QCR application, export it for completion, and then upload it to the QCR or fax it.
- **Non-Standard PAF:** Providers/groups that have an approved non-standard PAF with BlueCross in 2021 may continue to submit these assessments for 2022 either by uploading it into the QCR or by fax.
- Please note the current PAF form will be retired and not accepted after Dec. 31, 2021.
- A copy of the PAF form used should also be part of the patient's permanent medical record.

Providers will submit the **appropriate CPT® code** once per calendar year after the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code. A face-to-face visit is still required for PAF documentation. Also, during the National Public Health Emergency, a telehealth visit will also suffice for PAF documentation. No modifier is needed.

- **Electronic PAF:** CPT® code **96161** (new code beginning in 2022)
- **Approved Non-Standard PAF:** CPT® code **96160**

Reimbursement for completion of a PAF will be based on the PAF submission option outlined above.

- **Electronic PAF: $225** Jan. 1 through Dec. 31
- **Non-Standard PAF: $100** Jan. 1 through Dec. 31

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information about these PAF program updates.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Special Needs Plan Model of Care Training

Providers participating in BlueCare Plus, BlueCare Plus Choice and BlueEssential special needs plans are contractually required to complete our Model of Care training after initial contracting and every year afterwards. This training highlights how coordinated care for our members with complex, chronic or catastrophic health care needs can lead to better health outcomes. The training is a requirement from the Centers for Medicare & Medicaid Services (CMS). You can access the online self-study training and attestation by **clicking here**.

Patients with Diabetes Need Statin Medication Fill

American College of Cardiology and American Heart Association guidelines state patients with diabetes **should receive a statin medication** to help reduce the incidence of heart disease and stroke.

One of the Centers for Medicare & Medicaid Services (CMS) star measures – Statin Use in Persons with Diabetes (SUPD) – looks at Medicare Advantage Prescription Drug plan members who:

- Are between the ages of 40 and 75;
- Have filled at least two prescriptions for a medication to treat diabetes during the plan year; and
- Have received a prescription for a statin medication

This measure doesn't include a minimum dosage requirement. Members who have end-stage renal disease or are receiving hospice services are excluded from this measure.

Additionally, new **exclusions** were added by CMS to the measure specifications for 2021:

- Rhabdomyolysis
- Drug-induced myopathy
- Myopathy, unspecified
- Hepatic failure, unspecified, without coma
- Adverse effect of antihyperlipidemic and anti-arteriosclerotic drugs, initial encounter
- Myositis, unspecified
- Pre-diabetes
- Polycystic ovary syndrome (PCOS)

For a Medicare Advantage Prescription Drug (MAPD) plan member to be excluded from the measure, the treating physician must include the ICD-10 diagnosis code for the applicable exclusion condition on the claim submitted to the plan. **Documentation of a statin intolerance or contraindication in the chart alone won't exclude the member from this quality measure.**

Clinical decisions regarding whether a statin medication is appropriate are between the treating physician and their patient. Please note that when making prescribing decisions with patients who are MAPD plan members, all generic statins are included in the BlueCross Medicare Part D drug list when filled at preferred pharmacies. Copays range from $0-$1 for a 90-day supply depending on the member's specific plan type.

Pharmacy

This information applies to all lines of business unless stated otherwise.

New Pharmacy Benefits Manager Coming in 2022

Beginning Jan. 1, 2022, we're changing our pharmacy benefits manager from Express Scripts to CVS Caremark (CVS).

Although this change should have little-to-no impact on your day-to-day operations, we wanted to highlight some key points:

- We'll continue managing our **formularies** and notify you of major changes in BlueAlert.
- Our **2022 formularies** are online.
- More than 66,000 pharmacies are included in our national pharmacy network, so member disruption will be minimal. We'll notify members whose pharmacy won't be in-network as of Jan 1, 2022.
- Please send all mail order prescriptions to CVS Caremark. Current mail order refills will be automatically moved to CVS. The only step members will need to take is to update their payment information by calling:
  - Commercial mail order: **1-844-740-0604**
  - Medicare mail order: **1-844-740-0602**
- Continue submitting prior authorizations through Availity.
- We'll provide two years of pharmacy claims to CVS for seamless utilization review.
- You can check your patients' pharmacy benefits, see utilization management requirements and point-of-care costs in real-time through the e-prescribing workflow.
- CVS will oversee certain clinical programs. You may get communications from CVS Caremark on behalf of BlueCross members.

Members will receive new ID cards next month. We understand you may have some questions about joining the CVS retail network. If so, please **click here**. For questions about our preferred specialty pharmacy network, reach out to your Provider Network Manager.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Correction for New Prior Authorization Requirements on ADHD Medications

New prior authorization requirements on attention-deficit/hyperactivity disorder (ADHD) medications beginning Jan. 1, 2022, apply **only to members 19 years and older**. We erroneously sent disruption letters to all members prescribed ADHD drugs, including those under 19. We've sent correction letters to all impacted members. Moving forward, ADHD medications for those younger than 19 won't require prior authorization.

Updates to Key Online Resources

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Latest Information and Changes for Coding Updates, Provider Administration Manuals (PAMs) and Medical Policies

You can easily find the latest information and the changes on the way for several key items that are important to providers:

- **Commercial Provider Administration Manuals (60-Day Preview Version):** Access the Commercial Preview PAM 60 days before the effective date in the **Manuals, Policies & Guidelines** section at **provider.bcbst.com**.
- **Medical Policies, Administrative Services Policies, Utilization Management Guidelines (UMG):** View upcoming BlueCross policy or guideline changes at **provider.bcbst.com/coverage**. If you have questions, please send an email to **medical_policy@bcbst.com**.
- **Coding Updates:** Find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page.

If you have questions, please call us at **1-800-924-7141** and follow the prompts to Network Contracting and Credentialing.

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

BlueCross Medicare Advantage 2022 Quality Program Measures

To align with changes from the CMS Quality Rating Program for MA plans beginning Jan. 1, 2022, Medicare Advantage will make updates to the quality measures included in the Quality+ Partnerships program:

- Controlling Blood Pressure (CBP) will move to a three-weight measure
- The Member Experience CAHPS and HOS measures will move to two-weight measures
- Medication Reconciliation Post-Discharge (MRP) will be one of four components included in a new Transitions of Care measure

2022 Program Year Measures (in order of weight)	Source	Weight
Comprehensive Diabetes Care (CDC) - HbA1c Control <9%	HEDIS	3
Controlling High Blood Pressure (CBP)	HEDIS	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS	3
Member Experience — CAHPS	CMS Member Survey	2
Member Experience — HOS	CMS Member CAA	2
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Comprehensive Diabetes Care (CDC) - Eye Exam	HEDIS	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Transitions of Care (TRC)	HEDIS	1

If you have questions about the included 2022 measures, contact your Medicare Advantage Provider Quality Outreach Consultant.

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This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

21PED1445295 (11/21)