of Tennessee

JANUARY 2022

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.

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 in early January 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.

BlueCross Now Using Change Healthcare for EFT/ERA Enrollment

Effective Dec. 2, 2021, BlueCross transitioned to Change Healthcare for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) management. If you haven't already, please submit EFT and 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 CAQH's EnrollHub today, you'll continue to receive payments and remittance advice as you always have, and no action is required on your part. 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® for our provider enrollment, credentialing and directory efforts.

Telehealth Credentialing Updates

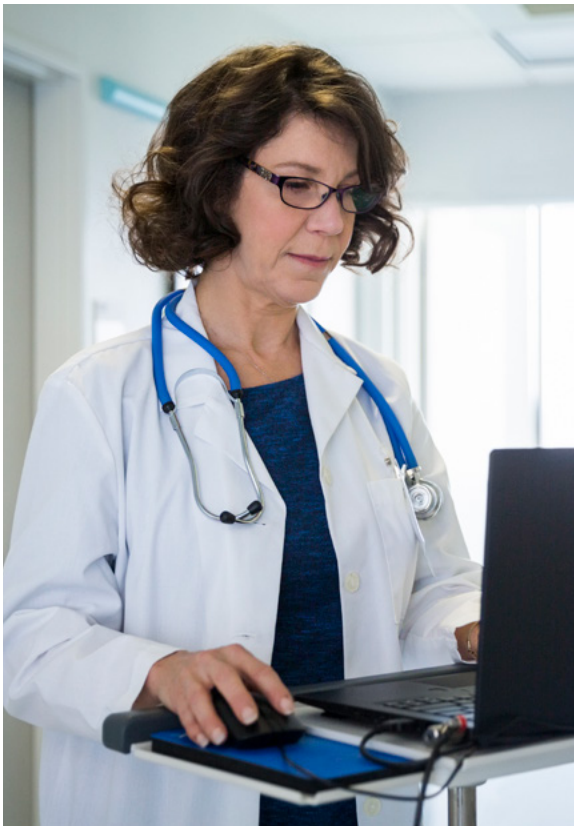
Effective Oct. 2021, we began credentialing our network providers who only offer telehealth services. These providers must meet the same requirements as our other credentialed providers practicing medicine in Tennessee. Telehealth-only providers must have a Tennessee address, a Drug Enforcement Administration (DEA) number and all DEA schedules.

Starting the first quarter of 2022, we'll start contacting our telehealth-only providers to help them start the credentialing process. Once that's complete, they'll be able to remain in our BlueCross networks. Please note that only credentialed providers will remain in network. If you have questions, please contact your Provider or Behavioral Health Network Manager.

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 through our Payer Spaces on **Availity**. There, you can 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 in to the secure Quality Care Rewards application to download. You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.
- **Financial Updates** – Transactional notices about billing, EFT and tax-related items



Here's How You Can Update Your Contact Preferences:

1. Log in to the BlueCross Payer Spaces in **Availity**.
2. Select the **Contact Preferences & Communication Viewer** tile
3. Choose your **Contact Type** and then your **Organization** (based on Tax ID or TIN).
4. Verify your **Provider Name** and **National Provider Identifier (NPI)** and click **Submit**.

   TIP: If you don't see your name in 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.
5. 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)**.

Upcoming Changes in Availity

We've updated **Eligibility and Benefits** Inquiry in **Availity** to show more information for the following benefits:

Pharmacy

- Under Pharmacy Deductible, a message has been added for when the pharmacy deductible doesn't apply to provider-administered specialty drugs.
- Messaging has been added for when a copay does or doesn't apply after the deductible.
- Authorization requirements have been extended to include procedure-level information when requesting pharmacy benefits directly.
- Third-party vendor information has been added for some pharmacy plans.

Dental Care

- Dental categorization added for Periodontics, Endodontics, Restorative – Basic and Major, Plan Waiting Period, Orthodontics and Oral Surgery.
- Corrected dental waiting period to reflect days instead of dollar amounts.

If you have benefits questions, be sure to use the **Contact Payer** button to reach us via the Fast Path line after you've viewed benefits on Availity. 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)**.

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. They 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**.

Commercial

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

New Requirements for Consolidated Appropriations Act, 2021; Requirements Starting Jan. 1, 2022

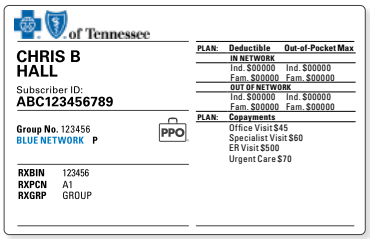
As of Jan. 1, 2022, you'll start seeing many of the changes required by the 2021 **Consolidated Appropriations Act (CAA), 2021**. The requirements listed below are a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

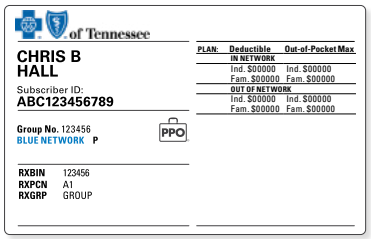
New health insurance ID cards that have been issued or downloaded on or after Jan. 1, 2022 will include this additional information:

- 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 example cards for common plan types – 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

Starting Jan. 1, 2022, providers will need to do the following to make sure their provider directory information is current:

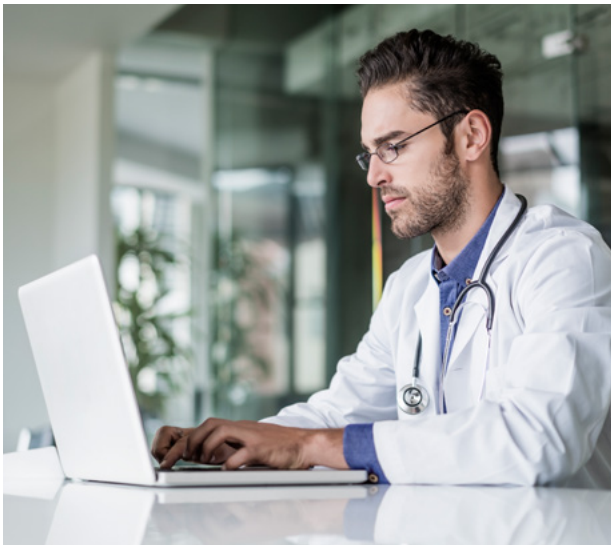
- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to BlueCross in a timely manner. New requirements outline when providers should submit their information:
  - When the provider enters into or terminates their provider agreement with the health plan
  - When there's a material change to their provider directory information
  - At any other time, including when requested by BlueCross
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network specific information on **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network specific information on **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your directory information, you can submit an attestation about your information to be added back in the directory.

Surprise Billing Protections

As of Jan. 1, 2022, the CAA includes new protections that prohibit OON providers from billing members for more than their cost-share for:

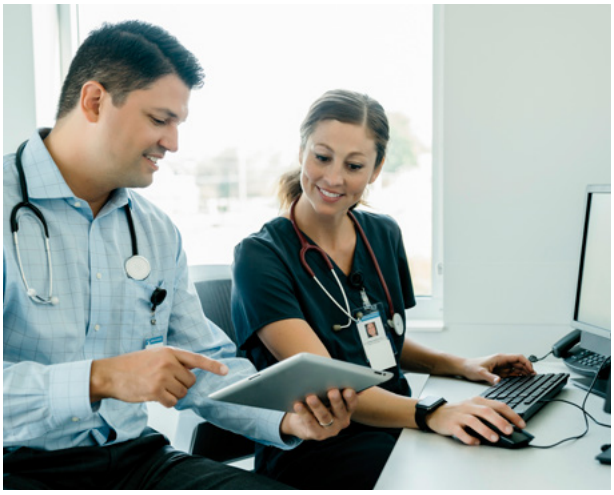
- Emergency services received at an OON hospital emergency room (ER) or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility except, with regard to non-ancillary providers, when the member receives notice of, and provides consent to, treatment by the 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)

For more information about the CAA, please click this **link**.

Commercial Ancillary Service Prior Authorization Requests

Please note, not all ancillary services, including Home Health Services, Outpatient Therapies, Hospice or Durable Medical Equipment (DME), need prior authorization. Please verify member benefits and eligibility by logging in to Availity, clicking Patient Registration and then Eligibility and Benefits Inquiry. If you have questions or need additional training, please contact your **eBusiness Regional Marketing Consultant**.

New Transparency Requirements – Transparency in Coverage Rule

On Nov. 12, 2020, the Departments of Health and Human Services (HHS), Labor and Treasury published the **Transparency in Coverage rule**. The rule imposes new price transparency requirements on most group health plans and health insurers in our individual and group plans. The **Transparency in Coverage rule** changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make available to the public three machine-readable files detailing:

- In-network rates
- Out-of-network allowed amounts
- Prescription drug rates and historical net prices

The law requires us to also publish the Tax ID Number (TIN) for our providers, which would be a Social Security Number (SSN) for providers who use their SSN as a TIN. If you're currently using an SSN, we recommend you apply for a TIN using this **link**.

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.

Advanced Specialty Benefit Management (ASBM) Program Pharmacy Expansion

As of Jan. 1, 2022, we've expanded 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 apply to members in fully insured group and Marketplace plans. Providers who chose our TransactRx specialty drug billing option should've received calendar year 2022 contracts in mid- to late-fall.

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. 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
- 1.61 units up to 1.7 units
- 1.91 units up to 2 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.**

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	0288U	0291U	0294U	0298U	81349
0286U	0289U	0292U	0296U	0299U	81523
0287U	0290U	0293U	0297U	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**.

Changes to Commercial Prior Authorization Requirements

Beginning Feb. 1, 2022, CPT® codes 53430, C1813 and C2622 will require prior authorization. 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**.

BlueCare Tennessee

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

Chiropractic Services Coverage Expansion Update

In the **November 2021 BlueAlert**, we announced that BlueCare Tennessee plans would cover chiropractic services for all members, regardless of age, beginning Jan. 1, 2022. Since that announcement, **the number of visits we can approve as notification has changed from 12 to 10**. Please continue reading for additional information about our members' benefits.

Important Coverage Details

Chiropractic services will require prior authorization, and you can use Availity to submit prior authorization requests. If you haven't signed up yet, please visit Availity.com to register.

When providing and billing for chiropractic services, please keep these guidelines in mind:

- You can submit the first **10** 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 **10** chiropractic visits, including therapy continuation beyond the initial **10** 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, 98942). Additional services won't be covered.

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.

2022 Episodes of Care Program Changes

The Division of TennCare released its **Memorandum of 2022 Episode Changes** for the Tennessee Health Care Innovation Initiative Episodes of Care (THCII) program in November 2021. The memo 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**, if you haven't already.

We look forward to working with you this year to make the 2022 performance year a success.

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**.

Document All Seven Components of EPSDT Exams

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have seven 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

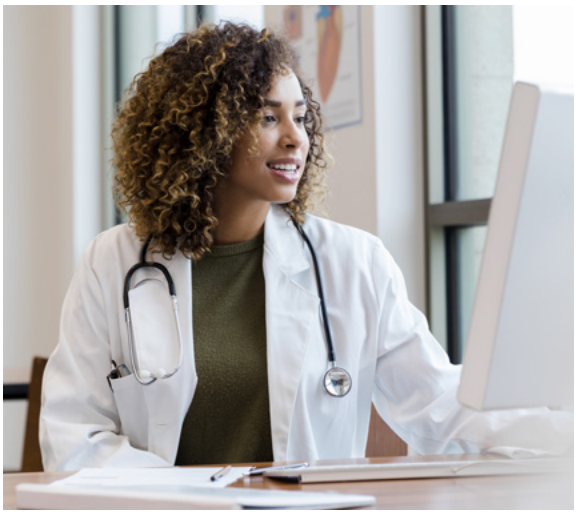
When your BlueCare patients visit your office for their well-child checkup, please document all seven required parts of the exam, as well as assessments of their nutrition and physical activity. Claims submitted for EPSDT visits must match your patients' medical records and contain codes for all parts. This includes the physical exam, vaccines, lab tests, as well as 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.

Telehealth Will Continue to Be Available

To help connect our members to care, we continue to offer telehealth services for a variety of visits, including well-care visits. If appropriate, consider performing certain components of well-child checkups through telehealth and following up with an in-person exam to administer immunizations and other services.

For more information about telehealth and related documentation requirements, please visit **BCBSTupdates.com**. To learn more about the required parts of an EPSDT exam and best practices for completing well-child checkups, please see our **EPSDT Provider Booklet**.



Save the Date: 2022 EPSDT and Pediatric Coding Workshops

The Tennessee Chapter of the American Academy of Pediatrics is hosting two virtual training provider workshops this month. These webinars are free for pediatricians, family physicians and their office staff.

To register, please click the link for the session you'd like to attend below:

- **Session 1 – Wednesday, Jan. 12, from 11:30 a.m. to 1:30 p.m. CT (12:30 p.m. to 2:30 p.m. ET)**
- **Session 2 – Tuesday, Jan. 18, from 6 p.m. to 8 p.m. CT (7 p.m. to 9 p.m. ET)**

Process Reminder: Proof of Delivery Requirements for Durable Medical Equipment Suppliers

Suppliers that provide durable medical equipment (DME) to our members must keep proof of delivery documentation in their files for seven years starting from the date of service. Proof of delivery fulfills contractual obligations (please see 42 CFR Section 424.57(c)(12) for more information). Federal regulations also allow Medicare Administrative Contractors to request information necessary for determining the payment amount due, including proof of delivery verifying the person received their items.

Documentation Requirements

Suppliers can distribute DME prosthetics, orthotics and supplies three ways:

- Delivering the items directly to the beneficiary or their designee
- Using a delivery or shipping service to transport the items
- Sending the items to a nursing facility on behalf of the beneficiary

Once people receive their supplies, they or their designees must sign to accept them. If the signature isn't legible, the supplier or shipping service should print the name of the designee on the delivery slip.

Documentation must also include a date of service – the same date included on the claim. The following dates qualify as the date of service, depending on the delivery method:

- The date the person received the item from the supplier
- The date the shipping label was created (if a shipping service is used)
- The date the package was retrieved for delivery (if a shipping service is used)

For more information about these requirements, please visit **cms.gov**.

Medicare Advantage

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

2022 Provider Assessment Form (PAF) Program Update Reminder

As of Jan. 1, 2022, Medicare Advantage has implemented changes to the PAF program. For 2022, there are 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 had 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.
- Note that the previous standard PAF form has been retired and won't be accepted for 2022 dates of service.

After you've submitted the PAF, you'll need to also submit the **appropriate CPT®** code annually as well as the appropriate Evaluation and Management (E/M) code because face-to-face visits are still required for PAF documentation. No modifier is needed.

- **Electronic PAF** – CPT® code **96161** (new code as of Jan. 1, 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, 2022 through Dec. 31. 2022
- **Non-Standard PAF** – **$100** Jan. 1, 2022 through Dec. 31, 2022

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.

In-Home Screenings 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 your BlueAdvantage and BlueCare Plus/BlueCare Plus Choice patients:

- 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 BlueAdvantage or BlueCare Plus/BlueCare Plus Choice patients, please contact your local Provider Network Manager.

Encourage Patients to Stay Active During Winter

The winter season can be a challenging time for older adults to stay active because of colder temperatures, slippery conditions, and fewer daylight hours. As you know, one of the best ways for seniors to improve mental and physical health is to stay physically active and continue to work toward fitness goals.

Here are some helpful tips to encourage your patients to stay active during the winter season:

- Take nature walks in a safe neighborhood or park.
- Workout online with free or low-cost aerobic, dance and strengthening activities.
- Do chores that require movement throughout the house, including carefully going up and down the stairs. Play some music to keep motivated.
- Volunteer in the community in active ways while maintaining social distancing.
- If outside,
  - Monitor the weather and plan ahead.
  - Wear layers to guard against overheating and becoming cold again.

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.

Prior Authorization Requirements for Xolair

In August, our Pharmacy & Therapeutics Committee approved Xolair to be self-administered. This means we've added it to our formularies with prior authorization requirements by line of business. For prior authorization criteria, please click on the links below:

- **Medicare Advantage**
- **Commercial**

Xolair is still permitted in provider-administered settings but requires a separate 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 changes on the way for several key items:

- **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

As of Jan. 1, 2022, Medicare Advantage has made changes to the quality measures in the Quality+ Partnerships program to align with changes made by CMS for the Star Quality Rating Program for Medicare Advantage Plans:

- Controlling Blood Pressure (CBP) is a three-weight measure.
- The Member Experience CAHPS and HOS measures are two-weight measures.
- Medication Reconciliation Post-Discharge (MRP) has updated to the new full Transitions of Care measure, which includes four components.

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.

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

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Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
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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)	
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eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
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Update your provider profile on the **CAQH Proview®** website

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

21PED1478800 (12/21)

of Tennessee

FEBRUARY 2022

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.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

Prior Authorization Requirements for Neuropsychological and Psychological Testing

Exciting news! We've enhanced our Availity® Authorization Form to allow more units to automatically approve when you request authorization for neuropsychological and psychological testing. You can use Availity to verify the authorization status and make additional unit updates to existing authorizations. If you'd like training on Availity, please contact your **eBusiness Marketing Consultant**.

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 soon. 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.

BlueCross Now Using Change Healthcare for EFT/ERA Enrollment

Effective Dec. 2, 2021, BlueCross transitioned to Change Healthcare for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) management. If you haven't already, please submit EFT and 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 CAQH's EnrollHub today, you'll continue to receive payments and remittance advice as you always have, and no action is required on your part. 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® for our provider enrollment, credentialing and directory efforts.

Telehealth Credentialing Updates

Effective October 2021, we began credentialing our network providers who only offer telehealth services. These providers must meet the same requirements as our other credentialed providers practicing medicine in Tennessee. Telehealth-only providers must have a Tennessee address, a Drug Enforcement Administration (DEA) number and all DEA schedules.

Now in the first quarter of 2022, we'll start contacting our telehealth-only providers to help them start the credentialing process. Once that's complete, they'll be able to remain in our BlueCross networks. Please note that only credentialed providers will remain in network. If you have questions, please contact your Provider or Behavioral Health Network Manager.

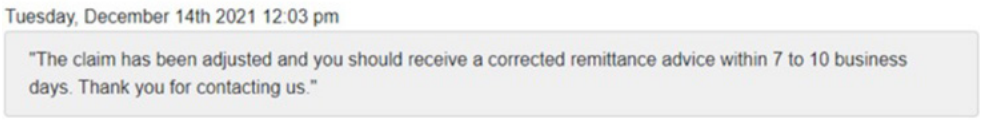
Availity Messaging Coming Soon

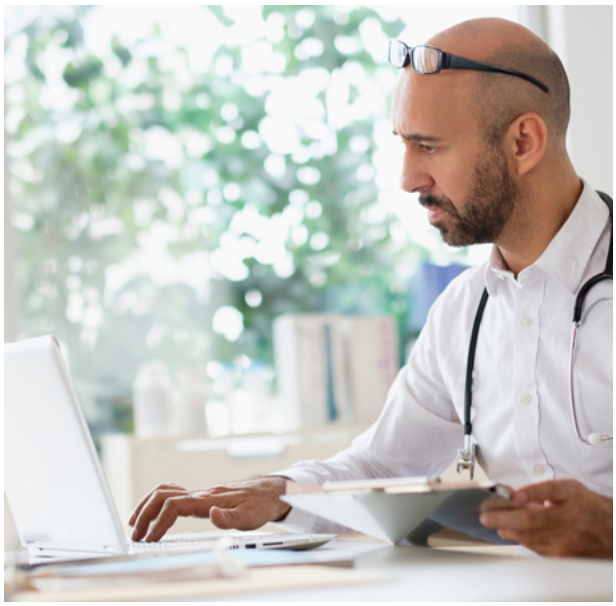
We'll be launching a new major feature in March 2022. Availity Messaging will enable easy-to-use digital correspondence with our customer service teams. To access Messaging, you must have the Claim Status and Messaging roles in Availity. To use Messaging, follow these steps:

1. To send us a message, find the claim you're inquiring about in Availity Claim Status and use the **Send a message to the payer** link on the right side of the screen

2. After we respond, click on the new notification to take you to your secure inbox

3. In your inbox, you'll see your original message and our service team's response





If you currently email us through "Send A Message" on BlueCross Payer Spaces, Availity Messaging will be your new way to ask us questions. All requests will be routed to the appropriate area for handling based on the line of business, so you don't need to worry about calling the right phone number, sending copies of remits or mailing letters to work with us. **Please note, we'll retire "Send A Message" near the end of March 2022. Check Availity News and Announcements for specific information and dates as we transition to Availity Messaging.**

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

Commercial

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

New Requirements for Consolidated Appropriations Act, 2021; Requirements Starting Jan. 1, 2022

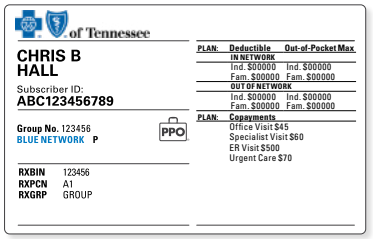
As of Jan. 1, 2022, you'll start seeing many of the changes required by the 2021 **Consolidated Appropriations Act (CAA), 2021**.
The requirements listed below are a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

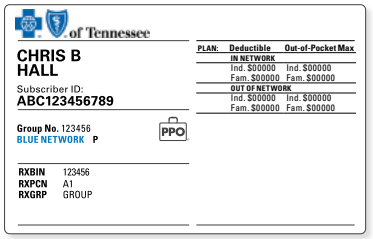
New health insurance ID cards that have been issued or downloaded on or after Jan. 1, 2022 will include this additional information:

- 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 example cards for common plan types – 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

Starting Jan. 1, 2022, providers will need to do the following to make sure their provider directory information is current:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to BlueCross 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 BlueCross
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network specific information on **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network specific information on **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your directory information, you can submit an attestation about your information to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON hospital emergency room (ER) or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility except, with regard to non-ancillary providers, when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

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

Beginning **April 1, 2022**, CPT® codes 0656T, 0657T, 0707T, 64628 and 64629 will be added to the MSK program prior authorization list and will require prior authorization for those members with the MSK program benefit.

CPT® codes 63194, 63195, 63196, 63198 and 63199 will be removed from the MSK program prior authorization list effective **April 1, 2022**, for those members with the MSK program benefit.

Advanced Specialty Benefit Management (ASBM) Program Pharmacy Expansion

As of Jan. 1, 2022, we've expanded 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 apply to members in fully insured group and Marketplace plans. Providers who chose our TransactRx specialty drug billing option should've received calendar year 2022 contracts in mid- to late-fall.

We began sending letters in November 2021 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. 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
- 1.61 units up to 1.7 units
- 1.91 units up to 2 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.**

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

Beginning May 1, 2022, the following CPT® codes will be added and require prior authorization through eviCore's Hi-Tech Imaging Program:

0697T	0698T	0710T
0711T	0712T	0713T

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**, or you may fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

New Transparency Requirements – Transparency in Coverage Rule

On Nov. 12, 2020, the Departments of Health and Human Services (HHS), Labor and Treasury published the **Transparency in Coverage rule**. The rule imposes new price transparency requirements on most group health plans and health insurers in our individual and group plans. The Transparency in Coverage rule changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make three machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts
- Prescription drug rates and historical net prices

The law requires us to also publish the Tax ID Number (TIN) for our providers, which would be a Social Security Number (SSN) for providers who use their SSN as a TIN. If you're currently using an SSN, we recommend you apply for a TIN using this **link**.

BlueCare Tennessee

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

Routine Screenings Reduce the Risk of Cervical Cancer

Despite the benefits of cervical cancer screening, not all women get screened. The human papillomavirus (HPV) test and the Papanicolaou (Pap) tests can be used for cervical cancer screening. Most cervical cancers are found in women who've never had a Pap test or who haven't had one recently.

The American Cancer Society recommends these screening guidelines to help with early detection:

- Cervical cancer testing (screening) should begin at age 25
- Those ages 25 to 65 should have a primary HPV test* every five years. If primary HPV testing isn't available, screening may be done with either a co-test that combines an HPV test with a Pap test every five years or a Pap test alone every three years

*A primary HPV test is an HPV test that's done by itself for screening. The U.S. Food and Drug Administration has approved certain tests to be primary HPV tests.

The Centers for Disease Control and Prevention (CDC) Lowers Lead Poisoning Standard for Young Children

In May 2021, the CDC updated its **blood lead reference guidelines** after recommendation by the federal Exposure Prevention and Advisory Committee. The definition of lead poisoning changed from 5 micrograms per deciliter of blood in children to 3.5 micrograms per deciliter. This means BlueCare Tennessee will now be following pediatric members until their level is below 3.5 micrograms per deciliter of blood. If you have questions, please visit the **CDC's website**.

TN Hope Line is Available for Older Adults

The TN Hope Line is a phone line just for older adults who are feeling lonely. Those who call can talk with a trained volunteer who can listen to them and encourage them. If a person needs help with food or other basic needs, the volunteer can connect them with someone who can help.

Older adults can call the TN Hope Line Monday through Friday from 9 a.m. to 3 p.m. CT by dialing **1-844-600-8262**. If feelings and emotions are getting in the way of someone's daily life, please consider referring them to this service.

Note: This doesn't apply to CoverKids.

Combining Well-Child and Sick Visits

Many kids, especially teenagers, go several years between checkups. An office visit for an illness, shots, prescription refill or other reason may be the only chance you have to conduct a well-care check. That's why 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 other visits.

As a reminder, stand-alone sports physicals and their corresponding codes aren't covered services. However, by converting that appointment into a complete well-care visit, you can meet all requirements of the sports physical and receive reimbursement for a covered service.

For more details about TennCare Kids/EPSDT exams, please visit the TennCare Kids ToolKit in the "Tools and Resources" provider section of **bluecare.bcbst.com**.

Note: This doesn't apply to CoverKids.

Chiropractic Services Coverage Reminder

In the **November 2021 and January 2022 BlueAlerts**, we announced that BlueCare Tennessee would cover chiropractic services for all members, regardless of age, beginning Jan. 1, 2022.

These services require prior authorization, and you can use Availity to submit these requests. Please use the **Outpatient Therapy** authorization/advance determination submission form in Availity when submitting chiropractic services requests. If you haven't signed up for Availity, please visit **Availity.com** to register for an account.

Important Coverage Reminders

When providing and billing for chiropractic services, please keep these guidelines in mind:

- You can submit the first **10** 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 **10** chiropractic visits, including therapy continuation beyond the initial 10 visits, will require a medical necessity review. Please submit all necessary clinical information with your request. You can review the MCG **here**.
- Chiropractic coverage is limited to spinal manipulation codes only (CPT® codes 98940, 98941, 98942). Additional services won't be covered.

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.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Further Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from December 2021, the Centers for Medicare & Medicaid Services (CMS) is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directs CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022.

Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members.

This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Screen Patients for Fall Risk and Urinary Incontinence

Your interaction with patients covered by BlueAdvantage 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 caused by pelvic floor dysfunction

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

Opportunity for Frailty Exclusions

The Centers for Medicare & Medicaid Services (CMS) allows individuals to be excluded from some quality measures when they have specific advanced illness or frailty diagnoses. Exclusions to these measures are made because the services recommended in the Healthcare Effectiveness Data and Information Set (HEDIS®) definition may not benefit older adults with advanced illness, which limits their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes aren't often 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 will make the patient eligible 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 additional information and codes related to exclusions for advanced illness and frailty, refer to our Guide to Advanced Illness and Frailty Exclusions **here**.

HEDIS® is a registered trademark of NCQA.

Pharmacy

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

Restrictions Applicable to Opioids

The Centers for Medicare and Medicaid Services (CMS) changed their opioid prescribing guidelines effective Jan. 1, 2019, which apply to all Medicare Advantage plans.

These restrictions were implemented in 2019 and will continue through 2022:

- Opioids are limited to a total of 90 morphine milligram equivalents (MME*) per day when two or more prescribers contribute to the opioid prescriptions
- Opioid-naïve members are limited to seven days for their initial fill
- Opioids are limited to a total of 200 MME per day when two or more prescribers contribute to the opioid prescriptions
- Concurrent use of long-acting opioids
- Concurrent use of opioids and benzodiazepines

*MME represents a drug's potency equivalent to morphine.

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

You can find more information about these Medicare Part D Opioid Overutilization Policies **here**.

Requirements for Prior Authorization

In addition to the above restrictions, we require prior authorization on all long-acting opioid medications. All opioids have a quantity limit restriction applied. You can **find our formularies** and **prior authorization criteria** online.

To request prior authorization or coverage determination for your patients, contact:

BlueAdvantage

Phone: **1-800-831-2583**
Fax: **(423) 591-9514**

BlueCare Plus

Phone: **1-800-299-1407**
Fax: **(423) 591-9514**

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.

HEDIS® Measurement Year 2021 Medical Record Requests to Begin Soon

Each year, we're required to report compliance rates for certain Healthcare Effectiveness Data and Information Set (HEDIS) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA uses this data to determine if members received needed screenings and care to improve their health.

You'll 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.

You can submit your records using any of the following methods.

- Remote access to your electronic medical records
- Secure email
- Fax
- On-site collection
- Through Availity

If you need help, please call us at **(423) 535-3187**.

HEDIS® is a registered trademark of NCQA.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program Reports Available This Month

Quarterbacks participating in the Episodes of Care Program will receive their 2022 Interim Performance Reports for our Medicaid and Commercial lines of business on Feb. 17. Please log in to Availity 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.

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MARCH 2022

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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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

BlueCross Now Using Change Healthcare for EFT/ERA Enrollment

Effective Dec. 2, 2021, BlueCross transitioned to Change Healthcare for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) management. If you haven't already, please submit EFT and ERA changes and enrollments through **Change Healthcare's Payer Enrollment Services** portal, which is accessible through **Availity®** and **provider.bcbst.com**.

If you're receiving payments and remittance advice as intended today, there's nothing you need to do. 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® for our provider enrollment, credentialing and directory efforts.

Telehealth Credentialing Updates

Beginning October 2021, we began credentialing our network providers who only offer telehealth services. These providers must meet the same requirements as our other credentialed providers practicing medicine in Tennessee. Telehealth-only providers must have a Tennessee address, a Drug Enforcement Administration (DEA) number and all DEA schedules.

Telehealth-only providers who haven't yet begun the credentialing process will be contacted and once credentialed, can remain in our BlueCross network. If you have questions, please contact your Provider or Behavioral Health Network Manager.

Prior Authorization Requirements for Neuropsychological and Psychological Testing

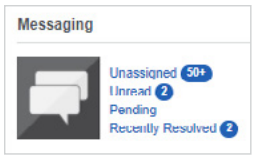
Exciting news! We've enhanced our Availity Authorization Form to allow more units to automatically approve when you request authorization for neuropsychological and psychological testing. You can use Availity to verify the authorization status and make additional unit updates to existing authorizations. If you'd like training on Availity, please contact your **eBusiness Marketing Consultant**.

Availity Messaging Coming Soon

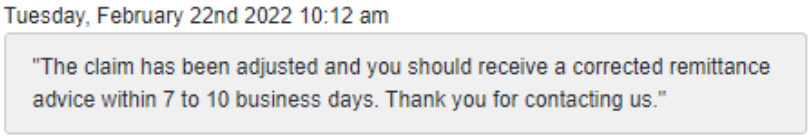
We'll be launching a new major feature soon. Availity Messaging will enable easy-to-use digital correspondence with our customer service teams. To access Messaging, you must have the Claim Status and Messaging roles in Availity. To use Messaging, follow these steps:

1. To send us a message, find the claim you're inquiring about in Availity Claim Status and use the **Send a message to the payer** link on the right side of the screen

2. After we respond, click on the new notification to take you to your secure inbox



3. In your inbox, you'll see your original message and our service team's response



If you currently email us through "Send A Message" on BlueCross Payer Spaces, Availity Messaging will be your new way to ask us questions. All requests will be routed to the appropriate area for handling based on line of business, so you don't need to worry about calling the right phone number, sending copies of remits or mailing letters to work with us. **Please note, we'll retire "Send A Message" near the end of Spring 2022. Check Availity News and Announcements for specific information and dates as we transition to Availity Messaging.**

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

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** through our Payer Spaces on **Availity**. There, you can 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 and performance and payment reporting for our value-based programs, which alert providers to log in to the secure Quality Care Rewards application to download their reports. You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.
- **Financial Updates** – Transactional notices about billing, EFT and tax-related items

Here's How You Can Update Your Contact Preferences:

1. Log in to the BlueCross Payer Spaces in **Availity**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type** and then your **Organization** (based on Tax ID or TIN).
4. Verify your **Provider Name** and **National Provider Identifier (NPI)** and click **Submit**.

   TIP: If you don't see your name in 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.
5. 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. For questions or to learn more, 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 specific to Availity, please visit **Availity.com** or contact our eBusiness Service team at **(423) 535-5717 (option 2)**.

It's Time for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

These surveys measure the patient's perception of both their health plan and their doctor. These simple tips may help to improve quality care for patients and their perception of their care.

Here are some easy tips that can help you make sure your patients don't feel overwhelmed, or misunderstand the information they need for their best care:

- 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.
- Make eye contact with your patients, and spend time listening carefully to them. Talk to them about the care they receive from other providers, and make sure they understand the information they're receiving.
- Be as respectful as possible about patients' thoughts and beliefs and try to continue conversations at the next visit if they refuse care.
- Use the teach-back method, which involves asking patients to explain what they need to do in their own words. This can help you see if they need more information or if they understand the information you presented.

Commercial

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

Tips for Submitting Authorization Requests

To prevent unnecessary delays, please keep these guidelines in mind when submitting prior authorization requests:

- Scheduled procedures/services must be authorized at least 24 hours prior to admission.
- Inpatient emergency admissions/services must be authorized within two business days after an admission.
- The date the member entered the facility is considered the admission date.
- Include the required clinical information in the initial authorization submission so the request can be completed without delay.

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 by calling our Provider Service Line at **1-800-924-7141**.

New Requirements for Consolidated Appropriations Act, 2021; Requirements Starting Jan. 1, 2022

As of Jan. 1, 2022, you may have seen many of the changes required by the 2021 **Consolidated Appropriations Act (CAA), 2021**.

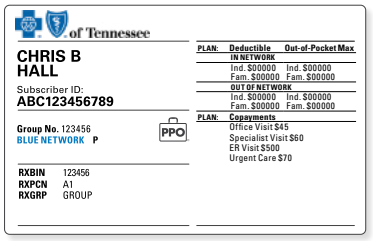
The requirements listed below are a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

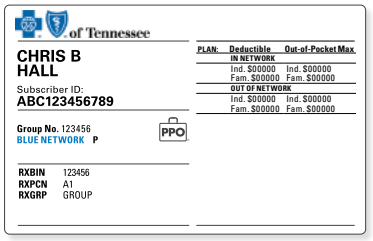
New health insurance ID cards that have been issued or downloaded on or after Jan. 1, 2022, include this additional information:

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

Here are two example cards for common plan types – 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



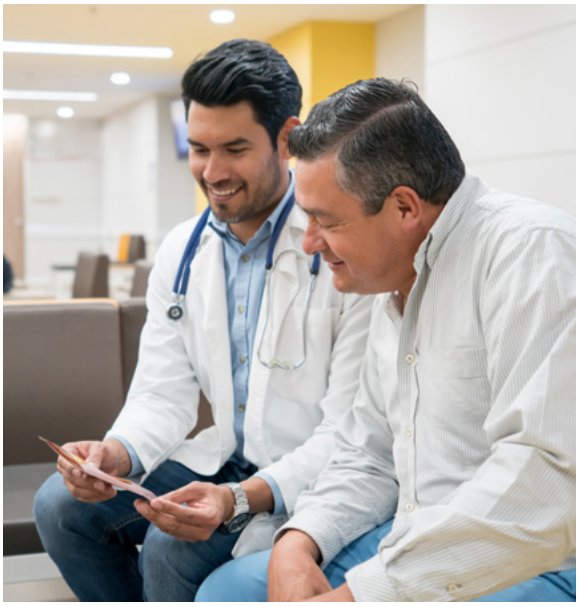
Sample HDHP Card

Provider Directory

To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to BlueCross in a timely manner. We've listed the new requirements for 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 BlueCross.
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your directory information, you can submit an attestation about your information to be added back in the directory.



Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

On Nov. 12, 2020, the Departments of Health and Human Services (HHS), Labor and Treasury published the **Transparency in Coverage rule**. The rule imposes new price transparency requirements on most group health plans and health insurers in our individual and group plans. The Transparency in Coverage rule changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make three machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the Tax ID Number (TIN) for our providers, which would be a Social Security Number (SSN) for providers who use their SSN as a TIN. If you're currently using an SSN, we recommend you apply for a TIN using this **link**.

BlueCare Tennessee

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

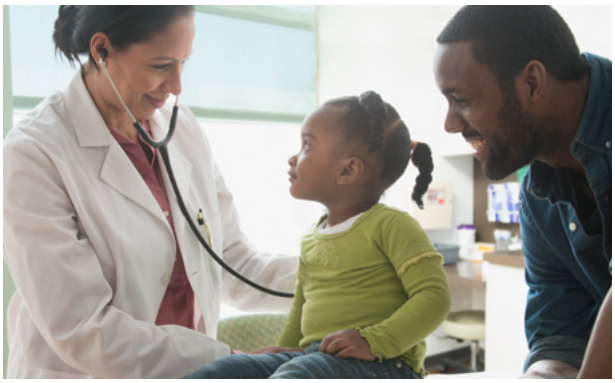
Policy Review: Accepting Out-of-Pocket Payments from BlueCare Tennessee Members

Specific policies outline when a BlueCare or TennCare*Select* network provider may bill our members. As a general rule, providers aren't allowed to accept out-of-pocket payments for covered services from a member with BlueCare Tennessee coverage, even if the member signs a financial responsibility statement. Members who've signed a financial responsibility statement sometimes send their bills from their provider to TennCare to pay as "reimbursement appeals" and may not have understood what they were signing.

Please refer to the **Financial Responsibility for the Cost of Services** pages located in the **Member Policy** section of your Provider Administration Manual (PAM) for more information. This section also provides a link to the TennCare policy with scenarios on when a provider can and can't bill a member.

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 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 TennCare*Select* are eligible for TennCare Kids exams from birth until their 21st birthday. The schedule for EPSDT exams follows the **Bright Futures/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

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.

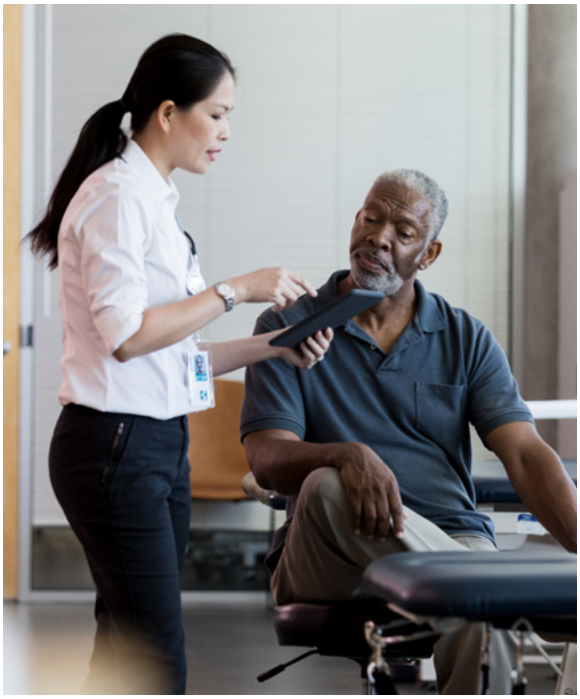
- W30 has two reported rates, which evaluate whether children get the correct number of well-child visits before age 15 months and between ages 15-30 months.
- WCV evaluates the rate of children and adolescents between ages 3 and 21 who receive an annual wellness visit during the measurement year.

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 see our **TennCare Kids Tool Kit**.

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

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



Chiropractic Services Coverage Update

In the **November 2021, January 2022 and February 2022 BlueAlerts**, we announced that BlueCare Tennessee would cover chiropractic services for all members, regardless of age, beginning Jan. 1, 2022. We wanted to clarify that coverage includes an initial exam and spinal X-ray, as well as ongoing spinal manipulation. The manipulation services require prior authorization, and the first 10 visits can be submitted as notification only. This notification helps to ensure we know when treatment begins and that claim payments aren't delayed.

Submit Prior Authorization Requests in Availity

For your convenience, you can use Availity to submit these requests. Please use the Outpatient Therapy authorization/advance determination submission form in Availity when submitting chiropractic services requests. If you haven't signed up for Availity, please visit **Availity.com** to register for an account.

Important Coverage Reminders

When providing and billing for chiropractic services, please keep these guidelines in mind:

- The first **10** manipulation visits, initial exam and spinal X-ray 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 **10** chiropractic visits, including therapy continuation beyond the initial **10** visits, will require a medical necessity review. Please submit all necessary clinical information with your request. You can review the Milliman Care Guidelines (MCG) **here**.
- Chiropractic coverage is limited to an exam, one spinal X-ray and ongoing spinal manipulation only (CPT® codes 98940, 98941, 98942). **Please note: We'll only cover one spinal X-ray during the initial exam. Additional X-ray services or services outside of spinal manipulation won't be covered.**

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.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

2022 Provider Assessment Form (PAF) Program Update

As of Jan. 1, 2022, Medicare Advantage has implemented changes to the PAF program. For the 2022 program, there are 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 had 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.
- Note that the previous standard PAF form has been retired and won't be accepted for 2022 dates of service.

Providers may 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 as of Jan. 1, 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.

City of New York Retirees in Tennessee Changing Health Plans in April

Beginning April 1, 2022, the City of New York is changing coverage to the **NYC Medicare Advantage Plus plan**. This means City of New York retirees will be able to access services through the BlueCross BlueShield Medicare Advantage PPO network, which includes our BlueAdvantage network.

What does this mean for your office?

As a provider in our local BlueAdvantage (PPO) network, you're a participating provider in BlueCross BlueShield Medicare Advantage PPO network sharing. Please visit the **Communication Viewer** tile in Availity for more details about member benefits, reimbursement and more.

If you have questions, please contact your Provider Network Manager. You can find their information at **provider.bcbst.com/contact-us/my-contact**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Screen Patients for Fall Risk and Urinary Incontinence

Your interaction with patients has a direct impact on their response to the Health Outcomes Survey (HOS). Incorporating some simple techniques, like the ones listed below, into your daily interactions with patients can provide them with a better experience, help drive better health outcomes, and can lead to better patient retention.

- Screen all patients 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 risk factors for falls.
- Recommend the use of assistive devices such as 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 patients at risk.
- Consider having home health perform a home safety assessment to look for risks for falls.

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

Opportunity for Frailty Exclusions

The Centers for Medicare & Medicaid Services (CMS) allows individuals to be excluded from some quality measures when your patients have specific advanced illness and/or frailty diagnoses. Exclusions to these measures are made because the services recommended in the HEDIS definition may not benefit older adults with advanced illness, thus limiting their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes are often not captured during routine office visits. **Annual Wellness Exams offer yearly opportunities to address gaps in care as well as possible exclusions**. Coding eligible frailty conditions during the current year will make the patient eligible 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 additional information and codes related to exclusions for advanced illness and frailty, refer to our Guide to Advanced Illness and Frailty Exclusions **here**.

Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement to providers who achieved quality scores of four STARs and above with coding accuracy during the 2021 measurement period (Jan. 1 through Dec. 31, 2021).

STARs ratings, based on last year's performance, will affect each provider's reimbursement rates starting April 1, 2022. Participating providers will receive a rate adjustment notification letter and a rate attachment with the new fee schedule by April 1. Your contract amendment will include information about your base rate, the quality escalator and total earning potential.

Further Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from December 2021, the Centers for Medicare & Medicaid Services (CMS) is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directs CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022.

Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members.

This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Pharmacy

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

Prescription Benefit Updates for Covermymeds.com

As of Jan. 1, 2022, our Pharmacy Benefits Manager RXBIN has changed to **004336**. The previous RXBIN was 610014. You'll need to use the new RXBIN 004336 when submitting coverage reviews through **Covermymeds.com**. To do this, just log in to Covermymeds.com and choose **Tennessee** to find the BlueCross BlueShield of Tennessee Commercial review form.

You can also log in to Covermymeds.com to submit prior authorization requests digitally. If you have questions, please call our Provider Service line at **1-800-924-7141**.

Note: The information in this article doesn't apply to BlueCare, TennCare*Select* or CoverKids.

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).

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**.

APRIL 2022

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.

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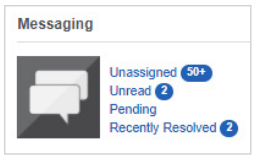
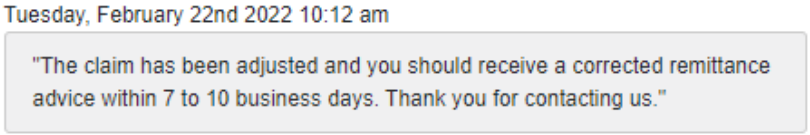
1. To send us a message, find the claim you're inquiring about in Availity Claim Status and use the **Send** link on the right side of the screen

2. After we respond, click on the new notification to take you to your secure inbox

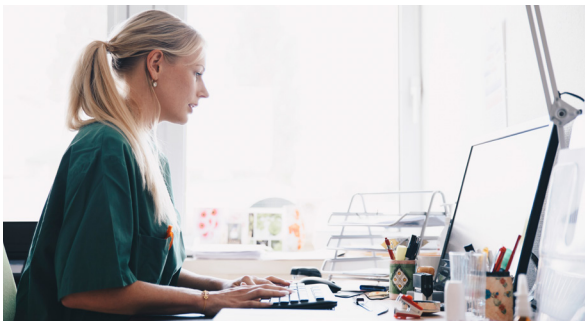


3. In your inbox, you'll see your original message and our service team's response



If you currently email us through "Send A Message" on BlueCross Payer Spaces, Availity Messaging will be your new way to ask us questions. All requests will be routed to the appropriate area for handling based on line of business, so you don't need to worry about calling the right phone number, sending copies of remits or mailing letters to work with us. **Please note, we'll retire "Send A Message" near the end of Spring 2022. Check Availity News and Announcements for specific information and dates as we transition to Availity Messaging.**

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



Update Your Contact Preferences in Availity

If you'd like to get important email messages that apply to you, simply update your Contact Preferences through our Payer Spaces on **Availity**. There, you can opt in to make email your preferred communication method for each of these communication types and the roles required for each contact types:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in the BlueCross Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications of available clinical data, performance and payment reporting for our value-based programs, which alert the provider to log in to the secure Quality Care Rewards application to download. You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, EFT and tax-related items	Financial Reports

* Availity Roles can update contact info and download the messages and attachment.

** For the Quality & Clinical contact type, you only need one of the roles listed.

Here's How You Can Update Your Contact Preferences

1. Log in to the **BlueCross Payer Spaces** in Availity.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type** and then your **Organization** (based on Tax ID or TIN).
4. Verify your **Provider Name** and **National Provider Identifier (NPI)** and click **Submit**.

   TIP: If you don't see your name in 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.
5. 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 your possible contact types.

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. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. 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**.

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 soon. 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:

- 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.

BlueCard® Claims Filing

The BlueCard Program allows members who are away from their Home Plan's* service area – traveling or living – to receive medical care from participating providers wherever services may be required. In many cases, that member will receive the same level of benefits they'd receive if the services were rendered in their Home Plan's service area.

The BlueCard Program also allows providers to submit claims for Blue Cross and/or Blue Shield plan members from other Blue Cross and Blue Shield plans, including international Blue Cross and Blue Shield plans, directly to the provider's local plan (Host Plan**). That plan will be the provider's contact for claims filing, claims payment, adjustments, inquiries and problem resolution.

If the provider is rendering services within Tennessee, they should submit claims to BlueCross. If services are rendered outside of Tennessee by a contiguous provider who may be participating with BlueCross, the claim should be filed to the provider's local (Host) plan in the state where services are rendered.

Note: If a provider contracts with more than one Blue Plan in a state for the same product type (i.e., PPO or Traditional), the provider should file based on the member and where services are rendered:

- BlueCross member – contracted with Tennessee – file to BlueCross BlueShield of Tennessee
- BlueCross member – only contracted with other plan – file to other plan
- BlueCross member – contracted with both plans – file to Tennessee
- Host member – contracts with Tennessee and services were in Tennessee – file to Tennessee
- Host member – services were rendered outside of Tennessee, then claim should be filed where services were rendered

* **Home Plan** – the plan that "owns" the member's coverage

** **Host Plan** – provider's local Blue Cross Blue Shield plan – for Tennessee providers treating members of other Blue Plans, it's BlueCross BlueShield of Tennessee.

Commercial

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

New Requirements for Consolidated Appropriations Act, 2021; Requirements Starting Jan. 1, 2022

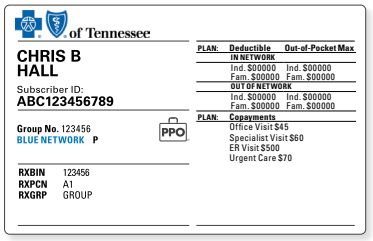
As of Jan. 1, 2022, you may have seen many of the changes required by the 2021 **Consolidated Appropriations Act (CAA), 2021**. The requirements listed below are a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

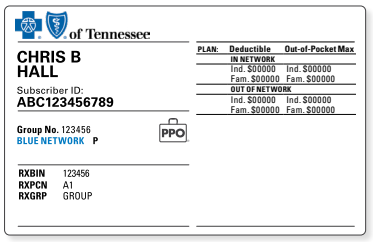
New health insurance ID cards that have been issued or downloaded on or after Jan. 1, 2022, include this additional information:

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

Here are two example cards for common plan types – 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

To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to BlueCross in a timely manner. We've listed the new requirements for 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 BlueCross.
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your directory information, you can submit an attestation about your information to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Beginning July 1, 2022, the Transparency in Coverage rule will impose new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make three machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for a TIN using this **link**.

Important Information on Discharge Dates

Providing a discharge date ensures appropriate follow-up and coordination of care for members. Discharge planning services help make sure that necessary health care services and equipment are in place. You can submit discharge dates through the **Auth Inquiry/Clinical Update** application tile in Availity. After entering the number, choose **Discharge Date** from the **Note Type** drop-down box. The discharge date and discharge disposition can be entered and submitted.

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**.

BlueCare Tennessee

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

View the Latest Behavioral Health Provider Education Resources

Behavioral health is an important part of patient health. Providers like you play a vital role in identifying and treating mental and substance use disorders in your patients. We're here to support you in helping your patients improve and maintain their mental and emotional well-being.

You can access the latest behavioral health provider education resources by going to **provider.bcbst.com/working-with-us/behavioral-health**. There, you'll find resources about transitions of care, telehealth best practices, Healthcare Effectiveness Data and Information Set (HEDIS®) updates and more.

You can also find BlueCare Tennessee behavioral health resources, including past years' quarterly educational resources, on **bluecare.bcbst.com/providers/tools-resources/** under **Behavioral Health**.

Extended Maternity and Dental Benefits for BlueCare Tennessee Members

Your patients enrolled in BlueCare and TennCare*Select* now have access to new and extended benefits. Beginning April 1, 2022, our members:

- Can keep their coverage for up to 12 months after they give birth.
- Age 21 and older can enroll in dental coverage during their pregnancy and for 12 months after giving birth.

Please let your patients know about these benefit changes so they can take advantage of them. To enroll in dental coverage, eligible patients will need to let TennCare know about their pregnancy by calling **TennCare Connect** at **1-855-259-0701** or updating their information at **tenncareconnect.tn.gov**.

Note: These benefits don't apply to CoverKids members.

Coming Soon: 2022 EPSDT Virtual Workshops

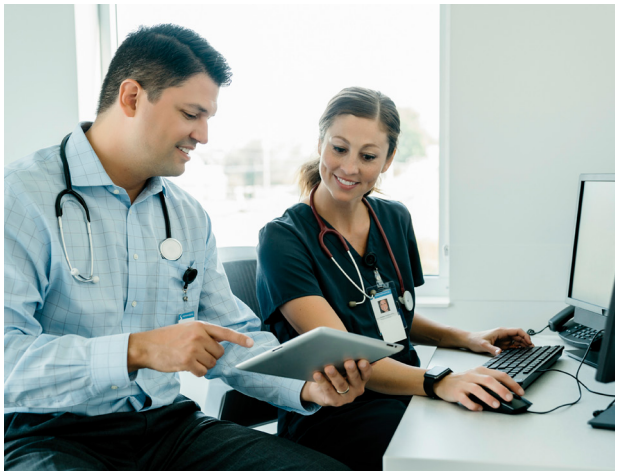
We're excited to invite you to our 2022 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Virtual Workshops. This year, we'll host two events with the Tennessee Chapter of the American Academy of Pediatrics. The first session is on May 12, 2022, from 1 p.m. to 3 p.m. ET (12 p.m. to 2 p.m. CT). The second will take place later in the year, and we'll share the date and time closer to the event.

Sign Up Today

Registration is required for the workshop on May 12. To sign up, please email **CommunityEngagement@bcbst.com** and let us know:

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

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



CMS to Host Payment Error Rate Measurement (PERM) Webinars April 12-14

We encourage Tennessee providers who participate in Medicaid or the Children's Health Insurance Program (CHIP) to attend one of the Centers for Medicare & Medicaid Services' (CMS) upcoming educational webinars on Payment Error Rate Measurement (PERM). Webinar topics include:

- The PERM process and provider responsibilities during a PERM review
- Recent trends, frequent mistakes and best practices
- The Electronic Submission of Medical Documentation through esMD

Providers have three opportunities to attend one of the PERM webinars:

- Tuesday, April 12 from 1 p.m. to 2 p.m. ET
- Wednesday, April 13 from 3 p.m. to 4 p.m. ET
- Thursday, April 14 from 4 p.m. to 5 p.m. ET

Registration closes April 10 at 5 p.m. ET. To register, use this link: **https://cms.zoomgov.com/webinar/register/WN_zhpBrzv3Se63X2XzzS3YJQ**.

Please note the webinars will be identical so providers only need to attend one. The webinars will be recorded, and one of the sessions will be uploaded to the PERM website.

For more information about PERM, please visit **tn.gov/tenncare/providers**. CMS also provides information about PERM and the review cycles **here**.

TennCare Kids Guidelines Allow "Interperiodic" Well-Child Exams

TennCare Kids guidelines don't limit the number of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child visits children get in a year. You may perform "interperiodic" checkups – exams that fall outside of the state's periodicity schedule – when medically appropriate and to help children get needed preventive care.

Here's an example: A child visits your office with a sore throat and is due for a checkup in one month. In this situation, you can perform an EPSDT exam during the appointment even though it's only been 11 months since the last checkup. Doing so increases the likelihood that the child will stay up to date on well-child care because they don't have to visit your office for another appointment.

Other cases when "interperiodic" screening may be appropriate include instances when children begin having symptoms that weren't present during their yearly well-child exam. For these patients, a well-child exam is medically necessary to screen for an illness or condition that may require additional care.

For more information, please review the Centers for Medicare & Medicaid's **EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents**. You can learn more about combining well-child and sick visits in our **EPSDT Provider Booklet**.

Coming Jan. 2023: EVV System Requirement for Home Health Agencies

Beginning in 2023, all agencies that provide in-home health care services to people enrolled in Medicaid must use an electronic visit verification (EVV) system to track member visits. This means your staff will need to use an EVV system to check in and out of all home health visits if they don't already. At a minimum, these systems automatically verify the:

- Type of service
- Member name
- Service date and location
- Staff member name
- Time the service began and ended

This requirement is part of the 21st Century Cures Act, and you can read more about it **here**. We know this may be a big change for your agency, and we're here to help. If you have questions, please contact your Provider Network Manager.

Updates to the Neonatal Intensive Care Unit (NICU) Authorization Process

We've updated the NICU authorization submission process for our providers, effective April 1, 2022.

NICU admissions for Levels II, III or IV (revenue codes 0172, 0173 and 0174) require authorization. However, providers shouldn't request authorization until babies are eligible for BlueCare Tennessee or CoverKids services and have been assigned their own Member ID. NICU authorization requests aren't subject to our utilization management timely submission standards. Providers won't be issued a denial for non-compliance. We're currently updating our submission requirements to make sure claim payments aren't delayed.

Requesting Prior Authorization for BlueCare Tennessee and CoverKids Members

Once the member is eligible for coverage and has been assigned a Member ID, please call or fax authorization requests to BlueCare Tennessee:

- **Phone:**1-888-423-0131
- **Fax:** 1-800-292-5311

We're updating Availity to allow providers to submit NICU authorization requests online, and we'll let you know when this change is ready.

As always, we're happy to help with any discharge or case management needs. You may call us with questions at the phone number listed above, even if the baby hasn't gotten their Member ID.

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.

Step 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. A claim may be denied for non-compliance if prior authorization guidelines aren't followed before giving care. You can read more about non-compliance denials and the process for appealing them in our BlueCare Tennessee Provider Administration Manual (PAM).

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 PAM**.

BlueCare Tennessee Now Covers COVID-19 Vaccine Counseling

Effective March 15, 2022, until the end of the federal public health emergency, we'll cover COVID-19 vaccine counseling for BlueCare, TennCare*Select* and CoverKids members. You'll receive reimbursement even if the patient chooses not to receive the vaccine.

You can counsel patients about the COVID-19 vaccines during preventive health visits, when providing acute care, refills or other services, or when COVID-19 vaccine counseling is the sole reason for the visit.

To receive reimbursement, please bill CPT® code 99401 with a CR modifier to indicate a public health emergency code. The following criteria also apply:

- If vaccine counseling was provided at the same time as an office visit for acute care, to address diagnosed illness or for medication refills, include modifier -25 with the office visit evaluation and management code.
- Include CR and GT modifiers if provided during a telehealth visit.
- Include CR and KX modifiers if provided telephonically.
- Only one code may be billed per day.
- When counseling parents and guardians who aren't BlueCare Tennessee or CoverKids members, you may bill the code to the child's Medicaid ID.

Please note: To qualify for reimbursement, this service must be provided by a professional with MD/DO, NP or CNM credentials. If a member receives vaccine counseling from an eligible provider in a local health department, federally qualified health center or rural health clinic, the payment will be outside the prospective payment system rate.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

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 2021 measurement period of Jan. 1-Dec. 31, 2021. Participating providers may view their 2021 Star rating in Availity by accessing the Quality Care Rewards application and clicking on their 2021 Medicare Advantage scorecard under the View Prior Year Scorecard tab. 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, 2022. 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.

Inpatient Professional Services Authorization Update

Medicare Advantage requires a prior authorization for all inpatient acute care facility admissions. Failure to secure an authorization results in the denial of the facility claim. Beginning with date of service July 1, 2022, if an authorization request for an acute care facility admission is denied or not obtained, all inpatient professional service claims related to the admission will also be non-covered.

City of New York Retirees Postponing Change in Medicare Advantage Plan

Last month, we published an article to let you know City of New York retirees – many who reside in Tennessee – would be subscribing to a new Medicare Advantage plan April 1, 2022. Since that time, we've learned this transition has been delayed. If you have questions about coverage, please continue to visit the Communication Viewer tile in Availity for details about member benefits, reimbursement and more.

BlueCare Plus (HMO SNP)℠

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus and BlueCare Plus Choice special needs plans are contractually required to complete our MOC Training after initial contracting, then 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**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Begin Medication Adherence Strategies Early

The three medication adherence measures are triple-weighted again for 2022 in the Medicare Advantage and BlueCare Plus Quality+ Partnerships programs, making these measures critically important to the overall Star score. To maintain or reach a high adherence rate for each one, it's necessary to actively work on adherence all year.

The medication adherence for cholesterol, hypertension and diabetes medications measures are looking for the patient to fill their medication at least 80% of the time that they're supposed to be taking the medication. The measures start off strong with high adherence rates and decrease as the year progresses.

Our pharmacy reports offer timely data that's useful for actionable interventions. The reports begin displaying patients after their first fill of an adherence medication. While the Centers for Medicare & Medicaid Services (CMS) requires two fills to be officially included in an adherence measure, only monitoring patients with two fills will negatively impact adherence scores if the second fill occurs late in the calendar year. At this point in time, the member won't be able to reach the 80% proportion of days covered threshold. Use the **Pharmacy Reports** tab in the **Quality Care Rewards** application in Availity to identify members late to fill after one fill and provide intervention, when possible, to help maintain adherence and improve clinical outcomes.

Transitions of Care Measure

The Medicare Advantage and BlueCare Plus Quality+ Partnerships Programs for 2022 include the Transitions of Care (TRC) measure. The TRC measure is made up of four components:

- Notification of inpatient admission (NIA)
- Receipt of discharge information (RDI)
- Patient engagement after inpatient discharge (PEID)
- Medication reconciliation post-discharge (MRP)

Each component receives its own rate, and the four rates are averaged together to determine the overall TRC measure rate and Star level. The information for the NIA and RDI components will be gathered from medical record review during Medicare Advantage's annual supplemental data collection project. The PEID component information will come from administrative claims reporting. The MRP component information will come from administrative claims reporting and/or attestation in the **Quality Care Rewards** application in Availity. Please refer to our **guide** for more information on this measure. Contact your local Medicare Advantage Provider Quality Consultant for more information on the annual supplemental data collection project.

Reminder: Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from Dec. 2021, the Centers for Medicare & Medicaid (CMS) is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan capitation payments, as well as Original Medicare Part A and Part B payments to providers.

The new law directs CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022. Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members.

This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Pharmacy

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

BlueCross Coverage Review Forms Available in Covermymeds.com

We wanted to let you know the best way to request approval for coverage reviews for your patients with BlueCross pharmacy benefits is through Cover My Meds. You can do this by visiting their website at covermymeds.com or through Availity. Once on **covermymeds.com**, find the BlueCross form by selecting **Tennessee** in the **Patient Insurance State** option. Then, enter the 4336 BIN in the **Plan or PBM Name** field. Please be sure to always use BlueCross forms when submitting coverage review requests for our members.

Note: The information in this article doesn't apply to BlueCare, TennCare*Select* or CoverKids.

Prior Authorization Now Required for Some ADHD Medications

We wanted to remind you that as of Jan. 1, 2022, we're requiring a prior authorization for FDA-approved medications for Attention-Deficit/Hyperactive Disorder (ADHD) for members 19 and older. This prior authorization was added to confirm the member has a documented diagnosis supported by the FDA-label and/or CMS-approved compendia.

Please note: This requirement doesn't apply to our members who are 18 and younger. Also, all of our members, regardless of age, are subject to the quantity limits for FDA-approved ADHD products. These quantity limits are by the FDA-label and/or CMS-approved compendia.

Prescription Benefit Updates for Covermymeds.com

As of Jan. 1, 2022, our Pharmacy Benefits Manager RXBIN has changed to **004336**. The previous RXBIN was 610014. You'll need to use the new RXBIN 004336 when submitting coverage reviews through **covermymeds.com**. To do this, just log in to covermymeds.com and choose **Tennessee** to find the BlueCross BlueShield of Tennessee Commercial review form.

You can also log in to covermymeds.com to submit prior authorization requests digitally. If you have questions, please call our Provider Service line at **1-800-924-7141**.

Note: The information in this article doesn't apply to BlueCare, TennCare*Select* or CoverKids.

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.

Division of TennCare Schedules Annual Feedback Session for Episodes of Care

The Division of TennCare's annual feedback session for providers participating in the Episodes of Care program will be May 11, 2022. The goal of the meeting is for Episodes of Care program participants to share success moments, ask questions, and recommend changes to improve episode design.

This year's event will be virtual and is free. To make sure you receive important updates about the event, including the time and registration information, please **click here** to subscribe to TennCare's Episodes of Care newsletter.

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**.

MAY 2022

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

All Blue Workshop℠ Set for Aug. 4, 2022

Save the date for this year's All Blue Workshop on Aug. 4, 2022. We'll be livestreaming this annual event again, but with a few changes. For 2022, the All Blue Workshop will be a full-day event and will include two breakout sessions. We look forward to discussing 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.

Telehealth Credentialing Updates

In October 2021, we began credentialing our network providers who only offer telehealth services. These providers must meet the same requirements as our other credentialed providers practicing medicine in Tennessee. Telehealth-only providers must have a Tennessee address, a Drug Enforcement Administration (DEA) number and all DEA schedules.

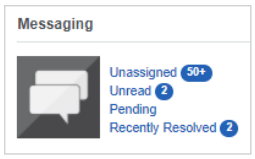
Telehealth-only providers who haven't yet begun the credentialing process will be contacted and once credentialed, can remain in our network. If you have questions, please contact your Provider or Behavioral Health Network Manager.

Availity® Messaging is Live

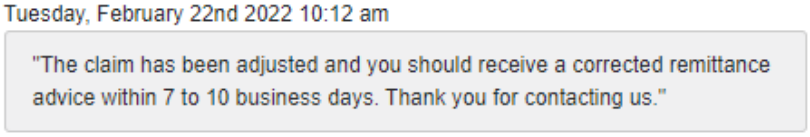
We're happy to announce we've launched a new, convenient feature in Availity. Availity Messaging now makes it easier to have digital correspondence with our customer service teams. To access Availity Messaging, you'll need to have the **Claim Status and Messaging** roles in Availity. And then, follow these steps to use the messaging tool:

1. Find the claim you're inquiring about in **Availity Claim Status** and use the **Send a Message** to the payer link on the right side of the screen.

2. After we respond, click on the new notification to take you to your secure inbox.



3. In your inbox, you'll see your original message and our service team's response.



If you previously emailed us through **Send a Message** on BlueCross Payer Spaces, please note that **Send a Message** has been retired. **Availity Messaging is now your only way to ask us questions online.** All requests will be routed to the appropriate area for handling based on the line of business, so you don't need to worry about calling the right phone number, sending copies of remits or mailing letters to us.

If you have questions or need help, please log in to **Availity** or call our eBusiness Service team at **(423) 535-5717 (option 2)**.

Update Your Contact Preferences in Availity

If you'd like to get important email messages that apply to you, simply update your **Contact Preferences** through our Payer Spaces on **Availity**. There, you can opt in to make email your preferred communication method for each of these communication types and the roles required for each contact types:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in the BlueCross Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications of available clinical data, performance and payment reporting for our value-based programs, which alert the provider to log in to the secure Quality Care Rewards application to download. You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, electronic funds transfer and tax-related items	Financial Reports

* Availity Roles can update contact info and download the messages and attachment.

** For the Quality & Clinical contact type, you only need one of the roles listed.

You Can Update Your Contact Preferences By:

1. Logging in to the **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verifying your **Provider Name** and **National Provider Identifier (NPI)** and clicking **Submit**.

   TIP: If you don't see your name in 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.
5. Following 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 updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all your possible contact types.

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. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. 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, please log in to **Availity** or contact our eBusiness Service team at **(423) 535-5717 (option 2)**.

BlueCard® Claims Filing

The BlueCard Program allows members who are traveling or living away from their Home Plan's (residential state's plan) service area to receive medical care from participating providers wherever services may be required.* In many cases, that member will receive the same level of benefits they'd receive if the services were rendered in their Home Plan's service area.

The BlueCard Program also allows providers to submit claims for Blue Cross and/or Blue Shield plan members from other Blue Cross and Blue Shield plans, including international Blue Cross and Blue Shield plans, directly to the provider's local plan (Host Plan).** The local host plan will be the provider's contact for claims filing, claims payment, adjustments, inquiries and problem resolution.

If the provider is rendering services within Tennessee, they should submit claims to BlueCross BlueShield of Tennessee. If services are rendered outside of Tennessee by a contiguous provider who may be participating with BlueCross, the claim should be filed to the provider's local (Host) plan in the state where services are rendered.

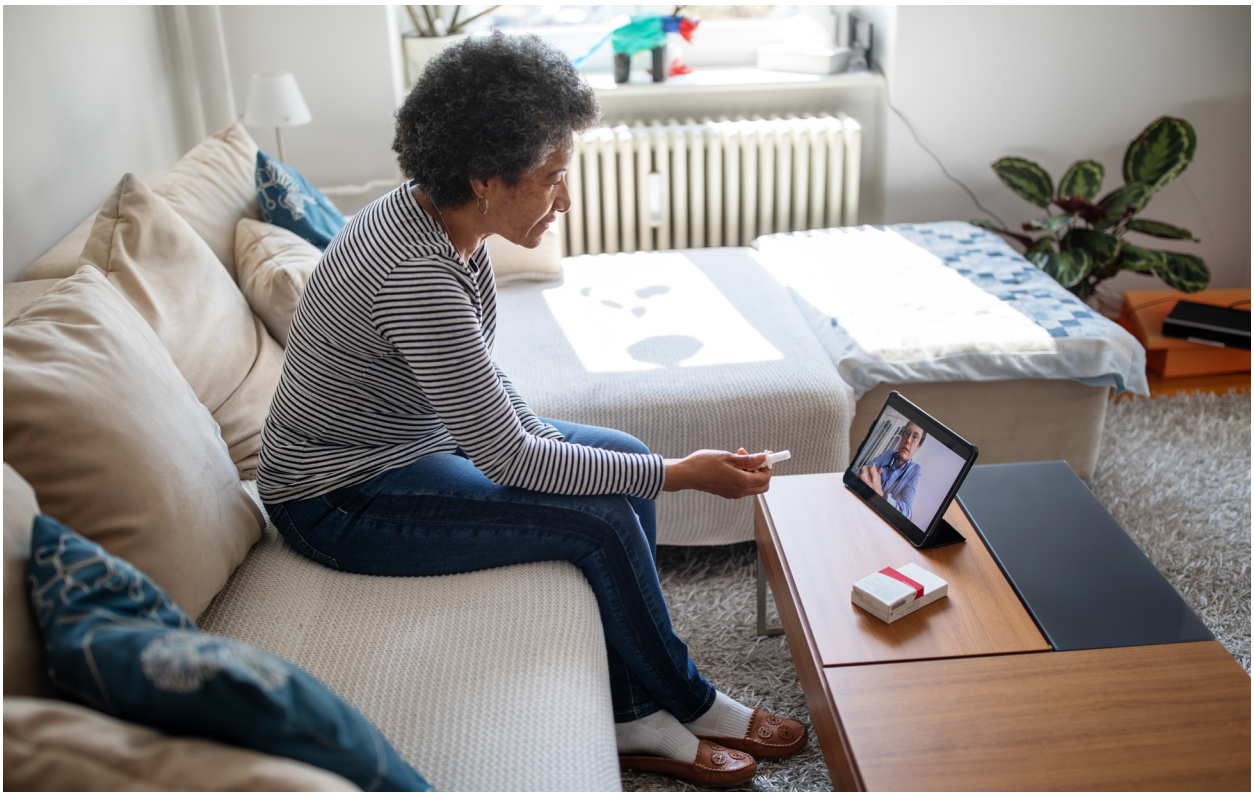
Note: If a provider contracts with more than one Blue Plan in a state for the same product type (i.e., PPO or Traditional), the provider should file claims based on the member and where services are rendered:

- BlueCross member – contracted with Tennessee – file to BlueCross BlueShield of Tennessee
- BlueCross member – only contracted with other plan – file to other plan
- BlueCross member – contracted with both plans – file to Tennessee
- Host member – contracts with Tennessee and services were in Tennessee – file to Tennessee
- Host member – services were rendered outside of Tennessee – claim should be filed where services were rendered

For more information about BlueCard, please refer to the BlueCard Program section of the BlueCross Commercial Provider Administration Manual (PAM).

* **Home Plan** – the plan that "owns" the member's coverage

** **Host Plan** – provider's local Blue Cross Blue Shield plan – for Tennessee providers treating members of other Blue Plans, it's BlueCross BlueShield of Tennessee.



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 soon. 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:

- Urinalysis
- Eye exams or X-rays
- Vaccinations

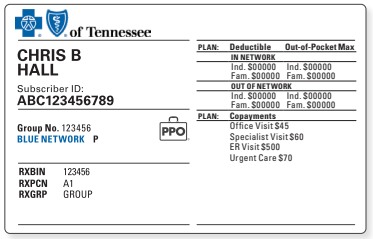
Please continue to visit our telehealth section at **bcbstupdates.com** for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

Commercial

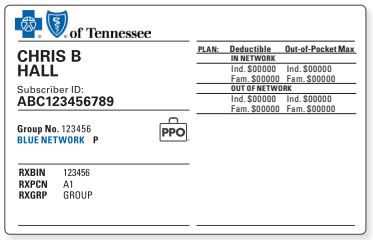
This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

New Requirements for Consolidated Appropriations Act effective Jan. 1, 2022

Starting Jan. 1, 2022, you may have seen changes required by the **Consolidated Appropriations Act (CAA), 2021**. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.



Sample PPO Card



Sample HDHP Card

Member ID Cards

New health insurance ID cards that were issued or downloaded 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

Here are two example cards for common plan types – 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.

Provider Directory

To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to BlueCross in a timely manner. We've listed the new requirements for 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 BlueCross.
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your directory information, you can submit an attestation about your information to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Beginning July 1, 2022, the Transparency in Coverage rule will impose new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage rule** changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make three machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for a TIN using this **link**.

BlueCare Tennessee

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

Cultural Competency Training Reminder

If you're a provider who has participated in BlueCare, TennCareSelect, CoverKids, CHOICES or ECF CHOICES, you can submit a **Cultural Competency Attestation Form** to let us know you've completed your cultural competency training. We help members identify providers who have completed this training in our Provider Directory.

You can take training from sources other than BlueCare Tennessee, as long as it emphasizes the delivery of services in a culturally competent manner. To be eligible for this classification, the training should include information about caring for people with disabilities, diverse cultural and ethnic backgrounds, or limited English proficiency, regardless of their sex. You can also complete brief online training created by BlueCare Tennessee at the links below:

- **508C BlueCare Tennessee Non-discrimination Compliance Information for Providers (bcbst.com)**
- **508C, Cultural Competency in Healthcare (bcbst.com)**

If you have questions about this training, please contact your Provider Network Manager.

View the Latest Behavioral Health Provider Education Resources

Behavioral health is an important part of patient health. Providers like you play a vital role in identifying and treating mental and substance use disorders in your patients. We're here to support you in helping your patients improve and maintain their mental and emotional well-being.

You can access the latest behavioral health provider education resources **here**. You'll find resources about transitions of care, telehealth best practices, Healthcare Effectiveness Data and Information Set (HEDIS®) updates and more.

You can also find BlueCare Tennessee behavioral health resources, including past years' quarterly educational resources, **here** under **Behavioral Health**.

Updated Guidance for Submitting Physical and Occupational Therapy Claims

Beginning July 1, 2022, we'll apply guidelines from the Centers for Medicare & Medicaid Services (CMS) when processing claims for physical and occupational therapy services provided by physical therapy assistants (PTA) and occupational therapy assistants (OTA). Reimbursement for services provided in whole or in part by a PTA or OTA will be limited to 88% of the applicable fee schedule. Claims must also include the appropriate modifier:

- **CQ modifier:** Outpatient physical therapy services provided in whole or in part by a PTA
- **CO modifier:** Outpatient occupational therapy services provided in whole or in part by an OTA

All other billing and processing guidelines associated with physical and occupational therapy services will continue to apply, including prior authorization requirements, coordination of benefits and timely filing. Additionally, all claims submitted to BlueCare Tennessee and CoverKids are subject to retrospective claims review and possible payment recovery.

Join Us for the May 2022 EPSDT Virtual Coding Workshop

Please plan to attend the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coding workshop scheduled for May 12 from 12 p.m. to 2 p.m. CT (1 to 3 p.m. ET). During the virtual session, we'll provide updates, and you'll hear from two Tennessee Chapter of the American Academy of Pediatrics (TNAAP) representatives: Janet Sutton, TNAAP program manager, and Becky Brumley, TNAAP program director/quality coach.

Topics we'll cover include:

- An overview of EPSDT
- Submitting appropriate diagnosis codes and billing procedures
- Submitting claims with appropriate codes and modifiers
- EPSDT documentation requirements
- BlueCare Tennessee Resources

Registration is required for the event. To sign up, please send an email to **CommunityEngagement@bcbst.com** letting us know:

- Your name
- The name of your practice
- Your email address
- 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 on the day of the event. We hope you can attend and look forward to connecting with you.

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

Assess Your Patients' Vision and Hearing During Well-Child Checkups

Vision and hearing screenings are important components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Please let your patients know that we cover vision and hearing screenings through age 20 and refer them to a specialist if you have concerns about their development.

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.

Division of TennCare Pregnancy Benefit Materials Available Online

As announced in the **April 2022 BlueAlert**, your patients with BlueCare and TennCareSelect plans can now keep their coverage for up to 12 months after they give birth. Our members ages 21 and older also now have dental coverage during their pregnancy and for 12 months after. TennCare has prepared materials you can use to educate your patients about the extended benefits. These resources can be downloaded from the **Provider Healthy Mom page** of **bluecare.bcbst.com**.

These extended medical and dental benefits went into effect on April 1, 2022. To access their dental benefits, patients will need to let TennCare know about their pregnancy by calling TennCareConnect at **1-855-259-0701** or visiting **tenncareconnect.tn.gov**.

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

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Submitting Expedited Requests for BlueCare Plus Members

Expedited requests for BlueCare Plus members should only be submitted if applying the standard review time frame of 14 days could seriously jeopardize the member's life, health and/or ability to regain maximum function. All other requests, such as appointments and scheduling, should be submitted as 'non-urgent' and allow for the CMS-mandated 14-day turnaround time. If you have concerns about turnaround times, please contact your Provider Services team at **1-800-299-1407**.

Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus and BlueCare Plus Choice are contractually required to complete our MOC training after initial contracting, then 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**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)SM and BlueCare Plus (HMO D-SNP)SM plans unless specifically identified below.

Care Coordination Tips to Promote Positive Patient Perception in CAHPS® Survey Responses

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) annual survey is used by CMS to evaluate care and services provided to your patients based on their perceptions. Care coordination is one specific category in which your patients are asked to respond to questions.

Incorporating these care coordination tips can help provide your patients with a better experience, help them achieve better health outcomes and can lead to better patient retention:

- Establish a system to follow up on each diagnostic test or lab result. Set appropriate time frames for communicating results and educate patients on when and how they'll receive their results.
- Educate patients on why they're being referred to a specialist and help coordinate the scheduling of referrals and transfer of records.
- Implement reminder systems to follow up with patients to ensure they've attended specialist appointments and that specialist reports are obtained in a timely manner.
- If you know patients received specialty care, discuss their visit and the treatment plan they received at their next clinic or telehealth visit.

Begin Medication Adherence Strategies Early

There are three triple-weighted medication adherence measures included in the Medicare Advantage Quality+ Partnerships program again this year (cholesterol, hypertension and diabetes medications). Each measure looks to see if your patients are filling their prescription(s) enough to cover 80% or more of the time that they're supposed to be taking the medication.

Beginning strategies early in the year is essential to maintain high adherence scores throughout the year. To boost medication adherence with your patients, make sure the patient has refills and current prescriptions on file. Note that prescriptions expire one year after the written date and all refills are canceled. When clinically appropriate, make sure the patient has enough refills to cover the calendar year. If a dose is changed, call the patient's preferred pharmacy, and cancel the old prescription. Be sure to include medication adherence in all visit discussions. Ask the patient to bring all medication bottles with them to their appointment to check fill dates, review contents to see if the pill count matches the fill date and check to see if any prescriptions are missing, duplicated or changed.

Home Meal Benefit After Discharge

BlueAdvantage and BlueCare Plus members have a supplemental benefit to receive prepared, refrigerated meals after they've been discharged from an inpatient stay at an acute hospital or skilled nursing facility. We're working with Mom's Meals NourishCare® to provide this service at no cost to our members.

Members may receive two meals per day for either seven or 14 days, depending on their plan, following discharge from an acute inpatient hospital or skilled nursing facility. There's no limit to how many times a member can qualify for this benefit in a year and most dietary restrictions can be accommodated. A BlueCross case management or care coordination team member can activate the benefit, or the member can contact Mom's Meals directly. Members can also purchase additional meals for an estimated $7 a meal directly after the benefit has ended. For more information, refer to the 2022 Medicare Advantage Quality Information guide **here**.

Inpatient Professional Services Authorization Update

Medicare Advantage requires a prior authorization for all inpatient acute care facility admissions. If you don't get an authorization before providing care, your facility claim will be denied. Beginning with date of service July 1, 2022, if an authorization request for an acute care facility admission is denied or not obtained, all inpatient professional service claims related to the admission will also be denied.

Reminder: Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from Dec. 2021, the Centers for Medicare & Medicaid (CMS) is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directs CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022. Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members. This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Pharmacy

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

BlueCross Coverage Review Forms Available in Covermymeds.com

We wanted to let you know the best way to request approval for coverage reviews for your patients with BlueCross pharmacy benefits is through Cover My Meds. You can do this by visiting their website at **covermymeds.com** or through **Availity**. Once on covermymeds.com, find the BlueCross form by selecting **Tennessee** in the **Patient Insurance State** option. Then, enter the 4336 BIN in the **Plan or PBM Name** field. Please be sure to always use BlueCross forms when submitting coverage review requests for our members.

Note: The information in this article doesn't apply to BlueCare, TennCareSelect or CoverKids.

Prior Authorization Now Required for Some ADHD Medications

We wanted to remind you that as of Jan. 1, 2022, we're requiring a prior authorization for FDA-approved medications for Attention-Deficit/Hyperactive Disorder (ADHD) for members 19 and older. This prior authorization was added to confirm the member has a documented diagnosis supported by the FDA-label and/or CMS-approved compendia.

Please note: This requirement doesn't apply to our members who are 18 and younger. Also, all our members, regardless of age, are subject to the quantity limits for FDA-approved ADHD products. These quantity limits are by the FDA-label and/or CMS-approved compendia.

Prescription Benefit Updates for Covermymeds.com

As of Jan. 1, 2022, our Pharmacy Benefits Manager RXBIN has changed to **004336**. The previous RXBIN was 610014. You'll need to use the new RXBIN 004336 when submitting coverage reviews through **covermymeds.com**. To do this, just log in to **covermymeds.com** and choose **Tennessee** to find the BlueCross BlueShield of Tennessee Commercial review form.

You can also log in to covermymeds.com to submit prior authorization requests digitally. If you have questions, please call our Provider Service line at **1-800-924-7141**.

Note: The information in this article doesn't apply to BlueCare, TennCareSelect or CoverKids.

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 at **provider.bcbst.com**. 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).

No Multiple Units Billed with J3490 or J3590

Billing multiple units with miscellaneous Not Otherwise Classified (NOC) codes for injectables causes delays in reimbursement. When submitting miscellaneous NOC codes, please refer to the Provider Administration Manuals on our website. Medications billed with unlisted, miscellaneous, non-specific NOC codes should be billed with a unit of one and require submission of the drug name, National Drug Code (NDC) and dosage administered in appropriate form as ordered by the provider. Incorrectly submitting this information may result in a delay of reimbursement.

Quality Care Rewards

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

Episodes of Care 2022 Annual Feedback Session Scheduled for May 11

The Division of TennCare is hosting a virtual Annual Feedback Session for the Episodes of Care program on May 11. The event is free, open to all Episodes of Care participants and stakeholders, and will begin at 8 a.m. CT (9 a.m. ET). The goal of the Annual Feedback Session is to share successes, ask questions and recommend changes to improve episode design.

Registration is required, and you can sign up **here**. For more information, **subscribe to TennCare's Episodes of Care newsletter**.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program Reports Available This Month

Quarterbacks participating in the Episodes of Care Program will receive their 2022 Interim Performance Reports for our Medicaid and Commercial lines of business on May 19. Please log in to Availity to review your reports.

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

A Statewide Collaboration for Coordinated Care: The THCII Journey Program

The Division of TennCare and the TennCare managed care organizations have launched a new Tennessee Health Care Innovation Initiative called the Journey Program. For the program, we've selected providers in the BlueCare network to exit the Episodes of Care program and serve as a regional Journey Partner. These Journey Partners are responsible for all episode-related costs of care and clinical outcomes in their region for two low-volume episodes: total joint replacement and bariatric surgery. The goal of the Journey Program is to ease challenges that influence the cost and quality of care for these procedures and aren't addressed by the Episodes of Care Program.

Your Role in the Journey Program

We're encouraging primary care providers in the Episodes of Care Program to refer their patients to their regional Journey Partner if they need this level of care. The Journey Partners in each region are:

- OrthoTennessee – total joint replacement (East)
- Premier Surgical Associates – bariatric surgery (East)
- Bone and Joint Institute of Tennessee – total joint replacement (Middle)
- Middle Tennessee Surgical Associates – bariatric surgery (Middle)
- West Tennessee Bone and Joint – total joint replacement (West)

The Journey Program provides an extra layer of support for eligible patients by connecting them with a BlueCare Tennessee clinical care manager and health navigator, who will help coordinate the care process. This BlueCare Tennessee team can help with things like scheduling appointments with the regional Journey Partner and coordinating any travel and lodging needs, medical records transfer, and postoperative care, including follow-up care and rehabilitation.

For more information about the Journey Program and the patient experience, please review our **Provider FAQs**.

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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**.

of Tennessee

JUNE 2022

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

Register for the 2022 All Blue Workshop℠

Registration for this year's All Blue Workshop officially opens June 7. Just click **here** to sign up for the full-day, virtual event, which is set for Thursday, Aug. 4. You can also register by visiting the All Blue Workshop page on **provider.bcbst.com**. Space is limited, so be sure and register soon. For more information, please contact your Provider Network Manager.

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 June 1, 2022.

Some examples of telehealth claims mistakenly received that we'll deny:

- 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.

Submitting Medical Records to BlueCard®

When submitting medical records to BlueCard, include the medical records request letter or a cover page containing the member's ID (including the alpha prefix), name and date of service, then fax to **(423) 535-3609** or **1-800-495-1944**.

Medical records must be returned within 10 (calendar) days from the date of the medical records request letter. Please help us make sure we're reviewing all records in a timely manner by following these steps to avoid delays in payment.

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 Aug. 1, 2022, CPT® code 0104U won't require prior authorization through eviCore's Genetic Testing Program. However, these codes have been added and will require prior authorization:

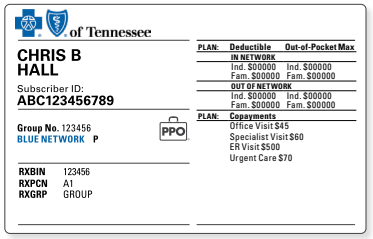
0002M	0120U	0134U	0244U	0314U	0326U
0003M	0129U	0135U	0245U	0315U	0329U
0017M	0130U	0136U	0246U	0317U	0331U
0111U	0131U	0137U	0306U	0318U	
0114U	0132U	0138U	0307U	0319U	
0118U	0133U	0242U	0313U	0320U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity®**, clicking **Patient Registration** and then **Eligibility and Benefits Inquiry**.

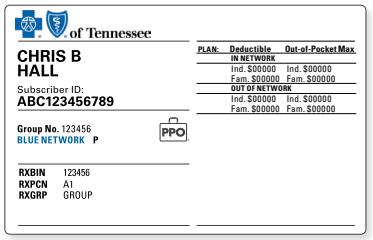
Prior authorization requests can be submitted through Availity, by fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

On Jan. 1, 2022, changes required by the **Consolidated Appropriations Act (CAA), 2021 took effect**. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.



Sample PPO Card



Sample HDHP Card

Member ID Cards

New health insurance ID cards that were issued or downloaded 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

Here are two example cards for common plan types – 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.

Provider Directory

To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for 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 we request it.
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Beginning July 1, 2022, the Transparency in Coverage rule will impose new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for a TIN using this **link**. For step-by-step instructions, refer to our **How to Change from a Social Security Number to Tax Identification Numbe**r Quick Reference Guide on Availity's Resource page.

Mid-Year Drug List Changes

Beginning Aug. 1, 2022, we're removing the drugs below from our Preferred Drug List for Commercial lines of business. We'll send letters to any members impacted by this change. If you have patients currently prescribed these medications, please consider prescribing a covered alternative.

We're grandfathering all active prior authorizations for members until their normal expiration date. The authorization will be valid through Dec. 31, 2022, or up to the authorization's expiration date — whichever comes first.

To see the full list of covered drugs and preferred alternatives, please review the **2022 Preferred Formulary Guide**. If you have questions, please contact your Provider Network Manager.

Autoimmune Drugs	
ACTEMRA®	SIMPONI®
CIMZIA®	ZEPOSIA®
Olumiant®	KEVZARA® injection
ORENCIA®	SILIQ®
SGLT2 Inhibitors	
INVOKAMET®	INVOKAMET XR®
INVOKANA®	
Anti-Coagulants	
Pradaxa®	

Appropriate Use of Modifiers

When preparing claims for submission, it's important to make sure all appropriate diagnosis codes are assigned to the claim and modifiers are used only when clinically appropriate based on published guidelines.

Our code edits are based on correct coding rules published by the Centers for Medicaid and Medicare Services (CMS) and Current Procedural Terminology (CPT®) coding guidelines to detect potential coding errors and incorrect billing practices, such as:

- Diagnosis indicates unspecified laterality while the procedure code specifies left/right.
- Diagnosis code indicates laterality which is contradicted by the modifier listed on the procedure code.

Additional information related to the appropriate use of modifiers can be found in the CPT® manual, BlueCross BlueShield of Tennessee Provider Manuals and the NCCI manuals on the CMS website.

BlueCare Tennessee

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

Updated Guidance for Submitting Physical and Occupational Therapy Claims

Beginning July 1, 2022, we'll apply guidelines from the Centers for Medicare & Medicaid Services (CMS) when processing claims for physical and occupational therapy services provided by physical therapy assistants (PTA) and occupational therapy assistants (OTA). Reimbursement for services provided in whole or in part by a PTA or OTA will be limited to 88% of the applicable fee schedule. Claims must also include the appropriate modifier:

- **CQ modifier**: Outpatient physical therapy services provided in whole or in part by a PTA
- **CO modifier:** Outpatient occupational therapy services provided in whole or in part by an OTA

All other billing and processing guidelines associated with physical and occupational therapy services will continue to apply, including prior authorization requirements, coordination of benefits and timely filing. Additionally, all claims submitted to BlueCare Tennessee and CoverKids are subject to retrospective claims review and possible payment recovery.

Note: The guidance in this article only applies to professional claims.

Submission of Outpatient Claims Following an Audit

As a reminder, we'll accept outpatient claims from facilities for the outpatient services (e.g., ER visits, observation services, etc.) performed in conjunction with an inpatient admission when our recovery audit vendor has determined that the inpatient admission wasn't medically necessary. We'll process the outpatient claims according to our normal processing and reimbursement rules.

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it's the result of a vendor audit and submit it within 120 days of the date of our remittance advice reflecting recovery of the inpatient claims. If a facility has appealed an audit decision and received a denial, the outpatient claim should be submitted within 120 days of the date of the appeal decision. A copy of the appeal decision should also be submitted to help ensure proper handling of the claim. Additionally, hospitals must maintain documentation to support the services billed on the outpatient claim.

Make Sure You're Up to Date on Reportable Event Management (REM)

Thank you for your continued cooperation with the new REM process, which took effect in Sept. 2021. We're sharing some important reminders about reporting Tier 1 and Tier 2 events.

All Tier 1 events should be reported to the Department of Intellectual and Developmental Disabilities (DIDD) Investigation Hotline at **1-888-633-1313** as soon as possible, but within four hours of witnessing or discovering the event. All Tier 1 and Tier 2 event-related allegations of abuse, neglect and exploitation should also be reported to Adult or Child Protective Services within 24 hours:

- **Adult Protective Services (APS): 1-800-277-8366** (phone), **1-866-294-3961** (fax) or **reportadultabuse.dhs.tn.gov**
- **Child Protective Services (CPS): 1-877-237-0004**

For all types of reportable events, providers must also submit a Reportable Event Form (REF) within one business day. When completing these forms, please remember to complete the Notification Section and the Reporter Details Section. Providers must include the date and time they notified all appropriate entities (APS/CPS, DIDD Hotline, law enforcement, legal representative, BlueCare Tennessee, etc.). They should also include the name of the person completing the REF, the person at the agency reviewing the REF, and a signature and date (the signature can be electronic).

Please submit completed REFs to **DIDD.ReportableEvents@tn.gov** and **ReportableEvents@bcbst.com**. To learn more about REM and download a copy of the REF, please visit **bluecare.bcbst.com/reportitnow**. There, you'll find more information on each type of reportable event, along with further instructions for reporting.

Help Your Patients Stay Up to Date with Preventive Care

It's not always easy to keep children on track with Early and Periodic Screening, Diagnostic and Treatment (ESPDT) exams. Consider these tips to make scheduling easier for your patients – and your practice:

- Schedule a full year of visits for newborns during their first visit. This not only helps new parents plan for upcoming visits, but also keeps a plan of care in place if a visit is missed. For children 2 years and older, schedule the next well-child exam at the end of each appointment. Children and teens covered by BlueCare Tennessee are eligible for well-care visits on the **same schedule recommended by the American Academy of Pediatrics**.
- Make the most of your patient reminder tools, such as letters, text messages and reports.
- Use our **Quality Care Rewards** application to view a list of patients who are past due for preventive services.
- 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 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

TennCare Policy Updates to Behavioral Health Services Furnished by Graduate Students and Candidates for Licensure

Services Furnished by Graduate Students

Effective July 1, 2022, behavioral health services may be provided to our members by a qualified graduate student who's operating in an approved setting and receiving appropriate supervision. Additionally, the agency providing supervision to the student may receive reimbursement from us for the services rendered by the student.

To provide services to our members before attaining a graduate degree, a student must be:

- Currently enrolled in a master's or other graduate-level academic program that has a behavioral health concentration
- Part of a regionally accredited institution
- In a field eligible for licensure in behavioral health in Tennessee such as psychology, social work, professional counseling, or marriage and family therapy
- A trainee for a clinical field placement, practicum, internship, or similar experience as a training requirement for a master's or doctoral degree
- Confirmed by a letter of recommendation from their graduate program
- Formally in agreement (e.g., Memorandum of Understanding) of the placement for a supervised training practice

Behavioral health services rendered by the student must be billed to us under the National Provider Identifier (NPI) and Medicaid identification number of the licensed supervising provider.

Services Furnished by Candidates for Licensure

In the future, the Division of TennCare will allow behavioral health services to be provided to our members by a trainee pursuing licensure when the trainee is qualified to render the services, is receiving appropriate supervision and has obtained a preliminary/provisional license from the appropriate Health Related Board. The individual rendering services to members **must be considered a candidate for licensure**.

Individuals may apply and be approved for a temporary license when seeking licensure as a:

- Psychologist with Health Services Provider (HSP) designation
- Licensed Professional Counselor with Mental Health Services Provider (MHSP) designation
- Licensed Marital and Family Therapist
- Licensed Clinical Social Worker (LCSW)
  - **Note:** The Licensed Master's Social Worker (LMSW) temporary license can't serve as an endpoint for licensure. The candidate must be pursuing licensure as an LCSW through an appropriate supervisory relationship.

For questions about updates to either policy, please contact your Provider Network Manager. If you're unsure of who to contact, **click here**.

Submit Neonatal Intensive Care Unit (NICU) Authorizations in Availity

In the **April 2022 BlueAlert**, we let you know about an additional process for submitting NICU authorizations. We're sharing some updates and letting you know about a new option for sending in these requests through Availity, which will be available June 1, 2022.

As part of our new NICU authorization process updates, facilities may choose to submit authorization requests under the mother's member ID or as soon as the baby is assigned a member ID. We've made updates to the Inpatient Confinement Form in Availity to allow backdating of requests for babies receiving NICU care. This will let you submit requests in Availity once the baby has their own ID and backdate the request to the date of birth. Using Availity, you may receive approvals more quickly because Availity can provide auto-approval of the NICU stay when all criteria are met for inpatient admission.

If you haven't signed up for Availity, please visit **Availity.com** to register for an account. For questions about using Availity, please contact our eBusiness technical support team at **(423) 535-5717, option 2**, or **eBusiness_service@bcbst.com**.

As always, we're happy to help with any discharge or case management needs. You may call us at 1-888-423-0131 with questions, even if the baby doesn't yet have a Member ID.

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.

Step 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. A claim may be denied for non-compliance if prior authorization guidelines aren't followed before giving care. You can read more about non-compliance denials and the process for appealing them in our **BlueCare Tennessee Provider Administration Manual (PAM)**.

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 PAM**.

TennCare's Katie Beckett Program

In 2020, the state of Tennessee implemented the Katie Beckett program for children under 18 with disabilities or complex medical needs who aren't eligible for Medicaid because of their parent's income or assets. Katie Beckett program members receive full Medicaid benefits, including benefits provided under the TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Members participating in the Katie Beckett program may have three separate coverage options:

- Part A – Member has TennCareSelect secondary coverage.
- Part B – Member doesn't have Medicaid coverage. This is considered a Medicaid diversion.
- Part C – Member has Medicaid coverage but no longer qualifies financially for Medicaid. These members are waiting to be recategorized in Part A.

Due to the complexity of care many of these children need, they may be followed by their pediatrician and/or specialist on a regular basis. For continuity of care, it's preferrable these children maintain their current provider relationship. However, providers caring for Katie Beckett members must be in the BlueCare network, and these services must be covered and meet TennCare guidelines.

A nurse care manager is assigned to each member and is responsible for coordination of services. These services are provided to ensure the child's safety and well-being, and they may include paying for medical care that the family's private insurance doesn't cover to help keep families together and support family caregiving.

Consent for Sterilization Form Approval Past Expiration Date

The current **Consent for Sterilization form** that's available to providers on the U.S. Department of Health & Human Services' website has an expiration date that's already past due. We're still accepting this form and we're not denying abortion, sterilization and hysterectomy (ASH) claims based on the expiration date of the form.

If you have questions about claims billing and reimbursement, please refer to the **BlueCare Tennessee Provider Administration Manual**. If you've submitted an ASH claim that you're concerned was inappropriately denied, please contact your Provider Network Manager.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

Clinical Documentation Reminder for Outpatient Professional Services Requiring Prior Authorization

We require clinical documentation to support the medical necessity of outpatient services that require a prior authorization. Please include this clinical documentation with your patient's prior authorization request so we can process it appropriately. If we don't receive the necessary clinical documentation, we'll have to deny the outpatient authorization request.

A New Process for Home Health Administrative Approvals

On April 18, 2022, we started using a new method of processing initial prior authorization requests for home health services submitted in Availity. Initial visits that meet criteria are now automatically approved, over a 60-day time frame. If you request additional visits beyond the 60-day time frame or the number of units initially requested, we'll consider this an extension request, and you'll need to submit supporting documentation.

Look for similar enhancements for initial outpatient therapies coming soon.

Date-of-Service Extensions Amid Public Health Emergency

During the COVID-19 national public health emergency (PHE), we're allowing date-of-service extensions for home health and outpatient therapy authorizations if all visits initially approved aren't completed by the end of the 60-day approval time frame. Date-of-service extensions won't be granted after the PHE ends, which is tentatively scheduled for July 15, 2022.

At that time, providers will need to submit updated clinical information for review and approval if visits aren't completed within 60 days.

Encourage Patients to Stay Active in Warmer Months

A change in season is an excellent time to encourage patients to get creative about their exercise routine and even try something new. Planning these activities with friends and family can help with motivation and prevent boredom.

As temperatures increase, getting outdoors can be an enjoyable way to stay active. Gardening, nature walks and bike rides are a few ways to explore the awakening of spring. Summer is also a great time for physical activity.

As the temperatures grow warmer, suggestions such as swimming or water aerobics, mall walking and bowling are safe and fun alternatives to beat the heat.

As a reminder, BlueAdvantage PPO plans include a fitness membership at no charge with access to fitness centers nationwide. Please encourage your patients to take advantage of this benefit.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus and BlueCare Plus Choice are contractually required to complete our MOC training after initial contracting, then 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**.

Home Health Aides Will Require Prior Authorization Effective July 1, 2022

Beginning July 1, 2022, home health aides (G0156) will require prior authorization. This includes home health aide services being billed with a home health skilled service. Requests should be submitted through **Availity**. Please ensure that the request for authorization includes information verifying that the home health aide was vital to the treatment of the patient's illness or injury. If you have questions about this change, please contact our Utilization Management line by calling **866-789-6314**.

Reminder: Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from Dec. 2021, the Centers for Medicare & Medicaid (CMS) is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directs CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022. Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members. This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Inpatient Professional Services Authorization Update

Medicare Advantage and BlueCare Plus require a prior authorization for all inpatient acute care facility admissions. If you don't get an authorization before providing care, your facility claim will be denied. Beginning with date of service July 1, 2022, if an authorization request for an acute care facility admission is denied or not obtained, all inpatient professional service claims related to the admission will also be denied.

Pharmacy

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

BlueCross Coverage Review Forms Available in Covermymeds.com

We want you to know the best way to request approval for coverage reviews for your patients with BlueCross pharmacy benefits is through Cover My Meds. You can do this by visiting their website at **covermymeds.com** or through **Availity**. Once on **covermymeds.com**, find the BlueCross form by selecting **Tennessee** in the **Patient Insurance State** option. Then, enter the 4336 BIN in the **Plan or PBM Name** field. Please be sure to always use BlueCross forms when submitting coverage review requests for our members.

Note: The information in this article doesn't apply to BlueCare, TennCareSelect or CoverKids.

Prior Authorization Now Required for Some ADHD Medications

On Jan. 1, 2022, we began requiring a prior authorization for FDA-approved medications for Attention-Deficit/ Hyperactive Disorder (ADHD) for members 19 and older. This prior authorization was added to confirm the member has a documented diagnosis supported by the FDA-label and/or CMS-approved compendia.

Please note: This requirement doesn't apply to our members who are 18 and younger. Also, all of our members, regardless of age, are subject to the quantity limits for FDA-approved ADHD products. These quantity limits are by the FDA-label and/or CMS-approved compendia.

Prescription Benefit Updates for Covermymeds.com

As of Jan. 1, 2022, our Pharmacy Benefits Manager RXBIN has changed to **004336**. The previous RXBIN was 610014. You'll need to use the new RXBIN 004336 when submitting coverage reviews through **covermymeds.com**. To do this, just log in to **covermymeds.com** and choose Tennessee to find the BlueCross BlueShield of **Tennessee** Commercial review form.

You can also log in to covermymeds.com to submit prior authorization requests digitally. If you have questions, please call our Provider Service line at **1-800-924-7141**.

Note: The information in this article doesn't apply to BlueCare, TennCareSelect or CoverKids.

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).

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

In late 2022, we'll review BlueCare, TennCareSelect and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2021, and June 30, 2022.

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 2021 and June 2022, 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.

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**.

of Tennessee

JULY 2022

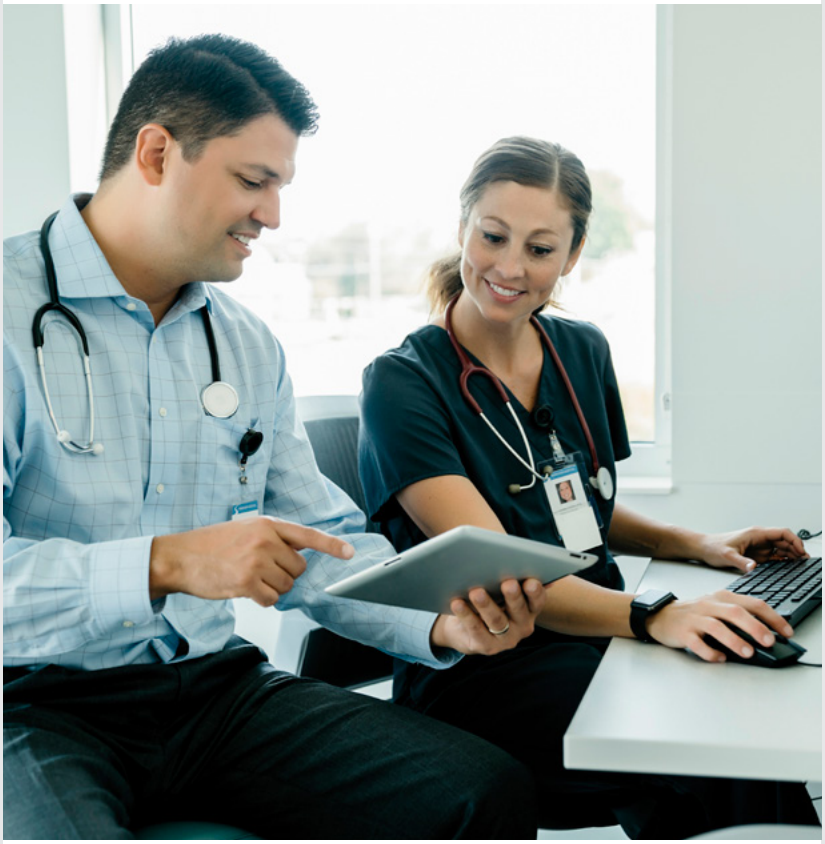
BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

Register for EFT to Complete Your Enrollment

Effective Sept. 16, 2022, all enrolling providers will be required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be credentialed with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity® and **provider.bcbst.com**. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Support. You can also reach out to your Provider Network Manager.

Register Today for the 2022 All Blue Workshop℠

It's not too late to register for this year's All Blue Workshop. Just click **here** to sign up for the full-day, virtual event, which is set for Thursday, Aug. 4. You can also register by visiting the All Blue Workshop **page** on **provider.bcbst.com**. Space is limited, so be sure and register today. If you have questions, you can access our All Blues email two weeks leading up to the event, during the event and two weeks afterward. Just reach out to **ABW_QA_feedback@bcbst.com**. And as always, you can contact your Provider Network Manager for more information.

Commercial

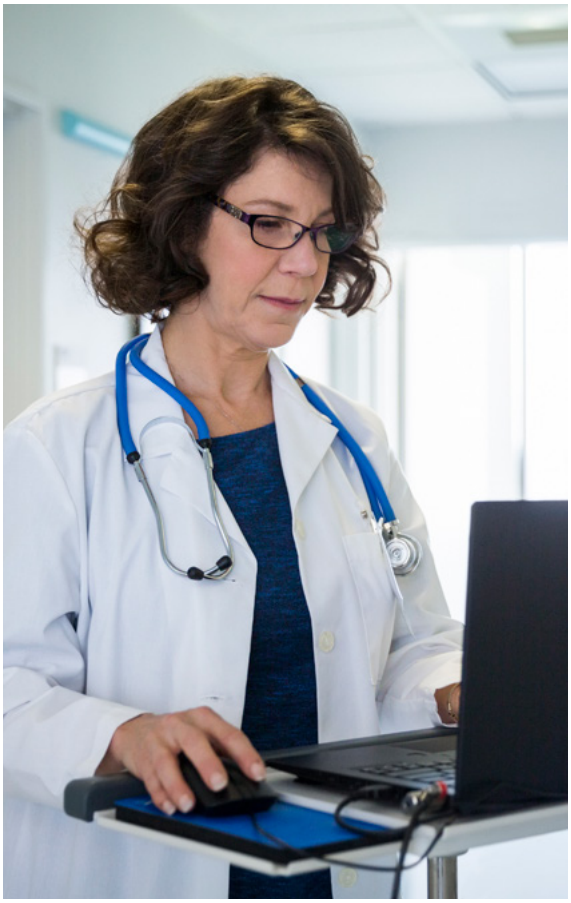
This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Commercial Primary Care Provider (PCP) Performance Ratings to be Refreshed Soon

In January 2020, we introduced a Commercial 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 third annual refresh cycle for this rating.

We'll send notification for this refresh cycle to the email address listed under the contract contact type in Payer Spaces through Availity. The notification will include 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 there isn't a valid email listed in Availity, we'll mail a letter with the same message to the practice.

If you need help updating an email address in Availity, please contact eBusiness Technical Support at **(423) 535-5717 option 2**, or **eBusiness_service@bcbst.com**.



Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Aug. 1, 2022, CPT® code 0104U won't require prior authorization through eviCore's Genetic Testing Program. However, these codes have been added and will require prior authorization:

0002M	0120U	0134U	0244U	0314U	0326U
0003M	0129U	0135U	0245U	0315U	0329U
0017M	0130U	0136U	0246U	0317U	0331U
0111U	0131U	0137U	0306U	0318U	
0114U	0132U	0138U	0307U	0319U	
0118U	0133U	0242U	0313U	0320U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity**, clicking **Patient Registration** and then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity, by fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

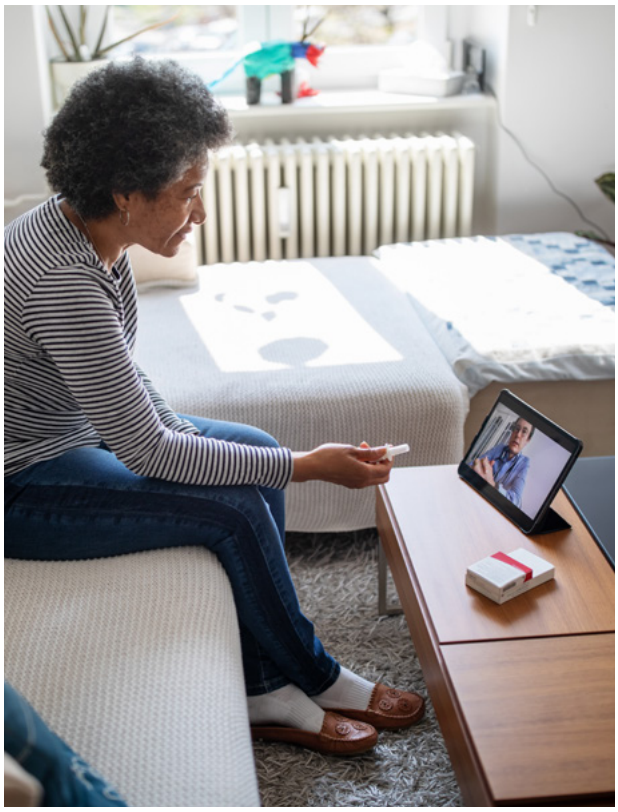
News About Upcoming Telehealth Updates

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 June 1, 2022.

Some examples of telehealth claims mistakenly received that we'll deny:

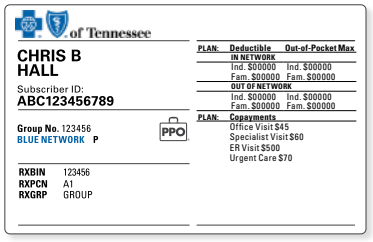
- Urinalysis
- Eye exams or X-rays
- Vaccinations

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.

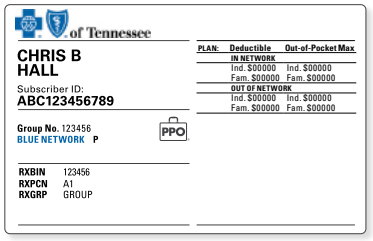


New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

On Jan. 1, 2022, changes required by the **Consolidated Appropriations Act (CAA), 2021, took effect**. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.



Sample PPO Card



Sample HDHP Card

Member ID Cards

New health insurance ID cards that were issued or downloaded 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

Here are two example cards for common plan types – 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.

Provider Directory

To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for 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 we request it.
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Beginning July 1, 2022, the Transparency in Coverage rule will impose new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for a TIN using this **link**. For step-by-step instructions, refer to our **How to Change from a Social Security Number to Tax Identification Number** Quick Reference Guide on Availity's Resource page.

BlueCare Tennessee

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

Mark Your Calendars!

We're hosting another Coding Workshop on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Please plan to join us on Aug. 11 from 12:30 p.m. to 2:30 p.m. CT (1:30 p.m. to 3:30 p.m. ET). We'll cover topics similar to those discussed during our May workshop, including information about EPSDT exams and required documentation. Representatives from the Tennessee Chapter of the American Academy of Pediatrics will also attend.

Be on the lookout for more information coming soon. If you have questions about the event or would like to register, please email **CommunityEngagement@bcbst.com**.

Promoting Childhood and Adolescent Vaccines

Vaccines are a key element of 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.

August is National Immunization Awareness Month, which highlights the importance of vaccinations. Use the months of July and August to encourage families to get caught up on EPSDT visits and routine vaccinations before the beginning of the school year. Reviewing your medical records and the information in our Quality Care Rewards tool can help identify patients who need preventive care and ensure they're up to date.

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

Immunization Administration (IA)

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 (Don't 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
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 (Don't report with 90460 or 90473)
+90472	IA, each additional injected vaccine
90473	IA by intranasal/oral route; one vaccine (Don't 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 isn't performed	

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

Below, we've included links to information from the Centers for Disease Control and Prevention and American Academy of Pediatrics you can use when talking with patients about and administering vaccines.

- See the **CDC Vaccine Toolkit** for a variety of provider resources, including the catch-up schedule for children who've missed a vaccine and information about the COVID-19 vaccine for children and teens.
- **Click here** to review a comprehensive list of all codes commonly administered pediatric vaccines.
- Help minimize patients' COVID-19 exposure with **these tips** from the AAP.
- Review the **immunization schedules** for children and adolescents.

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

BlueCare Tennessee and CoverKids Observation Room Guidelines

As a reminder, BlueCare Tennessee and CoverKids will allow for up to 48 hours of observation services that are medically necessary and appropriate. If an inpatient admission is ordered during the observation stay, the authorization request must be submitted within 24 hours of when the inpatient admission order is made or the next business day.

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.).

The chart below outlines certain scenarios and 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

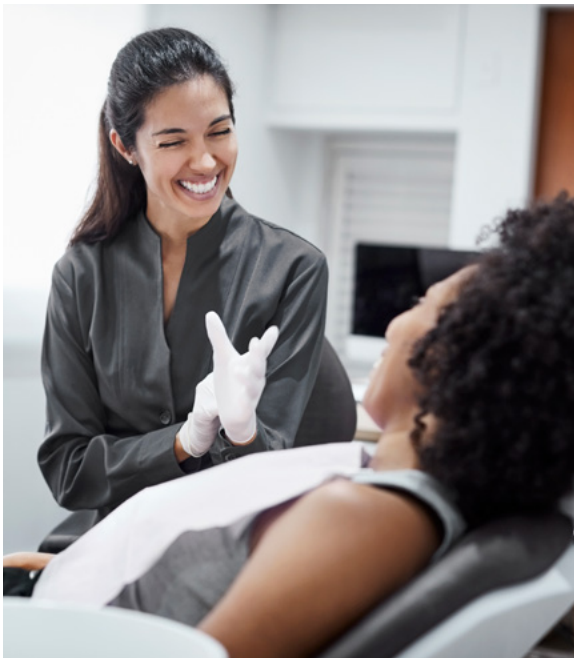
For more information, please see the **BlueCare Tennessee Provider Administration Manual**.

Update on Infant Formula Availability

To increase the availability of infant and specialty formula products, Abbott is releasing limited quantities of metabolic and Similac® PM 60/40 nutrition formulas. These products were previously on hold following a recall of some powder formulas from its Sturgis, Michigan, facility.

Formula will be provided at no charge to patients on a case-by-case basis. All requests must come from the health care provider and require a physician's order, with signature, indicating an urgent need for formula. Formula can be shipped to either a health care facility or the patient's home. To place an order, download the form at **abbottnutrition.com/metabolics**.

Note: Orders for formula can only come from health care providers.



Review Your Patients' Dental Benefits

Your patients with BlueCare coverage are eligible for dental benefits if they:

- Are under age 21
- Are pregnant
- Have recently had a baby (new moms can keep their dental benefits for 12 months after giving birth)

DentaQuest developed a dental health guide for our members, which is available **here**. It includes information about dental coverage and tips for oral health.

Please let your patients know about this dental health resource and the importance of getting dental cleanings and checkups. You can help connect them with a dental provider by calling DentaQuest at **1-855-418-1622** or visiting **dentaquest.com** and selecting **Find a Provider**.

School-Based Services Updates for BlueCare and CoverKids Members

On March 18, 2022, Gov. Bill Lee signed a law that includes changes to specific school-based services, which we've outlined below. These updates take effect on July 1, 2022.

Referrals for Services

Local educational agencies must get a referral or order to bill us for services in a child's individualized education program (IEP). Specifically, the referral or orders for audiology, physical, speech or occupational therapy may come from the child's primary care provider (PCP) or treating provider, or the referring/treating audiologist, physical therapist, occupational therapist or speech-language pathologist. Referrals or orders for all other covered, medically necessary IEP services must come from the child's PCP or treating provider.

School-Based Nursing Services

Effective with date of services beginning July 1, 2022, school-based nursing services providers may also bill for three additional nursing services if they're medically necessary and included in the student's IEP or individual health plan (IHP):

- Assessment and treatment of acute and chronic illnesses
- Blood glucose monitoring and testing
- Medication administration for medically fragile students

We'll continue to reimburse for **other covered, medically necessary services** included in the IEP or IHP. We will contract with any school district seeking to contract with us based on our standard fee schedule.

Timely Filing Guidelines

In July 2021, TennCare extended timely filing to 365 calendar days from the date of service for all medically necessary, covered IEP services. Beginning July 1, 2022, this standard will also apply to all medically necessary, covered school nursing services included in the IHP. These timely filing guidelines apply to both BlueCare and CoverKids members.

School-Based Services for CoverKids Members

You may receive reimbursement for providing medically necessary, covered school-based services to CoverKids members. Covered services include school-based medical services included in the IEP and IHP, and school-based behavioral health services. **Please note:** School-based behavioral health services don't have to be listed in the student's IEP for you to receive payment.

Parental Consent/Notice of Access Forms

The Division of TennCare updated the TennCare Kids Notice of Access Form and the Parent Consent Form that parents or legal guardians must sign to allow agencies to bill for medically necessary, covered school-based services. Based on the updated Parent Consent Form, TennCare will consider the signed Parent Consent Form valid for as long as the student is receiving IEP, IHP or Individualized Family Service Plans (IFSPs) services or until the parent or legal guardian revokes consent. The updated forms are effective with dates of services as of July 1, 2022, and are published in English, Spanish and Arabic.

We'll add these forms to our **BlueCare Tennessee Provider website**. The **Division of TennCare** and **Tennessee Department of Education** will also make the forms available on their websites.

If you have questions about any of the information in this article, please contact the Provider Service line for your patient's plan.

Provider Satisfaction Survey Coming Soon

Providers in the BlueCare and TennCare*Select* networks will receive our 2022 Provider Satisfaction Survey between June and September. When you receive the survey, we hope you'll take the time to share your feedback. We look forward to hearing from you.

To learn more about the survey and how you can participate, please read the Division of TennCare's survey letter, which you can find on the **News and Manuals Provider page** under the **Announcements** header.

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.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

Ways to Help Senior Patients Maintain Physical Fitness

Now is a great time to remind your senior patients about ways to maintain their physical fitness. Using certain tactics for encouragement can be helpful, such as:

- Addressing their fears
- Finding ways to track their stats like charts, day planners and digital devices
- Sharing stories of your personal fitness journey
- Creating a well-rounded plan
- Addressing their physical limitations, dietary restrictions and access to fitness opportunities

Addressing your patient's anxiety toward physical fitness can help them feel like their goals are attainable.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Home Health Aides Will Require Prior Authorization Effective July 1, 2022

Beginning July 1, 2022, home health aides (G0156) will require prior authorization. This includes home health aide services being billed with a home health skilled service. Requests should be submitted through **Availity**. Please ensure that the request for authorization includes information verifying that the home health aide was vital to the treatment of the patient's illness or injury. If you have questions about this change, please contact our Utilization Management line by calling **866-789-6314**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)SM and BlueCare Plus (HMO D-SNP)SM plans unless specifically identified below.

Reminder: Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from Dec. 2021, the Centers for Medicare & Medicaid (CMS) is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage and BlueCare Plus plan capitation payments, plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directs CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022.

Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members. This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Inpatient Professional Services Authorization Update

Medicare Advantage and BlueCare Plus require a prior authorization for all inpatient acute care facility admissions. If you don't get an authorization before providing care, your facility claim will be denied. Beginning with date of service July 1, 2022, if an authorization request for an acute care facility admission is denied or not obtained, all inpatient professional service claims related to the admission will also be denied.

Home Meal Benefit After Discharge

BlueAdvantage and BlueCare Plus (HMO SNP)SM members have a supplemental benefit to receive prepared, refrigerated meals after they've been discharged from an inpatient stay at an acute care hospital or skilled nursing facility. We're working with Mom's Meals NourishCare® to provide this service at no cost to our members.

Members may receive two meals per day for either seven or 14 days, depending on their plan, following discharge from an acute inpatient hospital or skilled nursing facility. There's no limit to how many times a member can qualify for this benefit in a year and most dietary restrictions or special diets can be accommodated. A BlueCross case management or care coordination team member can activate the benefit, or the member can contact Mom's Meals directly. Members can also purchase additional meals for an estimated $7 a meal directly after the meal benefit has ended. For more information, please refer to the 2022 Medicare Advantage Quality Information guide **here**.

Pharmacy

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

Mid-Year Drug List Changes

Beginning Aug. 1, 2022, we're removing the drugs below from our Preferred Drug List for Commercial lines of business. We'll send letters to any members impacted by this change. If you have patients currently prescribed these medications, please consider prescribing a covered alternative.

We're grandfathering all active prior authorizations for members until their normal expiration date. The authorization will be valid through Dec. 31, 2022, or up to the authorization's expiration date — whichever comes first.

To see the full list of covered drugs and preferred alternatives, please review the **2022 Preferred Formulary Guide**. If you have questions, please contact your Provider Network Manager.

Autoimmune Drugs	
ACTEMRA®	SIMPONI®
CIMZIA®	ZEPOSIA®
Olumiant®	KEVZARA® injection
ORENCIA®	SILIQ®
SGLT2 Inhibitors	
INVOKAMET®	INVOKAMET XR®
INVOKANA®	
Anti-Coagulants	
Pradaxa®	

Coverage Review Forms Available in Covermymeds.com

We want you to know the best way to request approval for coverage reviews for your patients with our pharmacy benefits is through Cover My Meds. You can do this by visiting their website at **covermymeds.com** or through **Availity**. Once on **covermymeds.com**, find the BlueCross form by selecting **Tennessee** in the **Patient Insurance State** option. Then, enter the 4336 BIN in the **Plan or PBM Name** field. Please be sure to always use BlueCross forms when submitting coverage review requests for our members.

Note: The information in this article doesn't apply to BlueCare, TennCare*Select* or CoverKids.

Prior Authorization Now Required for Some ADHD Medications

On Jan. 1, 2022, we began requiring a prior authorization for FDA-approved medications for Attention-Deficit/ Hyperactive Disorder (ADHD) for members 19 and older. This prior authorization was added to confirm the member has a documented diagnosis supported by the FDA-label and/or CMS-approved compendia.

Please note: This requirement doesn't apply to our members who are 18 and younger. Also, all of our members, regardless of age, are subject to the quantity limits for FDA-approved ADHD products. These quantity limits are by the FDA-label and/or CMS-approved compendia.

Prescription Benefit Updates for Covermymeds.com

As of Jan. 1, 2022, our Pharmacy Benefits Manager RXBIN haschanged to **004336**. The previous RXBIN was 610014. You'll need to use the new RXBIN 004336 when submitting coverage reviews through **covermymeds.com**. To do this, just log in to **covermymeds.com** and choose **Tennessee** to find the BlueCross BlueShield of Tennessee Commercial review form.

You can also log in to covermymeds.com to submit prior authorization requests digitally. If you have questions, please call our Provider Service line at **1-800-924-7141**.

Note: The information in this article doesn't apply to BlueCare, TennCare*Select* or CoverKids.

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.

Billing for External Insulin Pump Supplies

When billing for external insulin pump supplies used to maintain insulin infusion catheters, the use of span dates (the span of time between the "from and to" dates of service) is required and only billing for the amount of supplies members will use in one month is allowed. One unit of this supply item equals one week of supplies, and the number of units reported should represent the number of weeks in the month billed. If span dates and appropriate units aren't included, your reimbursement may be delayed or incorrect.

If you have questions, please contact your Provider Network Manager or consult the Provider Administration Manuals available on our website.

Note: This article only applies to Commercial and BlueCare Tennessee providers.

Coding Tips for Anesthesiology Claims

Just a friendly reminder that we can process some anesthesiology claims more quickly if you include certain information with your initial claims submissions for the initial review. For a quadratus lumborum block or an erector spinae block with unlisted code 64999, please:

- Indicate whether it's a unilateral or bilateral procedure by including the appropriate modifier(s).
- Indicate whether it's an injection or continuous infusion in the "supplemental information" section of the claim form preceded by the "ZZ" qualifier.

Providing this information up front can help prevent delays in claims processing and reimbursement. If you have questions or need more information, please contact your Provider Network Manager.

Coding Tips for Commercial Home Health Services Claims

Commercial claims for home health services don't require a procedure code. HealthCare Common Procedure Coding System (HCPCS) code T1000, shouldn't be billed on a claim for Commercial Home Health Services. "T" codes are based on HCPCS manual section notes and designed for use by Medicaid state agencies to administer the Medicaid program. Commercial claims inaccurately billed with T1000 will result in the claim being denied and will be the provider's liability without submission of a corrected claim billed in accordance with guidelines found in the **Commercial Provider Administration Manual**.

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

In late 2022, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2021, and June 30, 2022.

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 2021 and June 2022, 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.

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.

QCR Gets New Look with Additional Details

The QCR application is being restructured and will have an updated look. All current functionalities will be available, but now our technical platform will display a tile platform you can use to access the tasks you need more easily. A user guide and diagrams for functionalities will be available on QCR under Resources a few weeks prior to the release. The QCR home page, accessed through Availity, will have additional details and the exact release date.

Episodes of Care Risk-Sharing Updates for 2021 and 2022

To continue supporting providers during the COVID-19 pandemic, the Division of TennCare is waiving Episodes of Care risk-sharing payments for the 2021 performance year. Providers who owe a risk-sharing payment based on their final 2021 episode results won't have to make the payment. Those who've earned a gain-share payment will receive that payment as planned.

Risk-Share Payments Will Resume in 2022

Episodes of Care risk-sharing payments will resume for the 2022 performance year, which began Jan. 1, 2022. Final episode results for the 2022 performance year will be released in August 2023. Providers will know at that time if they owe a 2022 risk-share payment.

For more information, please review the **Division of TennCare memo** outlining these changes.

Note: The information in this article only applies to BlueCare.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program Reports Available in August

Episodes of Care quarterbacks in the Medicaid and Commercial programs will be able to review their final performance reports for the 2021 performance year on Aug. 19, 2022. These reports will be published in Availity.

If you have trouble accessing your reports in Availity, please call **(423) 535-5717 (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**.

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**.

of Tennessee

AUGUST 2022

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

Importance of Using Evidence-Based Screening Tools for Members with Behavioral Health Conditions

We want to make sure all members receive the right care at the right time. Using evidence-based screening tools ensures members are evaluated appropriately for behavioral health conditions.

Our **Behavioral Health provider page** has evidence-based screening tools for a variety of conditions including anxiety, depression, substance use disorders and trauma, along with provider education trainings and more.

Update Your Contact Preferences in Availity®

If you'd like to get important email messages that apply to you, simply update your Contact Preferences through our Payer Spaces in **Availity**. There, you can make email your preferred communication method for each of these communication types and learn more about the roles required for each contact type:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in the BlueCross Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications about available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application Note: You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, electronic funds transfer and tax-related items	Financial Reports

* Availity roles can update contact info and download the messages and attachment.

** For the Quality & Clinical contact type, you only need one of the roles listed.

You Can Update Your Contact Preferences By:

1. Logging in to **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verifying your **Provider Name** and **National Provider Identifier (NPI)** and clicking **Submit**. **Tip:** If you don't see your name in 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.
5. 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 updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all your possible contact types.

In some cases, it may take time to receive these messages via email, and you may temporarily receive them as you did before. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. 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, please log in to **Availity** or contact our eBusiness Service team at **(423) 535-5717** (option 2).

Register for EFT to Complete Your BlueCross Enrollment

Effective Sept. 16, 2022, all new enrolling providers will be required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with BlueCross. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness support. You can also reach out to your Provider Network Manager.

Commercial

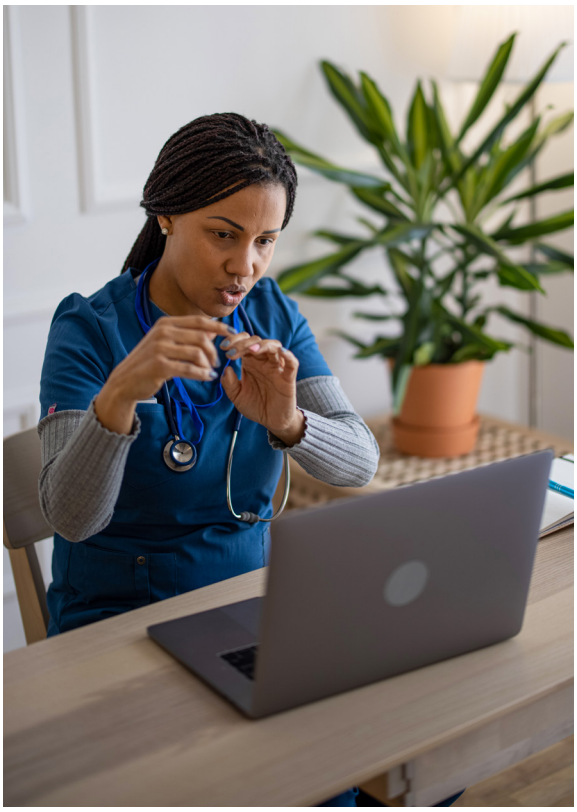
This information applies to Blue Network P℠, Blue Network S℠ and Blue Network L℠ unless stated otherwise.

Making the Most out of Availity Searches

When a patient doesn't have their Member ID card on hand, there are several ways to search for them in Availity, including:

- Patient ID
- Patient Social Security number (SSN)
- Patient last name, first name and date of birth (DOB)

If you choose to search for the patient by SSN, we recommend that you also add the patient's last name, first name and DOB to your search parameters. While it's possible to find patient details using their SSN, many of our lines of business no longer allow SSN data. If you're searching just by SSN, you might miss other available records, which can cause additional phone calls and member frustration. Adding this information or transitioning away from SSN searches can help you find records more consistently and will better protect member data by reducing reliance on SSN data.



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 we started denying inaccurate telehealth claims June 1, 2022.

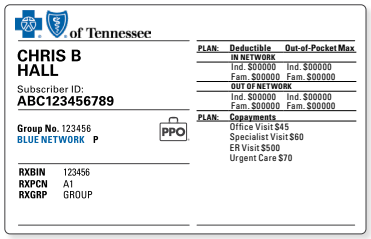
Some examples of telehealth claims mistakenly received that we'll deny:

- Urinalysis
- Eye exams or X-rays
- Vaccinations

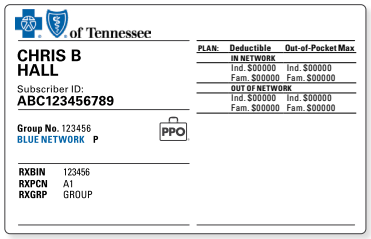
Please continue to visit our telehealth section at **bcbstupdates.com** for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

On Jan. 1, 2022, changes required by the **Consolidated Appropriations Act (CAA), 2021**, took effect. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.



Sample PPO Card



Sample HDHP Card

Member ID Cards

New health insurance ID cards that were issued or downloaded 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

Here are two example cards for common plan types – a preferred provider organization (PPO) plan and a high-deductible health plan (HDHP) with in-network and OON benefits. Actual cards may differ based on plan specifics.

Provider Directory

The CAA requires us to maintain a public database of our network providers. To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for 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 we request it.

- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the provider and balance billing
- OON air ambulance if the services would've beencovered if provided by an in-network air ambulance provider

Delayed Enforcement of the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Beginning July 1, 2022, the Transparency in Coverage rule will impose new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes include:

Machine Readable Files – Beginning July 1, 2022

We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for a TIN using this **link**. **Please note:** the IRS refers to the TIN asan Employee Identification Number (EIN), so please follow their instructions for applying for an EIN.

For step-by-step instructions about other processes related to this change, refer to our **How to Change From a Social Security Number to Tax Identification Number** Quick Reference Guide in Availity's Resource page.

BlueCare Tennessee

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

Register for Our EPSDT Coding Workshop Today

It's not too late to sign up for the EPSDT Coding Workshop scheduled for Aug. 11. Join us from 12:30-2:30 p.m. CT (1:30-3:30 p.m. ET) for coding information and to hear from two representatives from the Tennessee Chapter of the American Academy of Pediatrics. Topics we'll cover are similar to those discussed during our May workshop and include:

- An overview of EPSDT
- Submitting appropriate diagnosis codes and billing procedures
- Submitting claims with appropriate codes and modifiers
- EPSDT documentation requirements
- BlueCare Tennessee resources

Registration is required. For more information or to sign up for the event, please email **CommunityEngagement@bcbst.com**.

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

Help Your Patients Get Ready for the New School Year

As the new school year begins, consider checking in with your patients to make sure they're up to date on preventive care. You can use our **Quality Care Rewards** application in Availity to find out which patients are past due for a checkup or 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.

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

Process Clarification: Billing for Inpatient Services

Inpatient care for observation, surgical procedures, diagnostic tests and other treatments is subject to retroactive audit. To meet the criteria for an inpatient stay, patients must generally receive care for at least 48 hours. Unless medical records support the reason for the inpatient admission, we'll recoup the payment.

Please note: We'll continue to conduct retrospective medical necessity audits on inpatient care lasting more than 48 hours. If we determine services could've been performed safely in a less costly setting with no harm to the patient, we'll recover funds according to our audit recovery procedures.

If we recoup payment because the claim doesn't meet required criteria, providers have the option to file a corrected claim for outpatient services provided during the hospital visit.

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

Be on the Lookout for Southeastrans Information Requests

When BlueCare and TennCare*Select* 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.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Durable Medical Equipment (DME) Vendors Must Provide Clinical Proof for Member Bed Needs

DME vendors requesting beds for our members with chronic obstructive pulmonary disease (COPD) or congestive heart failure diagnoses must submit clinical proof of each member's level of function and/or capabilities for the order to be considered for approval.

According to the Centers for Medicare & Medicaid Services (CMS), the member's level of function/capabilities must be defined under the coverage database LCD L33820.

Note: To date, we don't perform single case agreements for participating providers including DME, home health and post-acute facilities.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Statin Therapy Considerations for Patients with Diabetes and Cardiovascular Disease

CMS has three statin measures in the Star ratings program. Along with medication adherence for statins, CMS includes statin therapy for people with cardiovascular disease and statin use for people with diabetes. These measures focus on two of the major statin benefit populations described in American College of Cardiology and American Heart Association guidelines, and they align with recommendations from the American Diabetes Association. Both statin prescribing measures recommend statin therapy for people with either cardiovascular disease or diabetes regardless of cholesterol levels.

If a patient shows intolerance, but not contraindication to a statin medication, consider these options:

- Assess the patient for drug interactions.
- Check for contributing factors such as hypothyroidism or vitamin D deficiency.
- Switch to a more hydrophilic statin.
- Try alternate day-dosing with a long-acting statin and write the prescription accordingly.

To improve patient adherence to statins:

- Clarify statin benefits. Explain the importance of statins for diabetes patients older than 40, regardless of low-density lipoprotein (LDL) levels.
- Put statin risks in perspective. Liver disease linked to statins is very rare. Statins don't cause dementia or cancer. Muscle pain is rarely harmful.
- Avoid relying on supplements. Fish oil supplements aren't a reliable substitute for statins and red yeast rice isn't safer than statins.

Patients with Diabetes Need Statin Medication Fills

The American College of Cardiology and the American Heart Association guidelines recommend moderate- to high-intensity statin therapy for primary prevention of atherosclerotic cardiovascular disease (ASCVD) in patients with diabetes.

One of the 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 receive a prescription for a statin medication.* The first diabetes medication fill must occur at least 90 days before the end of the measurement year. One fill of a statin medication will satisfy the requirement for this measure with no dosage minimum.

Patients are excluded from this measure if they:

- Are pregnant, breastfeeding or taking fertility treatment.
- Are receiving hospice services.
- Experience an adverse effect from an antihyperlipidemic or antiarteriosclerotic drug at any time in the measurement year.
- Have end-stage renal disease, rhabdomyolysis, myositis, myopathy, cirrhosis, pre-diabetes or polycystic ovarian syndrome.

Note: The diagnosis code for the applicable condition must be submitted on a claim to exclude the patient, and patients must be excluded each measurement year.

* Doesn't include dapagliflozin and empagliflozin medications.

Step Therapy for Additional Medicare Part B Drugs

Beginning August 1, 2022, BlueAdvantage and BlueCare Plus will implement step therapy for additional Part B drugs. This will affect members who are new to therapy. Prior authorization and step therapy will be in line with CMS regulations and will be required for these Part B drugs:

- Cortrophin® Gel
- Hyaluronic acid derivatives
- Soliris®
- Vabysmo®

These updates and existing step therapy requirements can be found on our **Part B Step Therapy Reference Guide**.

Components of the Transitions of Care Measure

The Medicare Advantage and BlueCare Plus Quality+ Partnerships Programs for 2022 include the Transitions of Care (TRC) measure. The TRC measure is made up of four components:

- Notification of Inpatient Admission (NIA)
- Receipt of Discharge Information (RDI)
- Patient Engagement After Inpatient Discharge (PEID)
- Medication Reconciliation Post-Discharge (MRP)

Each component receives its own rate, and the four rates are averaged together to determine the overall TRC measure rate and Star level. The information for the NIA and RDI components is gathered from medical record review during Medicare Advantage's annual supplemental data collection project. The PEID component information comes from administrative claims reporting. The MRP component information comes from administrative claims reporting and/or attestation in the Quality Care Rewards application in Availity.

Please refer to our guide **here** for more information on this measure. Practices not participating in the supplemental data collection project will need to contact their local Medicare Advantage Provider Quality Consultant for information on how to receive credit for this measure.

Reminder: Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from December 2021, CMS is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan and BlueCare Plus plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directed CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022.

Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members. This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Tips for Coding Professionals

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Billing for External Insulin Pump Supplies

When billing for external insulin pump supplies used to maintain insulin infusion catheters, providers must use span dates (the span of time between the "from and to" dates of service) and only bill for the amount of supplies members will use in one month. One unit of this supply item equals one week of supplies, and the number of units reported should represent the number of weeks in the month billed. If span dates and appropriate units aren't included, your reimbursement may be delayed or incorrect.

If you have questions, please contact your Provider Network Manager or consult the Provider Administration Manuals available on our website.

Note: This article only applies to Commercial and BlueCare Tennessee providers.

Coding Tips for Commercial Home Health Services Claims

Commercial claims for home health services don't require a procedure code. Healthcare Common Procedure Coding System (HCPCS) code T1000 shouldn't be billed on a claim for Commercial Home Health Services. "T" codes are based on HCPCS manual section notes and designed for use by Medicaid state agencies to administer the Medicaid program. If Commercial claims are inaccurately billed with T1000, the claim will be denied, and the provider will be liable if they don't submit a corrected claim billed in accordance with guidelines found in the **Commercial Provider Administration Manual**.

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- Indicate whether it's a unilateral or bilateral procedure by including the appropriate modifier(s).
- Indicate whether it's an injection or continuous infusion in the "supplemental information" section of the claim form preceded by the "ZZ" qualifier.

Providing this information up front can help prevent delays in claims processing and reimbursement. If you have questions or need more information, please contact your Provider Network Manager.

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

In late 2022, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2021, and June 30, 2022.

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 2021 and June 2022, 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.

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

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Quality Care Rewards

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

Medicaid Episodes of Care Risk-Sharing Updates for 2021 and 2022

To continue supporting providers during the COVID-19 pandemic, the Division of TennCare is waiving Episodes of Care risk-sharing payments for the 2021 performance year. Providers who owe a risk-sharing payment based on their final 2021 episode results won't have to make the payment. Those who've earned a gain-share payment will receive that payment as planned.

Note: The information in this article only applies to BlueCare.

Medicaid Risk-Share Payments Will Resume in 2022

Episodes of Care risk-sharing payments will resume for the 2022 performance year, which began Jan. 1, 2022. Final episode results for the 2022 performance year will be released in August 2023. Providers will know at that time if they owe a 2022 risk-share payment.

For more information, please review the **Division of TennCare memo** outlining these changes.

Note: The information in this article only applies to BlueCare.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program Reports Available in August

Episodes of Care quarterbacks in the Medicaid and Commercial programs will be able to review their final performance reports for the 2021 performance year on Aug. 19, 2022. These reports will be published in Availity.

If you have trouble accessing your reports in Availity, please call **(423) 535-5717** (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

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- 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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All other inquiries	1-800-705-0391
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BlueAdvantage	1-800-924-7141
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Important Note:

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of Tennessee

SEPTEMBER 2022

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

All Lines of Business

(Unless Stated Otherwise)

Register for Electronic Funds Transfer to Complete Your BlueCross Enrollment

Effective Sept. 16, 2022, all new enrolling providers will be required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

INSIDE THIS ISSUE

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Technical Support. You can also reach out to your Provider Network Manager.

News About 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 we started denying inaccurate telehealth claims June 1, 2022.

Some examples of telehealth claims mistakenly received that we'll deny:

- Urinalysis
- Vaccinations
- Eye exams or X-rays

Please continue to visit **bcbstupdates.com** for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

Update Your Contact Preferences in Availity®

If you'd like to get important email messages that apply to you, simply update your **Contact Preferences** through our Payer Spaces in **Availity**. There, you can make email your preferred communication method for each of these communication types and learn more about the roles required for each contact type:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in the BlueCross Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications about available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application **Note:** You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, electronic funds transfer and tax-related items	Financial Reports

* Availity roles can update contact info and download the messages and attachment.
** For the Quality & Clinical contact type, you only need one of the roles listed.

You Can Update Your Contact Preferences By:

1. Logging in to **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verifying your **Provider Name** and **National Provider Identifier (NPI)** and clicking **Submit**. **Tip:** If you don't see your name in 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.
5. 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 updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all your possible contact types.

In some cases, it may take time to receive these messages via email, and you may temporarily receive them as you did before. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. 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, please log in to **Availity** or contact our eBusiness Service team at **(423) 535-5717 (option 2)**.

Commercial

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

BlueCross to Offer Contracts in North Georgia

Effective Nov. 1, 2022, we're offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. With this change, BlueCross BlueShield of Tennessee member claims for services rendered in these three counties will no longer be processed through BlueCard®. Instead, pricing and benefits will be handled by BlueCross BlueShield of Tennessee directly.

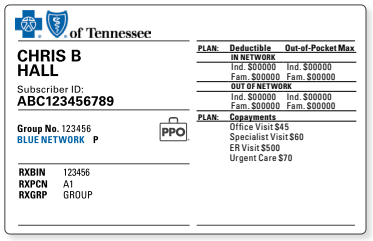
After Nov. 1, 2022, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our **website** and follow the steps for enrollment and credentialing.

For more information, please contact our Provider Service line at **1-800-924-7141** and then follow the prompts to select **Contracts and Credentialing**.

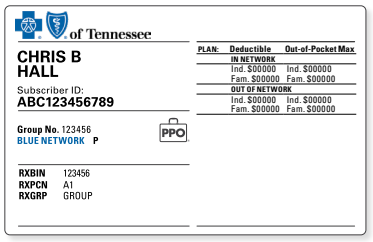
Note: The information in the article above applies to Commercial and Medicare Advantage. It does not apply to FEP.

New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

On Jan. 1, 2022, changes required by the **Consolidated Appropriations Act (CAA), 2021**, took effect. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.



Sample PPO Card



Sample HDHP Card

Member ID Cards

New health insurance ID cards that were issued or downloaded 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

Here are two example cards for common plan types – a preferred provider organization (PPO) plan and a high-deductible health plan (HDHP) with in-network and OON benefits. Actual cards may differ based on plan specifics.

Provider Directory

The CAA requires us to maintain a public database of our network providers. To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for 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 we request it.

- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA now includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the provider and balance billing
- OON air ambulance if the services would've beencovered if provided by an in-network air ambulance provider

Delayed Enforcement of the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

Effective July 1, 2022, the Transparency in Coverage rule imposed new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes included:

Machine Readable Files – Effective July 1, 2022

We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for an Employer Identification Number (EIN) using this **link**.

Please note: the IRS refers to an (EIN) as a federal tax identification number, so please follow their instructions for applying for an EIN.

For step-by-step instructions about other processes related to this change, refer to our **How to Change From a Social Security Number to Tax Identification Number** Quick Reference Guide in Availity's Resource page.

Commercial Peer-to-Peer Medication Review Updates

We've recently updated and refined the eligibility requirements for a pharmaceutical product to have a peer-to-peer review with one of our medical directors. Medications must meet all the requirements to be eligible for a review:

- Medication must not be a plan/benefit exclusion
- The request must be for a Food and Drug Administration (FDA)-approved indication or have credible and/or compendia-based documentation
- All required documentation must be provided by the prescriber unless unavailable required information or the need for a clinical clarification of the required information is the reason for the peer-to-peer request
- The request must have previously received two clinical denials **within the most recent 60 days or less** from a coverage review pharmacist or one clinical denial from a coverage review pharmacist and it's determined that risk may occur with additional delays*. Risks are defined as anything that could:
  - Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment
  - Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state
  - Subject the member to adverse health consequences, in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, without the care or treatment that's the subject of the request

For questions, please reach out to the Provider Service Team.

* Clinical denial is an unfavorable decision completed by the plan using applicable required documentation. It's not defined as an unfavorable decision due to a lack of information.

BlueCare Tennessee

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

Community Treatment Team (CTT) and Comprehensive Child and Family Treatment (CCFT) Levels of Care

Beginning Oct. 1, 2022, CTT and CCFT levels of care will be considered duplicate services to Tennessee Health Link (THL) services. To minimize service disruption and increase timely claim payments, providers need to submit discharge summaries for members who have received CTT or CCFT levels of care within 24 hours post-discharge. Providers should also provide notification to the managed care organization (MCO) if members were authorized but didn't receive care.

For questions, please reach out to your Provider Network Manager.

Process Refresher: Completing CMS-1500/CMS-1450 Claim Forms

BlueCare Tennessee network providers should submit claims for services electronically. We only accept paper claims if technical difficulties or other extenuating circumstances prevent electronic submission. In these cases, providers must be able to demonstrate why filing a paper claim was necessary.

If you submit your claim electronically, but need to send us paper documentation, please use the PWK06 segment (Loop 2300) to indicate you'll be sending documentation separately from the claim. Then, fax the supporting information and PWK coversheet, which is available on our **website**, to **(423) 591-9481**.

Please note: The documentation and fax sheet should be sent on the same day you submit your claim.

For more information and tips for successfully submitting electronic claims, please use the **BlueCare Tennessee Provider Administration Manual**.

Perform All Seven Components of an EPSDT Visit

Early and Periodic Screening, Diagnostic 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
- Complete a physical exam
- Administer lab tests and immunizations as needed
- Perform vision and hearing screenings
- Screen for age-appropriate developmental milestones and behavioral health concerns
- Provide anticipatory guidance for parents and guardians

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**.

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

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Availity Updates for Prior Authorizations

We're working to update Availity on prior authorization notifications and statuses. In the meantime, please contact the Provider Service Line at **1-800-299-1407** to verify notifications received of prior authorizations not needed for specific claims. We apologize for any confusion this may cause.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)SM plans unless stated otherwise.

Hormone Pellets Requiring Prior Authorization

Beginning Oct. 1, 2022, procedure code 11980 **Sub-Q hormone pellet implantation** will require a prior authorization. This implantation code will be considered for reimbursement if the corresponding drug is covered.

For questions, please contact your Provider Network Manager.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)SM and BlueCare Plus (HMO D-SNP)SM plans unless specifically identified below.

Medication Adherence Tips

There are three **triple-weighted** medication adherence measures included in the Medicare Advantage Quality+ Partnerships program (cholesterol, hypertension and diabetes medications). Each measure looks to see if your patients are filling their prescription(s) enough to cover 80% or more of the time that they're supposed to be taking the medication.

To maintain high adherence scores for the remainder of the year, it's essential to focus on medication adherence strategies now. To boost medication adherence with your patients, use the **Pharmacy Reports** tab in the Quality Care Rewards application in Availity® to identify opportunities for patient intervention for medication adherence. Additionally, make sure your patients have refills and current prescriptions on file. Note that prescriptions expire one year after the written date and all refills are canceled. When clinically appropriate, make sure patients have enough refills to cover the remainder of the calendar year. If a dose has changed, call the patient's preferred pharmacy and cancel the old prescription. Be sure to include medication adherence in all visit discussions.

Medicare and DSNP Peer-to-Peer Pharmacy Reviews

Providers can request a pharmaceutical product peer-to-peer review from one of our Medical Directors any time they don't agree with our initial coverage determination or redetermination. To initiate a review, contact your Provider Service Team.

Supplemental Data Collection for Transitions of Care Measure

Practices not participating in the annual supplemental data collection project will need to contact their local Medicare Advantage Provider Quality Consultant for information on how to receive credit for the Notification of Inpatient Admission (NIA) and Receipt of Discharge (RDI) components of the Transitions of Care (TRC) Measure.

The information for the NIA and RDI components is gathered only from medical record review during Medicare Advantage's annual supplemental data collection project. Please refer to our guide **here** for more information on this measure.

Opportunity for Frailty Exclusions

The Centers for Medicare & Medicaid Services (CMS) allows individuals to be excluded from some quality measures when your patients have specific advanced illness and/or frailty diagnoses. Exclusions to these measures are made because the services recommended in the Healthcare Effectiveness Data and Information Set (HEDIS®) definition may not benefit older adults with advanced illness, thus limiting their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes are often not 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 will make the patient eligible 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 walking (R26.2)

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

Reminder: Delay in Reinstatement of Sequestration Payment Reduction

Based on new legislation from December 2021, CMS is further delaying reinstatement of its 2% sequestration payment reduction to BlueCross Medicare Advantage plan and BlueCare Plus plan capitation payments, as well as Original Medicare Part A and Part B payments to providers. The new law directed CMS to begin applying a 1% reduction on April 1, 2022, followed by an additional 1% reduction on July 1, 2022.

Effective as of those same dates, and consistent with the terms of your provider participation agreement(s) and our Provider Administration Manuals (PAMs), we'll implement the same payment reductions for covered services provided to BlueAdvantage, BlueCare Plus and BlueCare Plus Choice plan members. This notice replaces prior communications about our reinstatement of sequestration-related payment reductions. If you have questions or need to discuss further, please contact your Provider Network Manager.

Tips for Coding Professionals

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

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Coding Tip for Billing Global Procedures

Billing globally for services that are split into separate professional component (PC) and technical component (TC) services is only possible when the PC and TC are furnished by the same physician or supplier entity. For example, when the PC and the TC of a diagnostic service are provided in the same service location. In this case, the physician/entity may bill globally. However, if the PC and the TC are each provided in different service locations, the PC and the TC must be billed separately.

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of Tennessee

OCTOBER 2022

BlueAlert℠

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A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

New Customer Service Resource Team for Tennessee Providers

To help support Tennessee-based providers and members, we've assigned a specially trained customer service team who can answer provider questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who are facing a non-viable pregnancy. These representatives are also able to provide information about behavioral health benefits, coverage and eligibility for these members.

To reach the team, please call **866-268-3502**, from 8 a.m. to 6 p.m. ET.

Help Protect Your Patients Against the Flu

Fall signals the beginning of flu season in Tennessee. Consider these tips to help prepare your patients – and team – for the 2022-2023 flu season.

- Talk with families about the importance of the flu vaccine and things they can do to lower their risk of getting sick during cold and flu season.
- Schedule patients' flu vaccines in advance and send appointment reminders. The Centers for Disease Control and Prevention (CDC) recommends that everyone age 6 months and older get a flu shot, preferably by the end of October.
- It's especially important that people 65 years and older get the flu shot because they're at higher risk of serious complications from the flu. The CDC recommends they get a higher dose or an adjuvanted flu shot.
- Changes in the immune system, heart and lungs make pregnant people more prone to serious illness from the flu. Getting vaccinated during pregnancy can protect pregnant people and help protect their babies from flu during the first several months after birth.
- Review patient medical records before visits, including Early and Periodic Screening, Diagnostic and Treatment (ESPDT) exams, to see if patients have already gotten their flu shot. If not, consider administering the vaccines during the visits as appropriate.
- 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. Children need two doses of the flu vaccine at least four weeks apart during their first flu season, and it's often in short supply in February, March and April. To learn more about the CDC's recommendations about the flu season and young children, please click **here**.

Updates to Remit Processing

Effective Nov. 1, 2022, we'll be making updates to when we make electronic remittance advice (ERA) data and paper-equivalent remittance advices available to providers and other trading partners like Availity®. This change may impact you if you're using automated postings of remit data based on ERA files downloaded by your clearinghouse or software vendor, or if you review remittance data via Availity Payer Spaces.

We currently produce remits weekly on Sunday, with a goal to distribute all versions by Wednesday of each week. Our current process allows some lines of business, such as BlueCare Tennessee, to produce files outside the elapsed time requirements established by the Council for Affordable Quality Healthcare (CAQH) for healthcare payments.

According to the regulation, we can't produce ERA files more than three business days prior to the cash concentration and disbursement (CCD+) effective entry date of the associated electronic funds transfer transaction that's sent to your bank for payment. If needed, we may have up to three days after the paid date to have the ERA posted. This means if we send an ERA on Monday for a payment that's dated for Friday of that week, we'll fall outside of this window. To prevent this, remits will be produced on the following schedule:

Claim Type/ Line of Business	Paid Date	PDF/ERA Run Date
Dental	Wednesday	Monday
Hospital	Wednesday	Monday
Physician	Thursday	Monday
BlueCare Tennessee	Friday	Tuesday

As an example, since BlueCare Tennessee has a Friday paid date, we anticipate this change may impact your posting of remits as data won't be available until later in the week. These changes impact the availability of the paper-equivalent PDF files posted in the 'View/Print Remittance Advice' application in Availity Payer Spaces as well as the multi-payer Availity Remittance Advice application that also relies on ERA data.

Our goal will still be to produce all files by Wednesday as that target falls within the three-day window for all payments. But, depending on how your office handles the impacted lines of business, these changes may impact your processes.

If you have questions about this change, please contact eBusiness at **eBusiness_service@bcbst.com**.

Register for Electronic Funds Transfer to Complete Your BlueCross Enrollment

As of September 2022, all new enrolling providers are required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity® and provider.bcbst.com. It's easy, and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Technical Support. You can also reach out to your Provider Network Manager.

News About 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. We started denying inaccurate telehealth claims June 1, 2022.

Some examples of telehealth claims mistakenly received that we'll deny:

- Urinalysis
- Vaccinations
- Eye exams or X-rays

Please continue to visit **bcbstupdates.com** for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

Clinical Laboratory Improvement Amendments -Waived Tests and Modifier QW

The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). Modifier QW is used on a claim to indicate that a test is CLIA-waived and that the reporting physician's practice has a CLIA certificate that allows them to perform and report CLIA-waived tests. Waived tests include test systems cleared by the Food and Drug Administration (FDA) for home use and those tests approved for waiver under CLIA criteria.

Beginning Nov. 1, 2022, any claim billed with modifier QW on a procedure that is not CLIA-waived will be rejected and returned. The list of CLIA-waived tests can be found **here**.

Additional CLIA information can be found on **CMS.gov**.

Commercial

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

BlueCross to Offer Contracts in North Georgia

Effective Nov. 1, 2022, we're offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. With this change, BlueCross BlueShield of Tennessee member claims for services rendered in these three counties will no longer be processed through BlueCard®. Instead, pricing and benefits will be handled by BlueCross BlueShield of Tennessee directly.

After Nov. 1, 2022, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our **website** and follow the steps for enrollment and credentialing.

For more information, please contact our Provider Service line at **1-800-924-7141** and then follow the prompts to select Contracts and Credentialing.

Note: The information in the article above applies to Commercial and Medicare Advantage. It does not apply to FEP.

New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

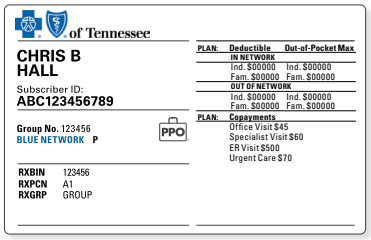
On Jan. 1, 2022, changes required by the **Consolidated Appropriations Act (CAA) 2021**, took effect. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

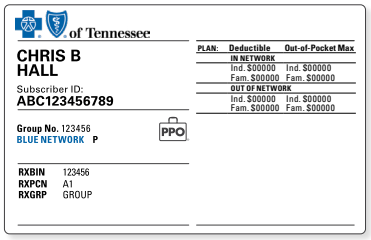
New health insurance ID cards that were issued or downloaded on or after Jan. 1, 2022, will include this additional information:

- 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 example cards for common plan types – a preferred provider organization (PPO) plan and a high-deductible health plan (HDHP) with in-network and OON benefits. Actual cards may differ based on plan specifics.



Sample PPO Card



Sample HDHP Card

Provider Directory

The CAA requires us to maintain a public database of our network providers. To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for when providers should submit their information:
  - When the provider enters in to 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 we request it.
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Effective July 1, 2022, the Transparency in Coverage rule imposed new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes included:

Machine Readable Files – Effective July 1, 2022

We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for an Employer Identification Number (EIN) using this **link**.

Please note: the IRS refers to an (EIN) as a federal tax identification number, so please follow their instructions for applying for an EIN.

For step-by-step instructions about other processes related to this change, refer to our **How to Change From a Social Security Number to Employer Identification Number** Quick Reference Guide in Availity's Resource page.

BlueCare Tennessee

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

Upcoming Applied Behavior Analysis (ABA) Code Changes

Beginning Jan. 2023, providers will be required to use dedicated ABA CPT® codes.

All authorizations obtained before Jan. 1, 2023, will crosswalk (transfer) to the new codes for dates of service beginning Jan. 1, 2023. Providers won't need to get a new authorization for the new codes. They should continue using current codes through Dec. 31, 2022.

For questions, please reach out to your **Provider Network Manager**.

Home Health Providers Should Prepare to Use Electronic Visit Verification Systems

In the **April BlueAlert**, we let you know about an upcoming federal requirement for home health providers who deliver in-home services to Medicaid members. Beginning Jan. 1, 2023, agencies will need to use an electronic visit verification (EVV) system to track member visits. This means home health providers in our BlueCare and TennCare*Select* networks will need to adopt an EVV system or connect their existing system to the Sandata aggregator by Jan. 1, 2023. The Sandata aggregator will allow providers with third-party EVV systems to share data about member visits with us.

We're working with Sandata to help providers meet this requirement, including hosting a series of town halls and agency training. Home health providers will receive more information soon about important dates and documents. For more information or if you have questions about this requirement, please contact your Provider Network Manager.

Updates to the Quest Diagnostics Lab Exclusion List

Please see below for recent and upcoming changes to the Quest Diagnostics® Lab Exclusion List:

- On Aug. 15, 2022, CPT® code 88142 for cervical or vaginal cytopathology was added to the exclusion list.
- Effective Nov. 1, 2022, the following codes will be removed from the list:
  - 80150 – Amikacin
  - 80170 – Gentamicin
  - 80200 – Tobramycin
  - 80202 – Vancomycin
  - 80299 – Methotrexate
  - 82150 – Amylase
  - 83690 – Lipase
  - 83735 – Magnesium
  - 82438 – Sweat chloride

To view the entire updated list, please click **here**.

Review Guidelines for Medicaid and Medicare Provider Enrollment

The Division of TennCare requires certain provider types to enroll in traditional Medicare before requesting a Medicaid ID number. Providers in these categories must enroll in Medicare first, even if they don't see Medicare beneficiaries.

TennCare uses the CMS Provider Enrollment, Chain and Ownership System (PECOS) to confirm applicable providers are enrolled in Medicare. The Division may terminate a provider's Medicaid ID if it discovers a provider isn't enrolled in Medicare. In this case, the provider will receive a letter from TennCare letting them know their ID will be reactivated once they enroll in PECOS.

To review TennCare's policy and a list of the provider types that must enroll in Medicare first, please see the **Provider Screening Requirements Policy 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 such as Lyft, multiple passengers in the vehicle, 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 refund them for the miles traveled.

Scheduling transportation

All 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**

TennCare*Select* **1-866-473-7565**

You may also use the **Southeastrans Provider Portal** to help your patients with scheduling. To request a portal account, email: **tnfacilityportal@southeastrans.com**. Please note you may need to complete an application to access the portal.

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**

TennCare*Select* **1-800-263-5479**

Important Announcement from TennCare: Providers CARE Survey

Good health outcomes start in the communities where your patients live. Starting Oct. 7, 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.

Please complete the survey **here**.

Your answers won't have your name on them and will be combined with information from other providers.

Thank you for caring about the health of your community.

Updated Cultural Competency Training Available Online

We recently updated the **Non-Discrimination Compliance Training** for providers in our BlueCare, TennCare*Select* and CoverKids networks. This training includes information about cultural competency in health care, applicable laws and regulations, tips for providing culturally competent care, and resources for more information.

The Division of TennCare and CMS require us to provide cultural competency training to our network providers. Please review the training, share it with your team, and if you haven't already, submit the **Cultural Competency Training Attestation Form** to let us know that you've completed it. We acknowledge completion of this training in our online provider directory to help members select a provider.

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 and clinical authorization appeals.

Step 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. A claim may be denied for non-compliance if prior authorization guidelines aren't followed before giving care. You can read more about non-compliance denials and the process for appealing them in our **BlueCare Tennessee Provider Administration Manual (PAM)**.

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 PAM**.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus and BlueCare Plus Choice special needs plans are contractually required to complete our Model of Care Training after initial contracting, then 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 **here**.

Clarification of High-Tech Imaging Phone Number

When requesting prior authorization for high-tech imaging, please call Magellan at **1-888-258-3864**. The phone number currently listed in your PAM is incorrect and will be updated during the next quarterly update.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)SM plans unless stated otherwise.

Concurrent Inpatient Submissions

To ensure timely discharge planning, please submit concurrent inpatient extensions by the last approved day. Discharge planning details are required with each update and will limit calls to facilities. Please note, late submissions may cause delays in claims payment.

For questions, please contact your **Provider Network Manager**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)SM and BlueCare Plus (HMO D-SNP)SM plans unless specifically identified below.

Medication Adherence Tips

There are three **triple-weighted** medication adherence measures included in the Medicare Advantage Quality+ Partnerships program (cholesterol, hypertension and diabetes medications). Each measure looks to see if your patients are filling their prescription(s) enough to cover 80% or more of the time that they're supposed to be taking the medication.

To maintain high adherence scores for the remainder of the year, it's essential to focus on medication adherence strategies now. To boost medication adherence with your patients, use the **Pharmacy Reports tab** in the Quality Care Rewards application in Availity to identify opportunities for patient intervention for medication adherence. Additionally, make sure your patients have refills and current prescriptions on file. Note that prescriptions expire one year after the written date and all refills are canceled. When clinically appropriate, make sure patients have enough refills to cover the remainder of the calendar year. If a dose has changed, call the patient's preferred pharmacy and cancel the old prescription. Be sure to include medication adherence in all visit discussions.

Supplemental Data Collection for Transitions of Care Measure

Practices not participating in the annual supplemental data collection project will need to contact their local Medicare Advantage Provider Quality Consultant for information on how to receive credit for the Notification of Inpatient Admission (NIA) and Receipt of Discharge (RDI) components of the Transitions of Care (TRC) Measure.

The information for the NIA and RDI components is gathered only from medical record review during Medicare Advantage's annual supplemental data collection project. Please refer to our guide **here** for more information on this measure.

Patients with Diabetes Need Statin Medication Fills

The American College of Cardiology and the American Heart Association guidelines recommend moderate- to high-intensity statin therapy for primary prevention of atherosclerotic cardiovascular disease (ASCVD) in patients with diabetes.

One of the 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 receive a prescription for a statin medication.* The first diabetes medication fill must occur at least 90 days before the end of the measurement year. One fill of a statin medication will satisfy the requirement for this measure with no dosage minimum.

Patients are excluded from this measure if they:

- Are pregnant, breastfeeding or taking fertility treatment.
- Are receiving hospice services
- Experience an adverse effect from an antihyperlipidemic or antiarteriosclerotic drug at any time in the measurement year
- Have end-stage renal disease, rhabdomyolysis, myositis, myopathy, cirrhosis, pre-diabetes or polycystic ovarian syndrome

Note: The diagnosis code for the applicable condition must be submitted on a claim to exclude the patient, and patients must be excluded each measurement year.

* Doesn't include dapagliflozin and empagliflozin medications.

Pharmacy

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

2023 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 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 2023 drug list changes:

- **2023 Preferred Formulary Changes**
- **2023 Essential Formulary Changes**
- **2023 BlueAdvantage Formulary**
- **2023 BlueCare Plus Formulary**

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.

Quality Care Rewards

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

BlueCare Episodes of Care Reporting Update

We're writing to share an update about the Aug. 2022 Interim Reports for the BlueCare Episodes of Care program. The Aug. 2022 Interim Reports for the Asthma episode of care didn't contain a new informational quality metric for the 2022 performance period. The new metric, "Follow-Up Care for Newly-Diagnosed Asthma Cases," will be included in the Nov. 2022 reports for episodes ending in the first or second quarter of 2022.

Note: This article only applies to BlueCare.

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.

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

Before the end of 2022, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2021, and June 30, 2022.

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 2021 and June 2022, 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 PAM** or contact your Provider Network Manager.

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).

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**.

of Tennessee

NOVEMBER 2022

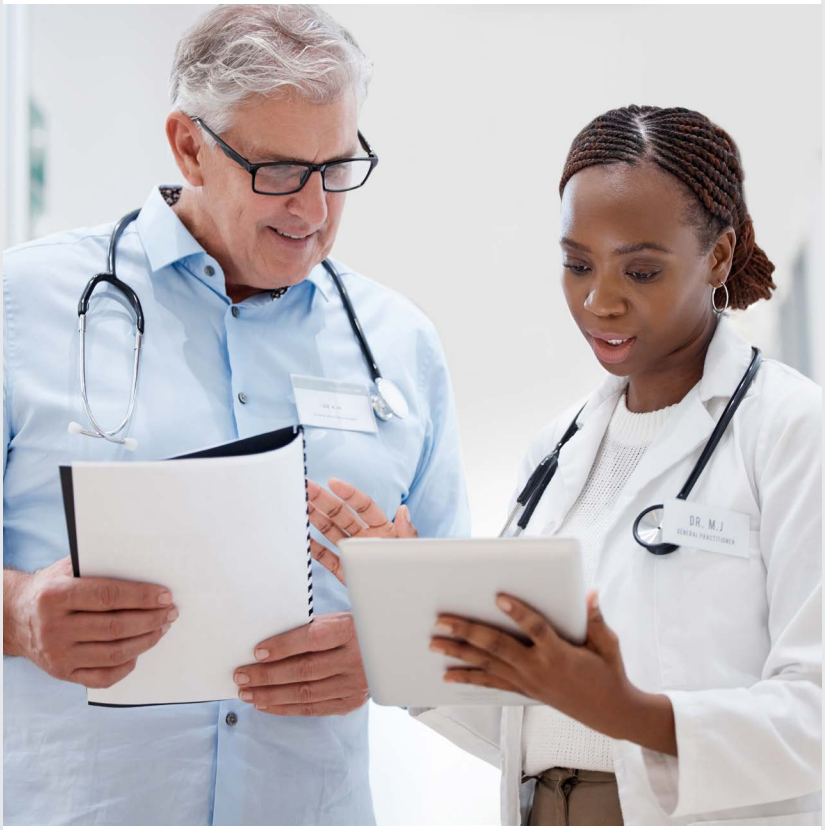
BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

New Customer Service Resource Team for Tennessee Providers

To help support Tennessee-based providers and members, we've assigned a specially trained customer service team who can answer provider questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who are facing a non-viable pregnancy. These representatives are also able to provide information about behavioral health benefits, coverage and eligibility for these members.

To reach the team, please call **866-268-3502**, from 8 a.m. to 6 p.m. ET.

Register for Electronic Funds Transfer to Complete Your BlueCross Enrollment

As of September 2022, all new enrolling providers are required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity® and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

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- Vaccinations
- Eye exams or X-rays

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Commercial

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

Changes to Home Health and Therapy Authorizations

Beginning Jan. 1, 2023, home health and therapy authorizations will only be valid on a calendar-year basis from Jan. 1 through Dec. 31. Authorizations extending into the next year will have a new case and an updated authorization reference number.

BlueCross to Offer Contracts in North Georgia

Effective Nov. 1, 2022, we're offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. With this change, BlueCross BlueShield of Tennessee member claims for services rendered in these three counties will no longer be processed through BlueCard®. Instead, pricing and benefits will be handled by BlueCross BlueShield of Tennessee directly.

After Nov. 1, 2022, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our **website** and follow the steps for enrollment and credentialing.

For more information, please contact our Provider Service line at **1-800-924-7141** and then follow the prompts to select Contracts and Credentialing.

New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

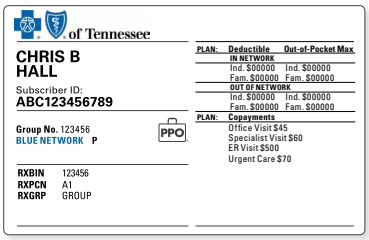
On Jan. 1, 2022, changes required by the Consolidated Appropriations Act (CAA) 2021 took effect. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

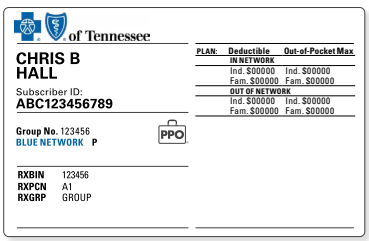
New health insurance ID cards that were issued or downloaded on or after Jan. 1, 2022, will include this additional information:

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

Here are two example cards for common plan types – a preferred provider organization (PPO) plan and a high-deductible health plan (HDHP) with in-network and OON benefits. Actual cards may differ based on plan specifics.



Sample PPO Card



Sample HDHP Card

Provider Directory

The CAA requires us to maintain a public database of our network providers. To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for 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 we request it
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in **Availity**. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. We must receive a response for every Data Verification Form.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Effective July 1, 2022, the Transparency in Coverage rule imposed new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes included:

Machine Readable Files – Effective July 1, 2022

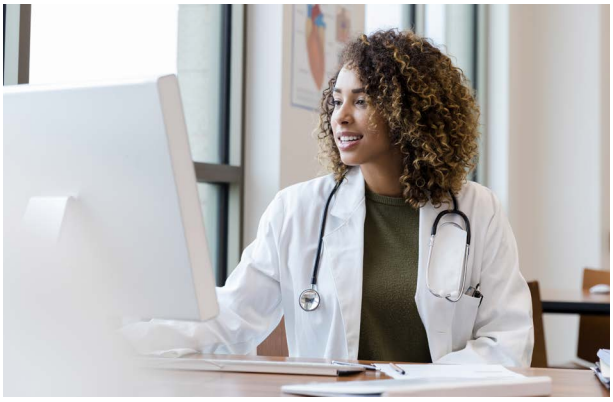
We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for an Employer Identification Number (EIN) using this **link**.

Please note: the IRS refers to an (EIN) as a federal tax identification number, so please follow their instructions for applying for an EIN.

For step-by-step instructions about other processes related to this change, refer to our **How to Change From a Social Security Number** to Employer Identification Number Quick Reference Guide in Availity's Resource page.



BlueCare Tennessee

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

Home Health Providers Should Prepare to Use Electronic Visit Verification Systems

In the **April BlueAlert**, we let you know about an upcoming federal requirement for home health providers who deliver in-home services to Medicaid members. Beginning Jan. 1, 2023, agencies will need to use an electronic visit verification (EVV) system to track member visits. This means home health providers in our BlueCare and TennCare*Select* networks will need to adopt an EVV system or connect their existing system to the Sandata aggregator by Jan. 1, 2023. The Sandata aggregator will allow providers with third-party EVV systems to share data about member visits with us.

We're working with Sandata to help providers meet this requirement, including hosting a series of town halls and agency training. Home health providers will receive more information soon about important dates and documents. For more information or if you have questions about this requirement, please contact your Provider Network Manager.

Review the Coding Guidelines for Maternity Care Payments

As part of our Maternity Care Program, providers can earn payments in addition to regular reimbursements for maternity care when certain guidelines and coding requirements are met. These payments are available when administering prenatal care, postnatal care and mental health screening to patients with BlueCare, TennCare*Select* or CoverKids coverage.

For more information, please see our **Maternity Care Program page** in the Provider Tools and Resources section of bluecare.bcbst.com. Here, you'll also find more information about our members' maternity benefits and incentives that may be available for getting maternity care.

Tennessee Healthcare Innovation Initiative (THCII) Episodes of Care Program News and Updates

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available Nov. 17, 2022. 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**.

BlueCare Episodes of Care Reporting Update*

The Aug. 2022 Interim Reports for the Asthma episode of care didn't contain a new informational quality metric for the 2022 performance period. The new metric, "Follow-Up Care for Newly-Diagnosed Asthma Cases," will be included in the Nov. 2022 reports for episodes ending in the first or second quarter of 2022.

Coming Soon: 2023 Program Changes*

The Division of TennCare recently released its Memorandum of 2023 Episode Changes, which outlines recommendations from the Episodes Annual Feedback Session in May 2022 and corresponding improvements that have been made for the 2023 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 2023 performance year a success.

Make Health Education a Priority During Well-Child Checkups

Between 2001 and 2017, rates of type 1 diabetes increased by 45% and rates of type 2 diabetes rose by 95% in patients under age 20, according to the Centers for Disease Control and Prevention. While research into the causes is ongoing, growing rates of childhood obesity likely contribute to the increase in type 2 diabetes levels. You can help address these rising rates by discussing healthy habits, like eating a healthy diet and making time for active family fun, during checkups.

Health education is an essential part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. This important step allows you to address age-appropriate topics, including nutrition, physical activity, media use, sleep position counseling, and violence, injury and illness prevention.

Additionally, consider using this time to talk with patients about any specialists they're seeing or other medications they're taking. Some prescriptions and over-the-counter medications can raise blood sugar levels. For example, children and adolescents who take antipsychotic medication need yearly metabolic screening tests to check their blood sugar and cholesterol levels.

For more information about the components of EPSDT visits, please see our **TennCareKids Toolkit** in the **Provider Tools and Resources** section of **bluecare.bcbst.com/providers**.

*** Note:** These program changes only apply to BlueCare.

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 available in Availity 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 **BlueCross Payer Spaces**. 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 platform, please call your **eBusiness Regional Marketing Consultant**.

You May Have Patients Who Would Benefit from Pyx Health

Your BlueCare Tennessee patients who are members of CHOICES levels 2 and 3 may benefit from using our pilot program with Pyx Health. Pyx is an app for members who may be dealing with loneliness or social isolation. Within the app, members can interact with an avatar who will chat with them, share activities, videos and more.

Please talk with eligible patients about Pyx if you feel they would benefit. If you have questions, feel free to email us at **Pyx_Support@bcbst.com**.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid, dual-eligible special needs plans.

New Hearing Aid Benefit from TruHearing®

Beginning Jan. 1, 2023, we're offering a new hearing aid benefit through TruHearing that includes access to some of the most advanced hearing aids on the market. Hearing aids can be expensive, especially for some of our D-SNP members and those on a fixed income. We're working with TruHearing to help our members receive one routine hearing exam per year, and up to two TruHearing hearing aids every year (one per ear, per year).

If you have patients with hearing loss asking about hearing aids, please refer them to TruHearing at **1-855-205-6376, (TTY 711)**, Monday through Friday, 8 a.m. to 8 p.m. TruHearing will help them find a qualified network audiologist who will provide a comprehensive exam and talk with them about treatment with hearing aids. TruHearing's Provider Relations team is also available to answer your questions at **1-866-581-9462**, Monday through Friday, 8 a.m. to 8 p.m.

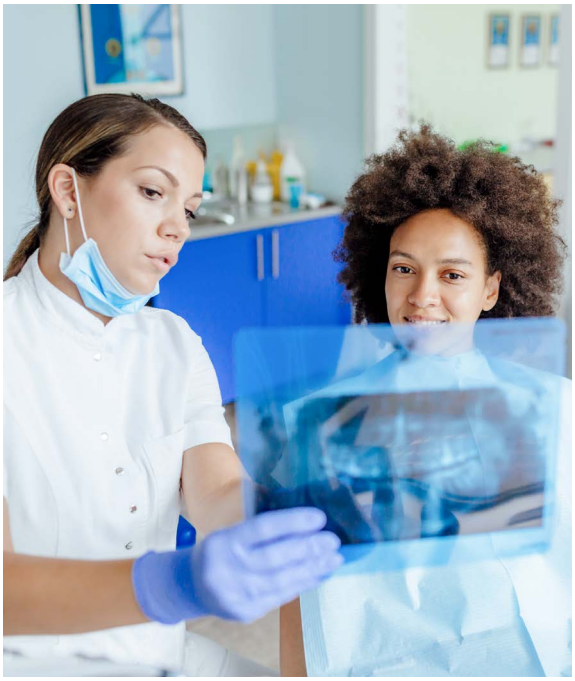
*** Note:** Hearing exams must be performed by a TruHearing provider to be covered.

Updates to Dental Benefits

In 2023, changes are coming to BlueCare Plus dental benefits. We'll still cover routine dental services as we do today. You can still file claims for routine services the same way you normally would. However, the comprehensive services benefits will now be a pre-loaded flex card issued to the member at the start of the plan year (you won't need to file a claim for this charge). Benefit limits and exclusions still apply, details can be found in the member's evidence of coverage.

Effective Jan. 1, 2023, your patients enrolled in BlueCare Plus Choice or BlueCare Plus *Select* will have dental coverage through the Division of TennCare Dental Benefits Manager (DBM).

For more information, please see the **Adult Dental Comprehensive Notice** or reach out to your Provider Network Manager.



Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus and BlueCare Plus Choice special needs plans are contractually required to complete our Model of Care Training after initial contracting, then every year after. 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 **here**.

Nervous System Unlisted Code Requires Prior Authorization

Effective Nov. 1, 2022, the nervous system unlisted code 64999 will require prior authorization. Providers should submit requests for prior authorization through **Availity**. If you have questions, please contact Utilization Management at **1-866-789-6314**, Monday through Friday, 8 a.m. to 6 p.m. ET.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

Concurrent Inpatient Submissions

To ensure timely discharge planning, please submit concurrent inpatient extensions by the last approved day.
Discharge planning details are required with each update and will limit calls to facilities. Please note, late submissions may cause delays in claims payment.

For questions, please contact your **Provider Network Manager**.

New Centers for Medicare & Medicaid Services (CMS) Tiering Exception Rules

Due to recent **CMS updates**, if an enrollee requests a tiering exception for an approved drug that's not on our drug list, the request is deemed invalid and will be dismissed. This means if a member receives approval for a drug that's not on our drug list, they can't also receive a tiering exception on that same drug. If we receive a tiering exception request on a previously approved drug that's not on our drug list, we'll have to deny the request.

Thank You for Helping us Achieve 5 STARs!

We're grateful for all you do to serve our members. This year, you helped us achieve a 5 STAR rating from the Centers for Medicare & Medicaid Services (CMS), the highest given. STAR ratings are based on about 40 measures, from those related to preventive health screenings, to how members perceive experiences with providers and their health plan. We couldn't have achieved this without you. Thank you, again, for your valuable efforts to meet quality measures and give our members the best experience they can have.

The article below describes next year's quality measures. If you have a moment, reviewing the 2023 Quality Measures will help us maintain 5 STARs in the future.

2023 Quality Program Measures

Beginning Jan. 1, 2023, we're implementing the following changes to the quality measures included in the Quality+ Partnerships 2022 program.

- The Kidney Health Evaluation for Patients with Diabetes (KED) measure and the Follow-Up After ER Visit for People with Multiple High-Risk Chronic Conditions (FMC) will move from the monitoring section of the program to the scored section as single-weighted measures.
- The Member Experience – CAHPS measure is moving from a weight of two to a weight of four.
- The Comprehensive Diabetes Care (CDC) A1C and Eye Exam measure names will update to Hemoglobin A1C Control for Patients with Diabetes (HBP) and Eye Exam for Patients with Diabetes (EED).

The 2023 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Member Experience – CAHPS	CMS Member Survey	4
Controlling High Blood Pressure (CBP)	HEDIS®	3
Hemoglobin A1C Control for Patients with Diabetes (HBP)	HEDIS	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	PDE Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	PDE Files	3
Plan All-Cause Readmissions (PCR)	HEDIS	3
Member Experience – HOS	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Eye Exam for Patients with Diabetes (EED)	HEDIS	1
Follow-Up After ER Visit for People with Multiple High-Risk Chronic Conditions (FMC)	HEDIS	1
Kidney Health Evaluation for Patients with Diabetes (KED)	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)	PDE Files	1
Transitions of Care (TRC)	HEDIS	1

Please contact your Provider Quality Outreach Consultant for more information about the measures included in the 2023 quality program.

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

Diabetic Retinopathy Screenings

We're working with Retina Labs to provide an in-home screening option for your patients to help increase access to diabetic retinopathy screenings. This screening is performed by technicians and interpreted by a licensed ophthalmologist. Results are mailed directly to the patient and their primary care provider so follow-up care can be completed, as necessary.

You can now refer your patients directly to Retina Labs to help them schedule an appointment for their in-home screening. If you'd like to learn more about the referral process, please reach out to your Provider Quality Consultant.

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.

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

Before the end of 2022, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2021, and June 30, 2022.

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 2021 and June 2022, 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 PAM** or contact your Provider Network Manager.

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).

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**.

of Tennessee

DECEMBER 2022

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

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've updated our policies to help you care for our members.

INSIDE THIS ISSUE

New Member Service Resource Team for Tennessee Providers

To help support Tennessee-based providers and members, we've assigned a specially trained member service team who can answer provider questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who are facing a non-viable pregnancy. These representatives are also able to provide information about behavioral health benefits, coverage and eligibility for these members.

To reach the team, please call **1-866-268-3502**, from 8 a.m. to 6 p.m. ET.

Register for Electronic Funds Transfer to Complete Your BlueCross Enrollment

As of September 2022, all new enrolling providers are required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity® and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Technical Support. You can also reach out to your Provider Network Manager.

BlueCross Offering Contracts in North Georgia

As of Nov. 1, 2022, we began offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our website and follow the steps for enrollment and credentialing or contact our Provider Service line at **1-800-924-7141** and then follow the prompts to select Contracts and Credentialing.

Note: The information in the article above doesn't apply to the Federal Employee Program (FEP). Additionally, all providers located in Catoosa, Dade and Walker Counties should know that with this change, our BlueCross BlueShield of Tennessee member claims for services rendered in these three counties are no longer processed through BlueCard®. Instead, pricing and benefits are handled by BlueCross BlueShield of Tennessee directly. Now, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. For questions about these claims, please contact your Provider Network Manager or call our Provider Service line at **1-800-924-7141**.

News About Telehealth Updates

During the pandemic, we greatly expanded our telehealth coverage so providers could continue offering quality care to our members. We're deeply invested in supporting telehealth and will broadly cover many telehealth services even after the 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. We started denying inaccurate telehealth claims June 1, 2022.

Some examples of telehealth claims mistakenly received that we'll deny:

- Urinalysis
- Vaccinations
- Eye exams or X-rays

Please continue to visit bcbstupdates.com for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

Update Your Contact Preferences in Availity® for Added Efficiency

Considering increases in telehealth visits, changes in office staff and office locations, we've noticed more providers are asking to receive important communications by email. If you'd like to switch to email, it couldn't be easier. Simply update your **Contact Preferences** through our Payer Spaces in **Availity**. There, you can make email your preferred communication method for each of these communication types and learn more about the roles required for each contact type:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in the BlueCross Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications about available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application Note: You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, EFT and tax-related items	Financial Reports

*Availity roles can update contact info and download the messages and attachment.

**For the Quality & Clinical contact type, you only need one of the roles listed.

You Can Update Your Contact Preferences By:

1. Logging in to **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verifying your **Provider Name** and **National Provider Identifier (NPI)** and clicking **Submit**.

   Tip: If you don't see your name in 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.
5. 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 updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all your possible contact types.

In some cases, it may take time to receive these messages via email, and you may temporarily receive them as you did before. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. Please visit our **Provider Service page** where you can find links to our Enrollment and Technical Support teams. If you have questions, please log in to **Availity** or contact eBusiness Technical Support at **(423) 535-5717** (option 2).

BlueCard® Claims Filing

The BlueCard Program allows members who are traveling or living away from their Home Plan's (residential state's plan) service area to receive medical care from participating providers wherever services may be required.* In many cases, that member will receive the same level of benefits they'd receive if the services were rendered in their Home Plan's service area.

The BlueCard Program also allows providers to submit claims for Blue Cross and/or Blue Shield plan members from other Blue Cross and Blue Shield plans, including international Blue Cross and Blue Shield plans, directly to the provider's local plan (Host Plan).** The local host plan will be the provider's contact for claims filing, claims payment, adjustments, inquiries and problem resolution.

If the provider is rendering services within Tennessee, they should submit claims to BlueCross BlueShield of Tennessee. If services are rendered outside of Tennessee by a contiguous provider who may be participating with BlueCross, the claim should be filed to the provider's local (Host) plan in the state where services are rendered.

Note: If a provider contracts with more than one Blue Plan in a state for the same product type (i.e., PPO or Traditional), the provider should file claims based on the member and where services are rendered. The Provider Administration Manual can be referenced under BlueCard Filing for more details.

*** Home Plan** – the plan that "owns" the member's coverage

**** Host Plan** – provider's local Blue Cross Blue Shield plan – for Tennessee providers treating members of other Blue Plans, it's BlueCross BlueShield of Tennessee.

Commercial

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

Quest*Select*™ Program Coming Soon

Beginning early 2023, we're adding the Quest*Select* program for our Marketplace members and members who are part of our AmplifyHealth advocacy program. It'll also be optional for self-funded employer groups.

With this program, members can show their Quest*Select* card at their appointment and request that their provider send their lab work to Quest. This is a voluntary, member-driven program designed to lower member costs for outpatient lab testing. If the member chooses not to use Quest, their normal lab benefits will apply.

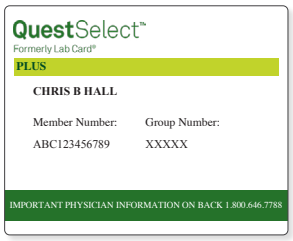
The testing must be covered and approved by the member's benefit plan, and the provider or lab technician must indicate Quest*Select* coverage on a Quest Diagnostics requisition that accompanies the specimens to Quest Diagnostics.

Providers can collect specimens in their office and be reimbursed for the collection by submitting a claim with the office charge. Quest Diagnostics will bill us directly for lab testing services.

Call Quest*Select* at **1-800-646-7788** for:

- A faxed copy of the necessary paperwork for your immediate use
- Personalized test order pads for requisitions
- Courier service
- Patient results

If you don't normally collect patient specimens, your patients can call **1-800-646-7788** or visit **QuestSelect.com** to find a Patient Service Center.



Sample Quest*Select* Card

Changes to Home Health and Therapy Authorizations

Beginning Jan. 1, 2023, home health and therapy authorizations will only be valid on a calendar-year basis from Jan. 1 through Dec. 31. Authorizations extending into the next year will have a new case and an updated authorization reference number.

New Prior Approval Requirements for Federal Employee Program (FEP) Members

Beginning Jan. 1, 2023, some drugs and procedures will require prior approval for FEP members, including:

- Onpattro®
- Tegsedi®
- Oxlumo®
- Givalaari®
- Vygart®
- Soliris®
- Proton beam therapy
- Stereotactic radiosurgery
- Stereotactic body radiation therapy

You can submit prior authorization request forms to **FEP_Pred@bcbst.com** or by faxing it to **(423) 591-9091**. Authorization for provider-administered specialty drugs can be submitted to Magellan Rx through Availity or by calling FEP Customer Service at **1-800-572-1003**. Listen for the specialty drug authorization prompt to connect directly to Magellan Rx.

For questions about these updates, please contact FEP customer service at **1-800-572-1003**.

Note: The information in this article only applies to FEP.

New Requirements for Consolidated Appropriations Act Took Effect Jan. 1, 2022

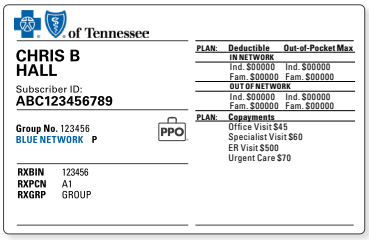
On Jan. 1, 2022, changes required by the Consolidated Appropriations Act (CAA) 2021 took effect. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

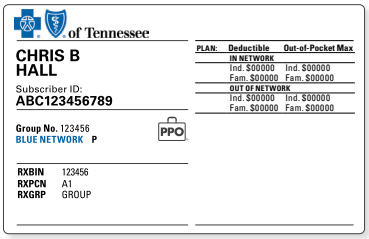
New health insurance ID cards that were issued or downloaded on or after Jan. 1, 2022, will include this additional information:

- 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 example cards for common plan types – a preferred provider organization (PPO) plan and a high deductible health plan (HDHP) with in-network and OON benefits. Actual cards may differ based on plan specifics.



Sample PPO Card



Sample HDHP Card

Provider Directory

The CAA requires us to maintain a public database of our network providers. To make sure your provider directory information is current, you'll need to:

- Verify and update provider directory information at least every 90 days.
- Submit provider directory information to us in a timely manner. We've listed the new requirements for 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 we request it
- **Individual practitioners** – Please continue to use **CAQH** to validate your provider directory information and update network-specific information in Availity. Information in CAQH must be reviewed and validated every 90 days.
- **Facilities and ancillaries** – Please continue using Data Verification Forms and update network-specific information in **Availity**. You must send an attestation for any information changes using the Data Verification Form. If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

If you're removed from the directory for non-compliance with this requirement to update your information, you can submit an attestation to be added back in the directory.

Surprise Billing Protections

The CAA includes new protections that prohibit OON providers from billing members for more than their cost-share for:

- Emergency services received at an OON ER or independent freestanding ER
- Non-emergency services received from an OON provider at an in-network facility (except regarding non-ancillary providers) when the member receives notice of, and provides consent to, treatment by the 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 the Advanced Explanation of Benefits (AEOB) – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies responsible for overseeing CAA implementation said they'll issue further guidance on AEOBs and won't enforce this provision of the CAA until a future date.

For more information about the CAA, please click this **link**.

New Transparency Requirements – Transparency in Coverage Rule

Effective July 1, 2022, the Transparency in Coverage rule imposed new price transparency requirements on most group health plans and health insurers in our individual and group plans. The rule was published by the Departments of Health and Human Services (HHS), Labor and Treasury on Nov. 12, 2020. The **Transparency in Coverage** rule changes included:

Machine Readable Files – Effective July 1, 2022

We're required to make two machine-readable files available to the public detailing:

- In-network rates
- Out-of-network allowed amounts

The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for an Employer Identification Number (EIN) using this **link**. **Please note:** the IRS refers to an (EIN) as a federal tax identification number, so please follow their instructions for applying for an EIN.

For step-by-step instructions about other processes related to this change, refer to our **How to Change From a Social Security Number to Employer Identification Number** Quick Reference Guide in Availity's Resource page.

BlueCare Tennessee

*This information applies to BlueCare℠, TennCare*Select* and CoverKids℠ plans unless stated otherwise.*

Coming Jan. 1, 2023: Dental Benefit Expansion

The Division of TennCare is expanding dental benefits for patients with Medicaid coverage. Beginning Jan. 1, 2023, all patients with BlueCare or TennCare*Select* coverage will have dental benefits. Previously, benefits were only available to those under age 21, during pregnancy and for 12 months after giving birth.

Please let your patients know about this upcoming coverage expansion. If you have questions or would like more information, please visit **bluecare.bcbst.com** or **dentaquest.com**. DentaQuest handles dental care and claims for our BlueCare Tennessee members.

Note: These new benefits don't apply to CoverKids members.

Home Health Providers, Make Sure You're Ready to Begin Using an Electronic Visit Verification System

In the **April BlueAlert**, we let you know about an upcoming federal requirement for home health providers who deliver in-home services to Medicaid members. Beginning Jan. 1, 2023, agencies will need to use an electronic visit verification (EVV) system to track member visits. This means home health providers in our BlueCare and TennCare*Select* networks will need to adopt an EVV system or connect their existing system to the Sandata aggregator by Jan. 1. The Sandata aggregator will allow providers with third-party EVV systems to share data about member visits with us.

We're working with Sandata to help providers meet this requirement. As we approach Jan. 1, we wanted to share a quick reminder about the steps you'll need to take to ensure your agency is ready.

- **If you're using a third-party EVV system**, we're hosting our final town hall before going live in early December. Please watch for an email with more information.
- **If you're using the Sandata EVV system**, training is now live. Sandata offers a variety of self-guided, on-demand and in-person training opportunities. Please **click here** to learn more about these educational resources and watch for an email with dates and times for in-person webinars coming early this month.

We look forward to successfully launching our EVV program. For more information or questions about the upcoming requirement, please contact your Provider Network Manager.

Process Reminder: Requirements for Provider Subcontracting

Providers and vendors 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 may be denied, and previous payment may be subject to recoupment.

To request approval for all provider subcontracts, providers in our networks 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**.
- 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**.

340B Drug Pricing Program: Brush Up on Claim Requirements

Providers who participate in the 340B Drug Pricing Program must include the appropriate modifier on all outpatient/office drug services that include a National Drug Code (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.

Please note: Each outpatient/office drug line item on the claim can only include one of these four 340B modifiers. It isn't appropriate to bill the UC modifier with any of the other three. Claims billed with multiple 340B modifiers on the same line item are subject to recoupment.

Additionally, please confirm that you're billing the correct NDC number and units on each outpatient/office drug line item. The NDC number must match the procedure code being billed. Claims billed with the incorrect NDC or NDC units are subject to recoupment. As a reminder, vaccine services don't require an NDC number.

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

Episodes of Care Risk-Sharing Updates

To continue supporting providers during the COVID-19 pandemic, the three TennCare Managed Care Organizations (MCOs) will waive Episodes of Care risk-sharing payments for the 2021 performance year. Providers who owe a risk-sharing payment based on their final 2021 episode results won't have to make the payment. Those who've earned a gain-share payment will receive that payment by the end of 2022, if they haven't already.

Risk-Share Payments Will Resume for the 2022 Performance Year

Episodes of Care risk-sharing payments will resume for the 2022 performance year, which began Jan. 1, 2022. Final episode results for the 2022 performance year will be released in August 2023. Providers will know at that time if they owe a 2022 risk-share payment.

For more information, please review the **Division of TennCare memo** outlining these changes.

Behavioral Health Screening: An Important Part of EPSDT Visits

Early detection and treatment of behavioral health conditions is an essential part of well-child checkups and helps provide better outcomes for children and teens. During Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits, consider performing an age-appropriate behavioral health screening:

- Depression and suicide risk screening is recommended starting at age 12 through age 21.
- A tobacco, alcohol and drug use assessment is recommended from age 11 until age 21.

For more information about the screenings needed at each stage of development, review the Periodicity Schedule published by **Bright Futures and the American Academy of Pediatrics**. Your patients covered by BlueCare and TennCare*Select* are eligible for EPSDT visits and screenings according to this schedule.

If you're concerned about substance use or your patient's behavioral health, call us at **1-888-423-0131** to initiate a behavioral health referral.

BlueCare Tennessee and BlueCare Plus (HMO D-SNP)SM

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

Southeastrans Name Change Effective Jan. 1, 2023

Our transportation vendor, Southeastrans, is changing its name to Verida. Even though the name is changing, transportation benefits will remain the same. Depending on your patient's plan, these benefits may include a shared ride, bus pass or mileage reimbursement.

Beginning Jan. 1, 2023, your patients with BlueCare Tennessee and BlueCare Plus Tennessee coverage can schedule transportation services by visiting **verida.com** or calling the appropriate number for their health plan (these statewide phone numbers aren't changing):

- BlueCare – **1-855-735-4660**
- TennCare*Select* – **1-866-473-7565**
- BlueCare Plus – **1-855-681-5032**

To learn more about your patients' transportation benefits, visit **bluecare.bcbst.com** and select Get a Ride or visit **bluecareplus.bcbst.com**.

Note: This article doesn't apply to CoverKids.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid dual-eligible special needs plans.

Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus and BlueCare Plus Choice special needs plans are contractually required to complete our Model of Care Training after initial contracting, then every year after. 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 **here**.

New Hearing Aid Benefit from TruHearing®

Beginning Jan. 1, 2023, we're offering a new hearing aid benefit through TruHearing that includes access to some of the most advanced hearing aids on the market. Hearing aids can be expensive, especially for some of our D-SNP members and those on a fixed income. We're working with TruHearing to help our members receive one routine hearing exam per year, and up to two TruHearing hearing aids every year (one per ear, per year).

If you have patients with hearing loss asking about hearing aids, please refer them to TruHearing at **1-855-205-6376**, (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. TruHearing will help them find a qualified network audiologist who will provide a comprehensive exam and talk with them about treatment with hearing aids. TruHearing's Provider Relations team is also available to answer your questions at **1-866-581-9462**, Monday through Friday, 8 a.m. to 8 p.m.

Note: Hearing exams must be performed by a TruHearing provider to be covered.

Updates to Dental Benefits

In 2023, changes are coming to BlueCare Plus dental benefits. We'll still cover routine dental services as we do today. You can still file claims for routine services the same way you normally would. However, the comprehensive services benefits will now be on a pre-loaded flex card and issued to the member at the start of the plan year (you won't need to file a claim for this charge). Benefit limits and exclusions still apply, details can be found in the member's evidence of coverage.

Effective Jan. 1, 2023, your patients enrolled in BlueCare Plus Choice or BlueCare Plus *Select* will have dental coverage through the Division of TennCare Dental Benefits Manager (DBM).

For more information, please see the **Adult Dental Comprehensive Notice** or reach out to your Provider Network Manager.

Guidelines for Submitting Form CMS-2728 for ESRD Patients

The Centers for Medicare & Medicaid Services (CMS) requires **Form 2728** to be submitted within 45 days of the start of dialysis services for your patients with end stage renal disease (ESRD). The form can be submitted electronically through **CROWNWeb**, a web-based data collection system mandated by CMS to enable dialysis facilities to meet the requirements for collecting administrative and clinical data by all Medicare-certified dialysis facilities.

If you have questions about submitting Form 2728, instructions are available on page four of the document. For other questions, please contact your Provider Network Manager.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

Concurrent Inpatient Submissions

To ensure timely discharge planning, please submit concurrent inpatient extensions by the last approved day. Discharge planning details are required with each update and will limit calls to facilities. Please note, late submissions may cause delays in claims payment.

For questions, please contact your Provider Network Manager.

Complete 2022 Provider Assessment Forms

It's not too late to complete Provider Assessment Forms (PAFs) this year. PAFs must be completed during a face-to-face or telehealth visit (using both video and audio components). PAFs may be completed in conjunction with a Medicare Annual Wellness Visit (AWV) or any other office visit type. There are two options for PAF submission:

- **Electronic PAF:** The 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 that have an approved non-standard PAF may continue to submit these assessments for 2022 either by uploading it to the QCR or by fax.
- Note that the previous standard PAF blank form has been retired and **isn't accepted** for 2022 dates of service.

Submit the **appropriate CPT®** code once the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code. No modifier is needed.

- **Electronic PAF Completed In/Exported From the QCR:** CPT® code **96161**
- **Approved Non-Standard PAF:** CPT® code **96160**

Reimbursement for completion of a PAF is based on the PAF submission options outlined above.

- **Electronic PAF Completed In/Exported From the QCR: $225** Jan. 1 through Dec. 31
- **Non-Standard PAF: $100** Jan. 1 through Dec. 31

Please contact your Provider Quality Outreach Consultant for assistance with Provider Assessment Forms.

Exercise Bands Available for Your Patients

As a result of the Health Outcomes Survey (HOS), we've developed a tangible toolkit that addresses several of the measures in the survey, including:

- Fall prevention/balance
- Monitoring physical activity
- Urinary incontinence/improving bladder control

This toolkit includes an exercise/resistance band (light resistance) and a postcard size informational insert, which includes:

- Sample exercises using the exercise band
- Messaging about balance/fall prevention
- Silver & Fit information promoting physical activity
- Additional messaging about urinary incontinence
- Messaging that encourages patients to discuss these topics with their doctor
- Additional resources

Providers can order these exercise bands and inserts in bulk to distribute to their patients during office visits. Not only will this help strengthen the message to members about fall prevention, balance, physical activity and managing urinary incontinence, but it can also help improve health outcomes. If you have questions about ordering a toolkit, please contact your Provider Quality Outreach Consultant.

Medicare Advantage 2023 Quality Program Measures

Beginning Jan. 1, 2023, Medicare Advantage will implement the following changes to the quality measures included in the Quality+ Partnerships 2022 program.

- The Kidney Health Evaluation for Patients with Diabetes (KED) measure and the Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) will move from the monitoring section of the program into the scored section of the program as single-weighted measures.
- The Member Experience – CAHPS measure moves from a weight of 2 to a weight of 4.
- The Comprehensive Diabetes Care (CDC) A1C and Eye Exam measure names will update to Hemoglobin A1c Control for Patients with Diabetes (HBP) and Eye Exam for Patients with Diabetes (EED).

The 2023 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Member Experience - CAHPS	CMS Member Survey	4
Controlling High Blood Pressure (CBP)	HEDIS	3
Hemoglobin A1c Control for Patients with Diabetes (HBP)	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 - HOS	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Eye Exam for Patients with Diabetes (EED)	HEDIS	1
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	HEDIS	1
Kidney Health Evaluation for Patients with Diabetes (KED)	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

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the measures included in the 2023 quality program.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Patients with Diabetes Need Statin Medication Fills

The American College of Cardiology and the American Heart Association guidelines recommend moderate- to high-intensity statin therapy for primary prevention of atherosclerotic cardiovascular disease (ASCVD) in patients with diabetes.

One of the CMS STAR measures – Statin Use in Persons with Diabetes (SUPD) – looks at Medicare Advantage Prescription Drug plan members between the ages of 40 and 75 who've filled at least two prescriptions for a medication to treat diabetes during the plan year and who also receive a prescription for a statin medication.* The first diabetes medication fill must occur at least 90 days before the end of the measurement year. One fill of a statin medication will satisfy the requirement for this measure with no dosage minimum.

*Doesn't include dapagliflozin and empagliflozin medications.

Measurement exclusions

Patients with end-stage renal disease, rhabdomyolysis, myositis, myopathy, cirrhosis, pre-diabetes, polycystic ovarian syndrome, or who are receiving hospice services, experienced pregnancy, lactation, fertility treatment or an adverse effect of an antihyperlipidemic or anti-arteriosclerotic drug at any time in the measurement year are excluded from this measure. The diagnosis code for the applicable condition must be submitted on a claim to exclude the patient. Patients must be excluded each measurement year.

If you have questions, please contact your Provider Quality Outreach Consultant.

Encourage Patients to Stay Active During Winter Months

Winter can be a challenging time for older adults to stay active with colder temperatures, slippery conditions and fewer daylight hours. As you know, one of the best ways for seniors to improve mental and physical health is to stay physically active and continue to work toward their fitness goals.

Places to visit and activities to suggest for keeping active when it's a bit too cold to be outdoors could include:

- Museums, aquariums, department stores, shopping malls, community centers and local Silver & Fit gyms
- Working on balance, low impact aerobics, bowling, billiards and virtual strength training

Staying active is the main goal to promote wellness and avoid poor health problems in the future.

Pharmacy

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

Medical Exclusion Updates

Beginning Jan. 2023, we'll implement a medical exclusion option for medication therapies covered under the Commercial Provider Administered Medical Benefit. After completing a clinical review, some products may be moved to excluded status and not be covered for Commercial members. Provider administered pharmacy products that are excluded from coverage can be found on our medical exclusion drug list which will be available in January at **provider.bcbst.com** under Documents & Forms.

Asceniv™ will be excluded from coverage for Commercial members starting Jan. 2023. Members are encouraged to discuss covered options with their provider if using one of our excluded products. If members choose to remain on an excluded product, benefits may not apply, and the member may be responsible for the entire cost of the drug therapy.

Note: The information in the article above applies only to Commercial members.

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).

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**.