BlueCross BlueShield of Tennessee

SEPTEMBER 2022

BlueAlert℠

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

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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.

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 SM, Blue Network S SM and Blue Network L SM 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

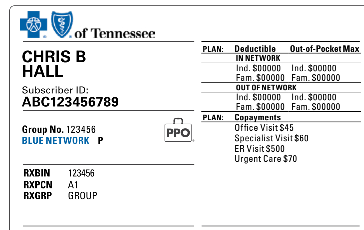
On Jan. 1, 2022, changes required by the **Consolidated Appropriations Act (CAA), 2021**, took effect. The requirements listed below detail a few of these changes. The information is based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

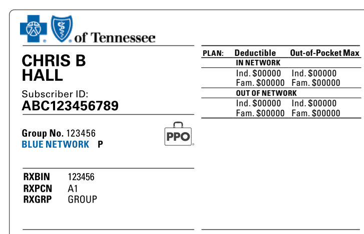
New health insurance ID cards that were issued or downloaded on or after Jan. 1, 2022 will include this additional information:

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

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 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)℠

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)℠ 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)℠ and BlueCare Plus (HMO D-SNP)℠ 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

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

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.

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.

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
1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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

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

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select* Community**	1-800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

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

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

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

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

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