of Tennessee

AUGUST 2024

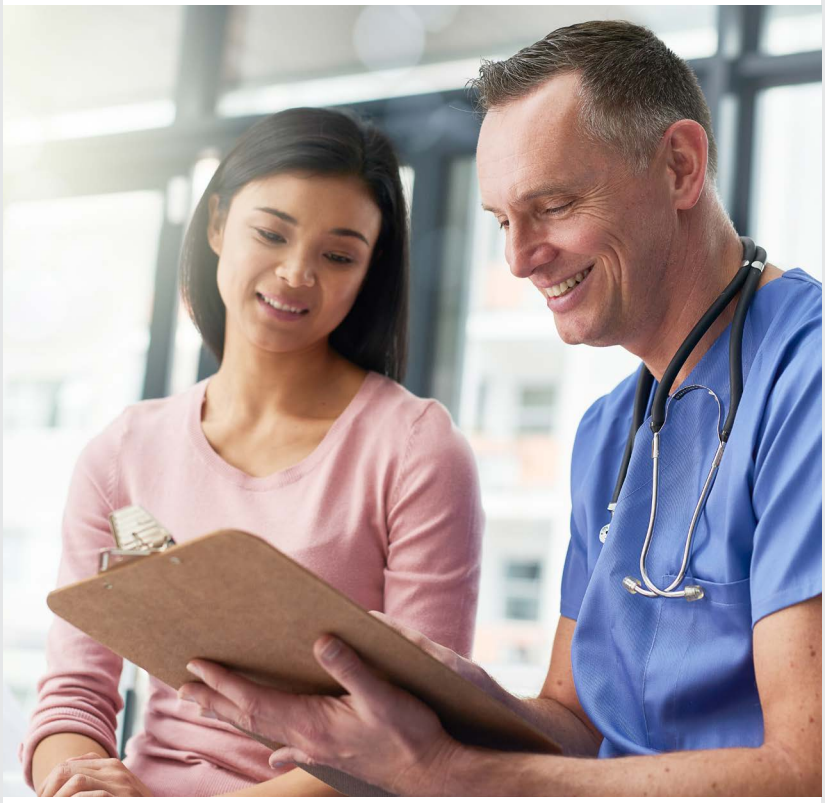
BlueAlert℠

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

Now that the National Public Health Emergency has ended, we're taking steps to return to some of our original policies and procedures. Please continue to visit the Provider FAQs at **bcbstupdates.com** for up-to-date guidelines to help you care for our members.

INSIDE THIS ISSUE

A Faster Way to Receive Important Communications From Us

You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. By selecting email and adding a contact name and email address, you can also request email for credentialing, network operations, network updates, quality and clinical information, and financial updates.

You can update your **Contact Preferences** through our **Payer Spaces** in **Availity®**. Simply select email instead of mail for all types of communications and add a contact name and email address for each one.

Follow these steps in Availity:

1. Log in to **BlueCross Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type**.
4. Select your **Organization** and **Tax ID**. (Tax ID is a newly added feature that lets you select a specific provider based on Tax ID. You can update contact information for all Tax IDs, including the primary Tax ID associated with the corresponding NPI.)
5. Pick a **Provider** from the drop-down list or by directly entering the provider's **NPI** and click **Submit**.

   Tip: If you don't see your name in the drop-down list, you can add it through the **Manage My Organization** dashboard. For contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.
6. Follow the remaining cues and check the email **Opt In** box. Make sure email is the first option in the **Communication Preference** list on the right side. When finished, 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 contact types you have access to. In some cases, you may find it takes time to receive these messages through your newly specified email, and you may temporarily receive them as you did before.

A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. If you have questions, please log in to Availity or contact eBusiness Technical Support at **(423) 535-5717, option 2**.

Important Information About PWK Electronic Attachments

If you submit a claim requiring medical records, operative reports/notes or invoices, use the PWK process to submit the attachments **the same day** the electronic claim is filed. Please carefully follow the instructions on the PWK cover sheet to make sure your records are received and your claim is processed successfully. The electronic claim and PWK attachments must include the same unique Attachment Control Number (ACN) to be accepted. Please don't submit attachments using the **PWK submit attachment** process if the claim has been processed and denied. We'll need additional supporting documents to finalize the claims processing.

The PWK form is available in the **Attachments Dashboard** application under the **Claims and Payments** section in Availity.

For additional information, please refer to the **PWK Attachments Quick Reference Guide** under the **Resources** tab in Availity **Payer Spaces**.

Please contact your eBusiness Regional Marketing Consultant for Availity training, including the PWK attachment process.

We're working on additional enhancements to our PWK process, so be sure to look for updates in upcoming BlueAlert issues.

Availity's 30-minute Security Time Out

Availity has a 30-minute inactivity time out within the portal for security. When you're entering authorizations, don't let the time out interfere with your authorization. As you go into **Payer Spaces** to launch the **Authorization** application, you'll notice it opens in a separate browser. To prevent the time out, click the **Availity** tab, and then click the **Home** link to reset the timer.

Search for Electronic Remittance Advice by Payer ID in Availity's Remittance Viewer

You can now search electronic remittance advice by entering a payer ID in the **Search** field on the **Check/EFT** tab and **Claim** tab within the **Remittance Viewer** application. For your reference, the BlueCross' payer ID is 00390.

Coming Soon: Enhanced Essentials Claims Entry and Quick Claims

Soon, we'll be introducing enhancements to our Availity Essentials claims data entry system.

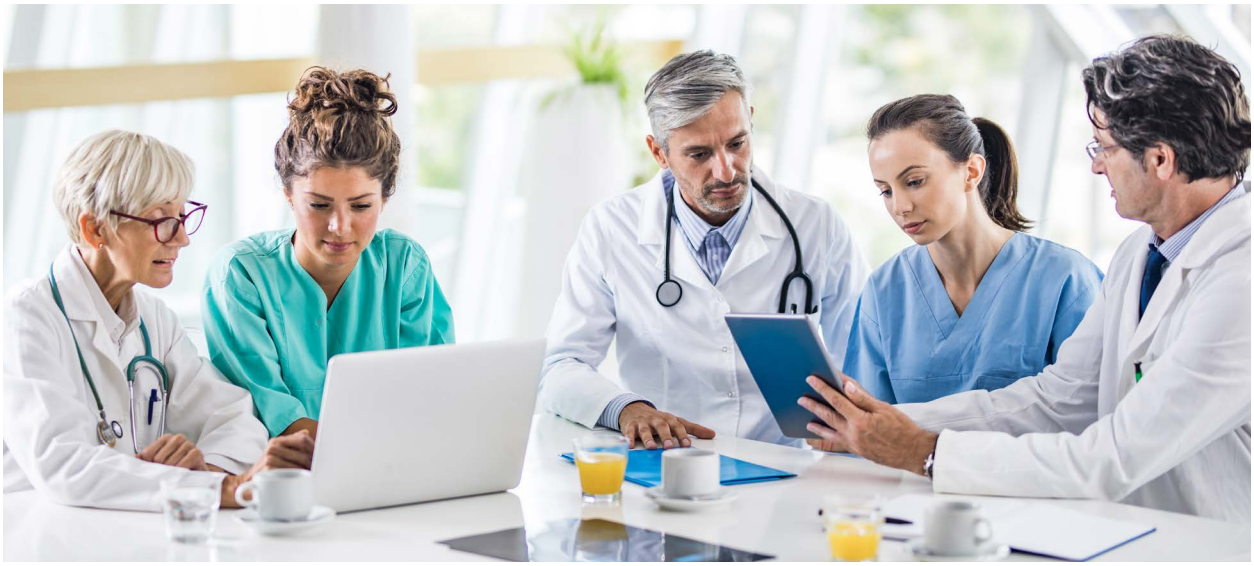
These improvements will include user-friendly forms, streamlined workflows and better error prevention. Also, the **Quick Claims** feature will simplify electronic submission for smaller and non-traditional health care providers.

If you have questions, please contact your eBusiness Regional Marketing Consultant, call us at **(423) 535-5717, option 2** or email **ebusiness_service@bcbst.com**.

Update CAQH With All Credentialing/Recredentialing Documentation

Please be sure to update the Council for Affordable Quality Healthcare (CAQH) with all information needed to be credentialed or recredentialed with us. This information includes, but isn't limited to, the name and NPI of the supervising physician, name and NPI of the person providing call coverage or covering for the colleague, certificate of insurance and all certifications needed to process the request.

Beginning **Sept. 1, 2024**, we'll no longer accept documentation that can be updated in CAQH via email. All credentialing or recredentialing updates must be made and attested to in CAQH. As a reminder, it's important to keep CAQH updated with all necessary information to ensure our data is as accurate as possible.



Transition From Availity Essentials™ Maintain User Feature to Manage My Team(s)

Availity announced earlier this year they would be retiring the **Availity Essentials Maintain User** feature, replacing it with a more advanced and versatile tool called **Manage My Team(s)**.

What This Means for You

Manage My Team(s) is a centralized dashboard designed to simplify the way administrators manage team members across multiple organizations. This feature offers several enhancements the Maintain User feature didn't have, including:

- Viewing team members for multiple organizations simultaneously
- Advanced filtering options for searching specific team members
- Easy viewing and user editing roles by category
- Options to deactivate or restore team member access
- Sending password reset requests or backup codes
- Adding, editing and deleting notes for team members
- Printing or exporting a list of team members

How to Access Manage My Team(s)

From the **Essentials** menu bar, select **[Your Name]'s Account** and click **Manage My Team(s)** to access the dashboard.

Reminder on the Provider Exclusion Screening Process

The health and safety of our members and your employees are important, which is why we'd like to remind you of your obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

If you have questions, please refer to the **Provider Networks - Federal Exclusion Screening Requirement** section of the **BlueCross BlueShield of Tennessee** and **BlueCare Tennessee Provider Administration Manuals**.

Discharge Summaries in Availity

As a reminder, you can save time by adding discharge summaries directly in Availity. Here's how to add:

1. Go to **Payer Spaces**.
2. Select the **Authorization Submission Review** application.
3. Select **Auth Inquiry/Clinical Update** and open the existing authorization.
4. Go to the Clinical Update section at bottom of page.
5. Add Discharge information.

Please contact your **eBusiness Regional Marketing Consultant** for your Availity questions or training needs.

Behavioral Health Acute Inpatient Prior Authorizations

As a reminder, inpatient behavioral health prior authorizations can be submitted online through Availity. If the member meets the clinical criteria for an authorization request, you may receive an approval. If you need to check the details or update an existing authorization, that's easily handled through Availity.

If your practice needs Availity training and education, contact your **eBusiness Marketing Consultant**.

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

Commercial

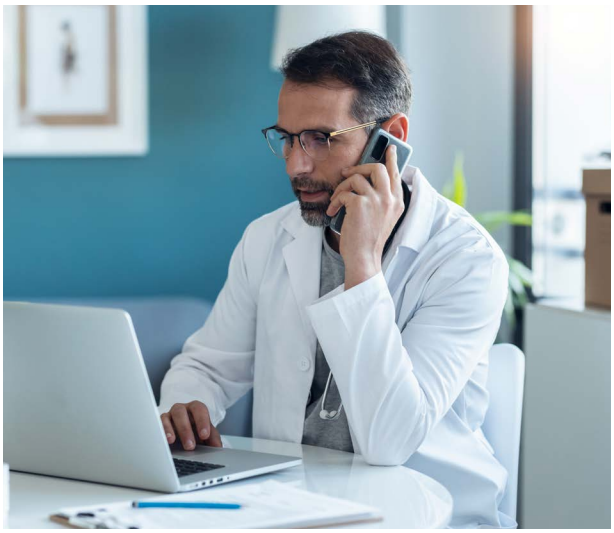
This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless stated otherwise.

New Submission Process for High-Tech Imaging, Genetic Testing and Radiation Oncology Authorizations

Beginning **Sept. 1, 2024**, you'll no longer submit authorization requests through eviCore for high-tech imaging, genetic testing and radiation oncology authorizations.

Instead, you'll submit those requests directly to us by calling **1-800-924-7141** or submitting them in Availity.

If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your eBusiness Regional Marketing Consultant.



Provider Satisfaction and Wait Times Surveys Coming Soon

Providers participating in our Commercial and Marketplace networks will receive our **2024 Provider Satisfaction and Wait Times** surveys between June and September. Please be sure to share your feedback so we can continue to work to enhance our service to you.

New Antibiotic Stewardship Pocket Tool Now Available

We're now offering an Antibiotic Stewardship Measures and Tips provider pocket tool. These plastic, wallet-size cards include tips on meeting antibiotic-related measure goals and encouraging proper antibiotic use with your patients. The tool also has a helpful chart from the Centers for Disease Control and Prevention (CDC) that lists common respiratory infections, if they're caused by a virus or bacteria and if antibiotic use is needed.

If you'd like to request an Antibiotic Stewardship Measures and Tips provider pocket tool, please email **Leigh_Sanders@bcbst.com**.

Behavioral Health Authorizations

Did you know your behavioral health authorizations (e.g., acute inpatient psychiatric, substance use disorder, mental health intensive outpatient program, partial hospitalization program, psychological testing and neuropsychological testing) may automatically approve if the member meets the clinical criteria for each guideline? When you complete your authorization in Availity, the authorization number associated with your case will display on the confirmation page. It'll also have a message that your authorization has been accepted and approved or is pending. Either way, you'll have the authorization number assigned to the member's case.

Authorizations can be updated, and you can view the letter associated with the authorization in the **Auth Inquiry/ Clinical Update** application.

If you need training for the authorization process, please contact your **eBusiness Regional Marketing Consultant**.

BlueCare Tennessee

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

Exciting Updates to Our Provider Website

We're proud to announce we've redesigned our BlueCare Tennessee provider website. Our goal was to improve your experience by:

- Simplifying site navigation for quicker access to the resources you need most
- Organizing critical information, including TennCare-mandated guidelines, forms, policies and more
- Removing outdated information

Everything you need – all in one place

To view the new site, you can still use the same URL – **bluecare.bcbst.com/providers**. We hope these updates make it easier to find the tools and resources you need to take care of our members.

Guidelines for Submitting Electronic Secondary Claims

It's important to use correct insurance indicators and policy numbers to avoid delayed payments and denials.

- Please bill the correct insurance indicator to identify the primary payer insurance type when billing claims secondary to any primary payer, including Commercial plans, TRICARE, traditional Medicare, Dual Special Needs Plans and Medicare Advantage plans.
- Use insurance indicator 16, Health Maintenance Organization (HMO) Medicare Risk, when submitting electronic claims for services secondary to traditional Medicare (Parts A and B), Dual Special Needs plans and Medicare Advantage plans.
- Use insurance indicator MA or MB when filing claims secondary to Medicare Part A or Part B. Insurance codes typically filed when a Commercial plan is primary include 12, BL, CI and HM, but this isn't an all-inclusive list and other codes may be more appropriate. You can find a more comprehensive list of indicator codes **here**.
- We'll deny claims submitted with incorrect insurance indicators. Please make sure to enter policy numbers correctly for all secondary claims. Secondary claims submitted with incorrect or invalid policy numbers will also be denied.

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

Upcoming Changes to Telehealth Coverage

We've worked closely with the Division of TennCare and TennCare managed care organizations (MCOs) to provide ongoing coverage for telehealth services. To better standardize coverage across all three MCOs, we're making some changes to our telehealth policies that will take effect Oct. 1, 2024. These changes apply to our BlueCare, TennCare*Select* and CoverKids lines of business.

Beginning Oct. 1, we'll only cover the codes listed on the **Telehealth Approved Code list**. We'll publish this list in advance of the Oct. 1 effective date on the **Manuals, Policies and Guidelines** page of **bluecare.bcbst.com/providers**. Additionally, we're reducing the rate for audio-only telehealth services by 15%. We'll use CPT® codes to identify audio-only services eligible for the rate reduction.

If you have questions, please contact the Provider Service line for your patient's plan:

- BlueCare – **1-800-468-9736**
- TennCare*Select* – **1-800-276-1978**
- CoverKids – **1-800-924-7141**

Join Us for the August 2024 EPSDT Virtual Coding Workshop

We're hosting our second Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coding workshop of 2024 on Aug. 22 from 11:30 a.m. to 1:30 p.m. CT (12:30 p.m. to 2:30 p.m. ET). If you missed our June workshop, please plan to join us to get important information and hear from the Tennessee Chapter of the American Academy of Pediatrics. 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. Please **click here** and fill out the registration form to save your spot. We hope you can attend and look forward to connecting with you.

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

Encourage Your Patients to Consider Breastfeeding

Breastfeeding offers health benefits for moms and babies, but breastfeeding rates in our state have traditionally fallen below national rates. According to CDC data, 79.1% of infants born in Tennessee in 2018 had been breastfed, compared to a national estimate of 83.9%. Education and support from health care providers can help promote breastfeeding among Tennessee families.

Lactation consultant services are part of your patients' BlueCare Tennessee and CoverKids benefits. We cover outpatient lactation consultant services from in-network providers during pregnancy and the extended postpartum period. Parents can get these services through telehealth or in person in a one-on-one or small group setting, and there's no limit on the number of visits allowed. However, we may request additional information after 15 units are billed.

If you're already offering this education, your Provider Network Manager can offer resources for billing. Or ask us how we can support you in adding lactation services in your office.

For more information about covered lactation consultant benefits, visit **bluecare.bcbst.com/providers** and select **Maternity Support**. To help your patients connect with an in-network lactation provider, use our **Find Care tool**. Search for **Lactation Services** to find an International Board-Certified Lactation Consultant or use the **All Expertise** filter to find providers who offer lactation services at their location.

Tips for 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 aged 2 and younger.

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

Important Vaccine Considerations

Tennessee law requires that providers get informed consent from a parent or legal guardian before giving a vaccine to a patient under age 18. For more information, you can view the relevant law here: **wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=HB1380&GA=113**.

When administering and submitting claims for immunizations, please use the following 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 (Do not report with 90471 or 90473)
+90461*	IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered
90460 and 90461 are reported when the patient is 18 years or younger and the physician or other qualified health care professional performs face-to-face vaccine counseling	
90471	IA, one injected vaccine (Do not report with 90460 or 90473)
+90472	IA, each additional injected vaccine
90473	IA by intranasal/oral route; one vaccine (Do not report with 90460 or 90471)
+90474	IA by intranasal/oral route; each additional vaccine
90471-90474 are reported when the patient is over the age of 18 or when counseling is not performed	

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

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

- **Click here** to review a comprehensive list of all codes commonly administered pediatric vaccines.
- Review the **immunization schedules** for children and adolescents.

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

Process Reminders for *Select*Kids Members: Financial Responsibility and Obtaining Informed Consent

Foster parents aren't financially responsible for their foster child's medical care and shouldn't list themselves as the person responsible for payment on medical forms. If you have questions about payment, please contact the child's Department of Children's Services (DCS) representative.

DCS also facilitates the informed consent process for children and teens in state custody so they get appropriate health care. This means a child's DCS representative may consent to care or delegate consent to the person who cares for the child daily (foster parents, legal guardians).

To review the related DCS policy, click **here**. More information about obtaining informed consent is also available in our **Provider Administration Manual**.

Note: Information in this article only applies to TennCare*Select*.

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

In late 2024, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2023, and June 30, 2024.

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 2023 and June 2024, 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.

Delivering School-Based Services to BlueCare Tennessee Members

Some children with an Individualized Education Program (IEP), Individual Health Plan (IHP) or Individual Family Service Plan (IFSP) require support that goes beyond addressing educational needs. They also require medical or behavioral health care services while at school. In-school nurses may be reimbursed for school-based medical or behavioral health services.

Medically necessary, TennCare-covered services in the student's IEP, IHP or IFSP may be reimbursed by a child's BlueCare or TennCare*Select* health plan when provided at school. To be eligible to bill for health care services, the school district and any individual health care provider treating the student must be in our provider network.

Examples of covered services include:

- Physical, speech or occupational therapy
- Assessment and treatment of acute and chronic illnesses
- Blood glucose monitoring and testing
- Tracheostomy care and suctioning
- Colostomy care
- Catheterization
- O2 saturation monitoring (pulmonary or cardiac disease)
- Tube feeding
- Wound care
- Nebulizer treatment
- Medication administration for medically fragile students as identified in their IEP, IHP or IFSP
- Behavioral health services (**Note:** A student's primary care provider isn't required to order behavioral health services, and these services don't need to be included in the IEP, IHP or IFSP to receive payment.)

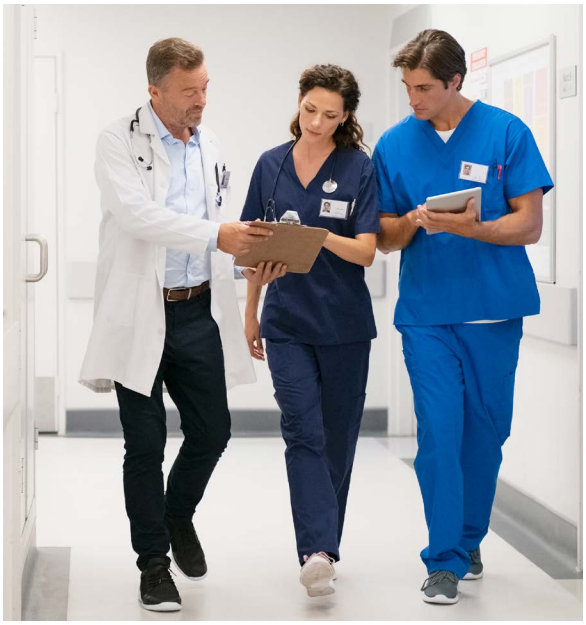
The following requirements must be met to bill for these services:

- Inclusion in the IEP, IHP or IFSP
- Physician's order
- Parental consent form
- Documentation of medical necessity and service delivery
- Services performed by a participating provider

School districts must submit claims for school-based services within 365 days of the date of service. For medically necessary, covered services in the IHP, please include CPT® code 99211 with place of service 03 as the daily billable CPT® code to include a global fee. For more information, you can view the most current version of the TennCare School-Based Services Billing Manual **here**.

If you have questions, please call BlueCare Provider Service at **1-800-468-9736**.

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



New Payment Guidelines: Assistant-at-Surgery Services Provided by a Physician Assistant

Effective **June 1, 2024**, we provide separate reimbursement for assistant-at-surgery services given to BlueCare and TennCare*Select* members by a physician assistant credentialed as an assistant at surgery. Please report these services by appending the Level II HCPCS modifier AS (physician assistant, nurse practitioner or clinical nurse specialist for assistant at surgery) to claims.

We base reimbursement of eligible services for physician assistants with the assistant-at-surgery credential on the lesser total of covered charges or 13.6% (i.e., 85% of 16%) of the maximum allowable fee schedule amount. The maximum allowable for assistant-at-surgery services provided by a physician assistant who isn't credentialed will be $0.

Please note: Physician assistants must bill assistant-at-surgery services using the unique provider number or the NPI assigned for this purpose. We'll also only reimburse assistant-at-surgery charges if filed with the appropriate taxonomy code.

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

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

Provider Satisfaction Survey Coming Soon

Providers in the BlueCare and TennCare*Select* networks will receive our **2024 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.

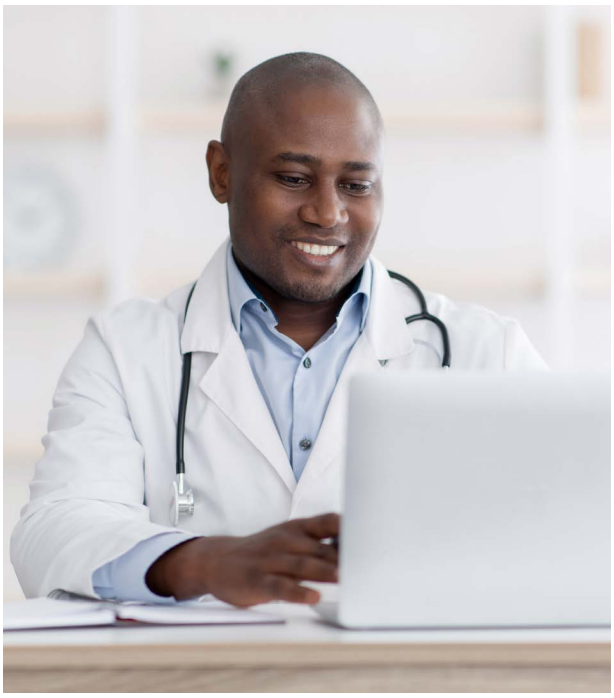
To learn more about the survey and how you can participate, please read the Division of TennCare's survey letter, on our website at **bluecare.bcbst.com/providers**.

Billing Requirement for Professional and Institutional Claims

The National Provider Identifier (NPI) submitted on professional and institutional claims for the secondary provider rendering services must belong to an individual (Type 1 NPI). If the NPI belongs to a group, facility or other organization/entity (Type 2 NPI), we'll deny the claim or return it unprocessed.

The Division of TennCare requires us to ensure secondary providers submit a Type 1 NPI instead of a Type 2 NPI on professional and institutional claims. Secondary providers include:

- Attending
- Rendering
- Ordering
- Operating
- Other operating
- Supervising
- Referring



Please note: CHOICES or Department of Intellectual and Developmental Disabilities (DIDD) 1915c claims, where the billing provider is atypical, are excluded from this requirement. For these claims, it's appropriate for the attending provider to not be an individual.

If you have questions about this requirement, please call the **Provider Service line** for your patient's plan.

Be on the Lookout for Verida Information Requests

Verida is our vendor that offers transportation services to our BlueCare and TennCare*Select* members. The company conducts regular pre- and post-trip audits to make sure these members use transportation only for covered services and the visits go as scheduled. As part of these audits, Verida may call your office to verify your patients' appointments. This is a normal part of Verida's process, and you may release the requested information.

Note: This information doesn't apply to CoverKids.

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless stated otherwise.

Guidelines for Submitting Electronic Secondary Claims

As a reminder, it's important to submit the correct primary policy numbers to avoid delayed payments and denials. Claims billed secondary to any primary payor must be billed with the correct primary policy number listed on the member's insurance card. Claims filed with incorrect or invalid policy numbers will be denied.

Use Availity to Change Members' Primary Care Provider

The **BlueCare Primary Care Provider (PCP) Change Maintenance** application is now available in Availity. We've phased out the existing PCP Change Request Form and no longer accept these requests by fax or email.

As of **June 1, 2024**, providers need to use the BlueCare PCP Change Maintenance application to change the PCP for a member with **BlueCare Plus** coverage.

Please note: This only affects the PCP change process providers use. Our members can still change their PCP by calling the Member Service line or through their member online account.

When you use the application, changes are made in real time. For step-by-step instructions for using the new Availity application, review our Quick Reference Guide in the **Resources** section of our **Payer Spaces**. If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your eBusiness Regional Marketing Consultant.

2024 Special Needs Plan Model of Care (MOC) Training is Now Available

Providers participating in BlueCare Plus Tennessee 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 at **bcbst.com/model-of-care-training**.

BlueCare and BlueCare Plus Tennessee

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

Instructions for Billing Corrected Claims

Providers should file corrected bills for Institutional and Professional claims electronically in the ANSI-837, version 5010, format. (We only accept paper claims if providers can show proof of a technical or temporary extenuating circumstance preventing them from filing claims electronically.)

When submitting a corrected bill to an institutional (ANSI 8371) or professional (837P) claim, the corrected bill must be submitted with the correct frequency code to indicate a "Replacement of a Prior Claim" (frequency code 7) or a "Void" (frequency code 8) as the third digit of the Type of Bill. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate if the bill is an Adjustment, Replacement or Void.

For more information, please see the Provider Administration Manual (PAM) for your patient's plan. We'll deny electronic and paper corrected claims that don't follow the billing guidelines outlined in the PAM as duplicate submissions. These guidelines also apply when submitting a correction to an Explanation of Benefits (EOB) form. The associated claim should be submitted as described above to prevent claims denial.

Medicare Advantage

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

Sleep Studies for CPT® codes 95810 and 95811

When submitting a prior authorization for CPT® codes 95810 or 95811 through Availity, always select the Local Coverage Determination (LCD) **Polysomnography L36593** as your guideline.

Wound Care Authorizations submitted through Availity

Wound Care Authorizations can now be submitted online through Availity for all Medicare Advantage members. Simply launch the **Prior Authorization Submission/Review** application from the **Payer Spaces** page. Locate the **Prior Authorization** tool, click on the **Authorization/Advance Determination Submission** drop-down menu, then select the **Outpatient Therapy** form from the left navigation menu.

If you have questions or need Availity training, please contact your **eBusiness Regional Marketing Consultant**.

Medicare Advantage and Dual Special Needs Plans

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

Submitting Clinical Documentation in Availity for New Members

CMS Final Rule for Continuity of Care, as part of the 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F), emphasizes the importance of timely access to care and streamlines the process for submitting clinical documentation. Under this rule, providers are required to submit clinical documentation when submitting initial authorization requests for new members, clearly demonstrating whether the request is for **ongoing care** or a **new diagnosis**.

For new diagnoses, include a detailed report of the diagnosis, the proposed treatment plan and the expected outcomes. You'll also need to include any relevant test results or medical history supporting treatment. **For ongoing care**, provide a summary of the treatment to date, including any progress notes. Make sure the documentation reflects the continuity of care and need for ongoing treatment.

If you have questions, please call the appropriate Provider Service line:

- BlueCare Plus: **1-800-299-1407**, seven days per week, 8 a.m. to 6 p.m. ET
- Medicare Advantage: **1-800-924-7141**, seven days per week, 8 a.m. to 9 p.m. ET

Pharmacy

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

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

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

Tips for Coding Professionals

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

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

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

Quality Care Rewards

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

Episodes of Care Announcement: 2024 Cost Threshold Adjustment

The Division of TennCare and the managed care organizations are making a **one-time** adjustment to the 2024 Acceptable and Commendable cost thresholds. Providers in the BlueCare network who participate in Episodes of Care will get an **across-the-board increase of 3.2%**. You'll see the updated thresholds reflected in your quarter 1 2024 performance reports, which we'll upload to Availity later this month. To review a memo from TennCare about the changes, please click **here**.

You can find an updated list of **Acceptable** thresholds for 2024 in the **Technical Documents section of TennCare's Episodes of Care provider page**. We'll post the **Commendable** thresholds on the **Quality Care Initiatives page** of **bluecare.bcbst.com/providers**.

Note: This article only applies to the BlueCare line of business.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Quarterly Reports Coming Soon

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available Aug. 15, 2024. 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**.

Note: This article applies to Commercial and BlueCare lines of business.

New Medical Record Requirement for Quality Care Rewards Application

Beginning **Sept. 5, 2024**, providers will be required to upload supporting documentation from patient medical records to the Quality Care Rewards (QCR) application in Availity when attesting to the Colorectal Cancer Screening (COL, COL-E*) measure. This helps ensure patient records to support the colorectal cancer screening attestations are readily available in the QCR application when attestations are reviewed annually, so you don't have to search for them later. We'll be applying the same requirement to other Healthcare Effectiveness Data and Information Set (HEDIS®) measures in the future, and we'll let you know when that change is coming.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

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Important Note:

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

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

Update your provider profile on the **CAQH Provider Portal** website.

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