of Tennessee

JULY 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

Throughout the COVID-19 pandemic, we made changes to help our members and providers stay safe. 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

Be Sure to Register for the 2024 All Blue Workshop℠

Don't forget 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. 1**.
You can also register by visiting the All Blue Workshop **page** on **provider.bcbst.com.** Space is limited, so please register soon. For more information, please contact your Provider Network Manager.

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.**

Electroconvulsive Therapy

Effective **July 1, 2024**, electroconvulsive therapy no longer requires prior authorization. If you have questions, please contact your Provider Network Manager.

Note: The information in this article only applies to BlueCare Tennessee, BlueCare Plus Tennessee and Medicare Advantage.

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.

A PWK Attachments Quick Reference Guide is available 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 set up within the portal for security. When you're entering authorizations, don't let Availity's 30-minute security 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, BlueCross' payer ID is 00390.

Member ID Cards Now in Availity

Availity's Eligibility & Benefits Inquiry tab now includes the Member ID card for all BlueCross members. Here's how to find your patient's information:

- Log in to **Availity**
- Select **Patient Registration**, then select **Eligibility & Benefits Inquiry**
- Fill in the provider information, then enter the member's information in **Search Options**
- Select a member from the results and click **Submit**

The member's benefits will display, and you can click the Member Card button to view the front and back of the ID card.

If you have technical issues or general questions, please call eBusiness Technical Support at **(423) 535-5717**, **option 2**.

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 make electronic submission easier for smaller and non-traditional health care providers.

If you have any questions, please contact your eBusiness Regional Marketing Consultant, call us at **423-535-5717, opt 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 via email that can be updated in CAQH. 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 view 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.

Updated Health Reimbursement Account (HRA) Information in Availity

The **Eligibility & Benefits** application has been enhanced in Availity to show the individual and family HRA balance including the remaining balance details. If you have questions about the member's benefits, you can click **Coverage Questions** to get to the **Fast Path** phone number and member transaction ID number.

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

Evaluation and Management CPT® Codes Shouldn't be Applied for Admission through Availity

When submitting prior authorizations for **inpatient or observation care**, please don't apply Evaluation and Management (E/M) CPT® codes such as 99221, 99222 and 99223. The Milliman Care Guidelines (MCG) will display correctly based on the diagnosis code on the authorization. If the member meets the MCG guideline criteria, authorizations may receive immediate approval without these procedure codes. If you use these CPT® codes, the authorization is more likely to be held for review.

Enter Individual NPIs When Requesting Prior Authorizations

Always enter the Individual NPI into the **Requesting/Servicing** provider field for BlueCard® and BlueCross BlueShield of Tennessee members when requesting prior authorization. If the Group NPI is submitted, the authorization will appear to be out of network, which may delay the authorization.

Save Time with Digital Drug Prior Authorization Requests

Did you know you can avoid on-hold wait times by submitting provider-administered drug prior authorization requests in Availity? You can speed up submission and have access to a dashboard of all your open and completed coverage reviews.

You can find instructions in the **Provider-Administered Drug Prior Authorization Quick Reference Guide** in Availity's **Payer Spaces** under **Resources**. If you need access to Availity, check with your office Availity Administrator. If your office doesn't have access to Availity, you can register your organization at: **availity.com/Essentials-Portal-Registration**.

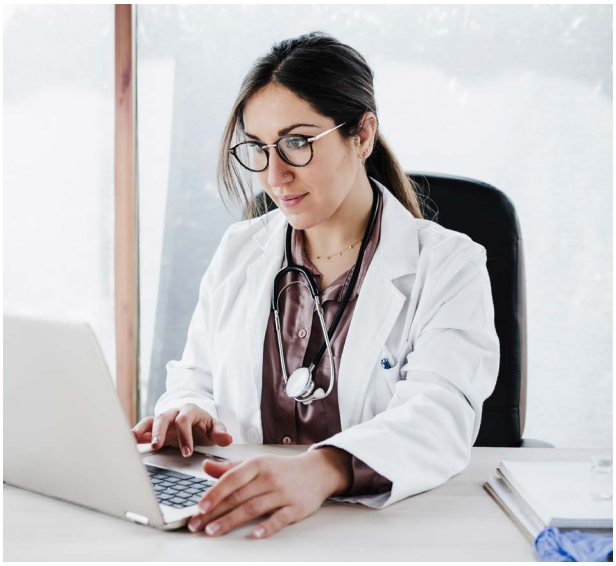
For help getting started, contact your eBusiness Marketing Consultant for training and education.
Please note, self-administered drugs can still be requested through **CoverMyMeds** or **Surescripts**.

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.

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.

Primary Care Provider Performance Ratings Refresh Coming Soon

Primary Care Provider (PCP) Performance Ratings in our online provider directory help our members make informed health care decisions when choosing a PCP in Networks P and S.

We're entering a new refresh cycle and we'll send a notification to the email address listed under the **Contract** contact type in Availity's **Payer Spaces**. The notification includes instructions on how to locate the refreshed ratings in the **Quality Care Rewards (QCR)** application before they're published in the provider directory this fall. If there isn't a valid email listed, we'll mail a letter with the same message to the practice.

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

Low Back Pain: Coding is Key

Patients with uncomplicated low back pain (LBP) should wait 28 days or more after receiving a primary diagnosis before ordering an imaging study (plain X-ray, MRI or CT scan).

It's important to include documentation and coding, along with the LBP diagnosis on the claim for "red flag" conditions (exclusions) where an imaging study should be ordered. This prevents an open gap in the measure that can't be closed. There's a six-month review period for any primary diagnosis of LBP during that time.

Encourage your patients to try alternative treatments like ice, heat and over-the-counter pain relief. As well, they'll benefit from your advice about proper back strengthening exercises and practicing safe back habits.

Additional resources are available in our **LBP Coding Guide** and **LBP Coding Toolkit**. Providers can request an **LBP Pocket Tool** by emailing **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**.

Changes to Genetic Testing Program Prior Authorization

Beginning **Aug. 1, 2024**, the following codes will be added to the Genetic Testing prior authorization list in the EviCore Genetic Testing Program.

0020M, 0452U, 0453U, 0454U, 0456U, 0460U, 0461U, 0464U, 0465U, 0466U, 0467U, 0469U, 0470U, 0473U, 0474U, 0475U

Beginning **Aug. 1, 2024**, the following codes will be removed from the Genetic Testing prior authorization list in the EviCore Genetic Testing Program.

0204U, 0353U

BlueCare Tennessee

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

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**.

Submitting Adverse Occurrence Reports

Effective **July 1, 2024**, you're required to submit Adverse Occurrence (AO) reports for all levels of Behavioral Health Supported Housing when appropriate. Previously, the requirement only applied to Psychiatric Acute Inpatient, Residential Treatment Centers, Crisis Stabilization Units and Specialized Enhanced Supported Housing levels of care.

Please complete the **Behavioral Health Adverse Occurrence** form located **on our website** under **Patient Administration**. Fax the complete form to **1-866-259-0203**.

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

Promote Behavioral Health Screenings During and After Pregnancy

A critical component of prenatal and postpartum care is screening for anxiety, depression and other behavioral health needs. According to the **Maternal Mortality in Tennessee 2021 report** prepared by the Tennessee Department of Health, behavioral health needs contributed to nearly 32% of all pregnancy-related deaths.

Screening for depression and anxiety during the perinatal period is especially important for people of color who are more likely to face health disparities and less likely to get the right prenatal care. In honor of National Minority Mental Health Awareness Month, consider talking with patients about their behavioral health needs and incorporating behavioral health screenings into prenatal and postpartum visits. Your patients should have a depression screening using a standardized tool, such as the Edinburgh Postnatal Depression Scale (EPDS) or Patient Health Questionnaire-9 (PHQ-9), during pregnancy and within seven to 84 days after delivery. If screenings are positive, follow up with patients within 30 days to connect them to care.

Our BlueCare Tennessee network providers can earn an extra payment on top of their regular reimbursement for performing a behavioral health screening during the perinatal period. For more information, including billing guidelines, please see our **Maternity Care** page at **bluecare.bcbst.com/providers**.

Tennessee Centers of Excellence: A Resource for Providers Caring for At-Risk Pediatric Patients

There are five Tennessee Centers of Excellence (COE), and they're designated tertiary care, academic medical centers, provider agencies and other partners with expertise in children's physical and behavioral health. These centers support children in Department of Children's Services (DCS) custody or who are at risk of entering custody.

The COEs have built relationships with the Department of Children's Services (DCS), local providers and other stakeholders, and provide treatment recommendations and consultations when children have complex needs and aren't responding to treatment as expected. They also provide direct evaluation and treatment services to children with complex medical and behavioral health needs.

Consider referring a patient in or at risk of DCS custody to one of the COEs when:

- The case is complex and there are diagnostic and mental health concerns.
- There are conflicting diagnoses among providers.
- A comprehensive review of the child's history (behavior, treatment or placement) would help determine the child's current needs.
- An evaluation or examination would add information needed for placement or treatment considerations.
- There's a concern about a developmental delay.
- There's a concern about the child's medications.

For more information about the COEs, including a list of centers and contact information, visit the **Division of TennCare's website**.

Help Prepare Your Patients for the New School Year

Children and teens throughout Tennessee will be heading back to school soon, and providers play a key role in making sure they're ready. As the new school year approaches, consider using our **Quality Care Rewards** application in Availity to find out which patients are past due for checkups or vaccines they may need for school. Then, contact patients to schedule appointments.

This is 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) well-child exams satisfy all components of a sports physical.

For more information and helpful tips, please see our **EPSDT Provider Tool Kit**.

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

Non-Discrimination Compliance Training Reminder

We encourage all providers who participate in BlueCare, TennCare*Select*, CoverKids, CHOICES or ECF CHOICES to complete your annual non-discrimination compliance training. You can find the Non-Discrimination Compliance Information for Providers presentation at **Tools and Resources** on the BlueCare website.

Stay Up to Date on the Provider Appeals Process

If you disagree with the amount we paid you for a particular 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, including all supporting medical records, by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or multiple claims.**

Please note, 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 – We must receive your appeal in writing with all supporting medical records **within 60 day**s after receiving the other party's response to its inquiry/reconsideration. I**f we don't receive it within 60 days, your appeal could be rejected as a timely filing denial**. 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 Tennessee

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

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 Space**. 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 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 at **bcbst.com/model-of-care-training**.

Medicare Advantage

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

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 Plan

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

Psychological and Neuropsychological Testing

Effective **July 1, 2024** psychological and neuropsychological testing no longer require prior authorization for BlueCare Plus Tennessee and Medicare Advantage members.

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

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

Medical and Behavioral Health Case Management Referrals in QCR Application

Providers can now submit referrals to our Medicare Advantage and BlueCare Plus Medical and Behavioral Case Management programs through the Quality Care Rewards (QCR) application.

These programs include fully integrated teams with registered nurses, licensed social workers, registered dietitians and health navigators who specialize in helping the senior and dual eligible populations. Our programs are available to all members at no additional cost. They provide additional education and support to your patients while promoting quality and cost-effective care coordination.

To refer a patient to a case management or behavioral health program through the QCR, navigate to the member's page, click onthe **Case Management Referrals** tab, click on **Make A Referral**, complete the **referral form** and then click **Submit**.

Individual member referral, case status and history are available on the **Case Management Referrals** tab on the member's page. Practice-level view of all members in case management is available in the **Case Management** tile on the QCR home page.

Please contact your Provider Quality Outreach Consultant for questions or help with Case Management or Behavioral Health program referrals.

Important Provider Assessment Form Reminders

Remember to complete Provider Assessment Forms (PAF) on your patients this year. A PAF must be completed during a face-to-face or telehealth visit (using both video and audio components). It can also be completed once per year in conjunction with a Medicare Annual Wellness Visit (AWV) or any other office visit type.

To complete a PAF, locate the brief, **hierarchical chronic condition (HCC)-focused PAF** in the Quality Care Rewards (QCR) application in Availity®. You can complete it in the QCR application, export it for manual completion and upload it to the QCR, or ax it to the number at the top of the form. **A copy of the completed PAF from the QCR is required to be maintained in the medical record.**

Please note, the non-standard PAF or office visit notes aren't accepted beginning with 2024 dates of service and won't be reimbursed.

Remember to check your **Assessment Approvals** under your **Approval Queue** in the QCR for any assessments awaiting submission by a clinical level role user and/or assessments awaiting completion and submission. **Please note**, assessments that are **Pending** or **In Progress** are voided if they're not completed and submitted within 90 days of the date of service.

Submit CPT® code 96161 along with the appropriate visit Evaluation and Management (E/M) code on your claim once the PAF is complete, submitted and on file in the patient's medical record. No modifier is needed. Reimbursement for completion of a PAF completed in/exported from the QCR application is $225.

If you have questions, please contact your Provider Quality Outreach 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.

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.

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**.

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

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
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	1-800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***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
Seven days/week, 8 a.m. to 9 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 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**.