of Tennessee

OCTOBER 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.

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## We Want to Hear From You!

We sent our 2024 Provider Satisfaction and Wait Time Surveys earlier this year to providers participating in certain BlueCross networks. If you got a survey and haven't completed it yet, please share your feedback with us as soon as possible so we can continue working to enhance our service to you.

## Help Prepare Your Patients for Flu Season

Fall signals the beginning of flu season in our state. Consider these tips to help prepare your patients – and your practice – for the 2024-2025 flu season.

- Talk with families about the importance of the flu vaccine and how they can lower their risk of getting sick.
- Schedule patients' flu vaccines in advance and send appointment reminders. The Centers for Disease Control and Prevention (CDC) recommends everyone age 6 months and older get a flu shot, preferably by the end of October.
- It's especially important that people 65 years and older get the flu shot because they're at higher risk of serious complications from the flu. The CDC recommends they get a higher dose or an adjuvanted flu shot.
- Changes in the immune system, heart and lungs make pregnant people more prone to serious illness from the flu. Getting vaccinated during pregnancy can protect pregnant people and help protect their babies from the flu during the first six months of life.
- Review patient medical records before visits, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams, to see if patients have already gotten their flu shot. If not, consider administering the shots during the visits as appropriate. While the CDC recommends vaccination in September or October, the agency notes that vaccination in July and August may be considered for children and teens who have health care visits during these months. These young people may not return to see a provider in September or October, so their well-care visit may be the only opportunity to give the vaccine.
- If you have patients who turn 6 months old toward the end of flu season, don't forget to order extra doses of the vaccine. Infants need two doses of the flu vaccine at least four weeks apart during their first flu season, and it's often in short supply in February, March and April. For more information about the CDC's recommendations about the flu season and young children, please click **here**.

## New Paper Check Process for Providers Enrolled for Electronic Remits

To reduce paper and streamline processes, we're changing the way we manage payment for providers who've asked for electronic 835 remits but want to receive paper checks. Beginning **Nov. 1, 2024**, these providers will begin receiving their checks by mail – but will no longer receive the paper remits that were attached to the checks. As always, these providers can access their remittance advice online through Availity® at **Availity.com**. **Please note: this won't affect providers enrolled for paper remits and checks at this time.** They'll continue to receive both items together in the mail.

If you have questions, please call our Provider Service line at **(423) 924-7141** and follow the prompts for general inquires. You may also reference the Provider Administration Manual for more details about registering with Availity or contact our eBusiness Service team at **(423) 535-5717 (option 2)**.

## Taxonomy Code Reminder

As a reminder, professional claims require a taxonomy code (a unique 10-character code that designates your classification and specialization) for billing and rendering providers. The **National Plan and Provider Enumeration System (NPPES)** directory shouldn't be the single source of determining the correct taxonomy.

It's important for both the billing and rendering provider taxonomy codes to match how you're credentialed and contracted with us. For example, if you have a pharmacy, specialty pharmacy and durable medical equipment (DME) provider contract, you'll need to file with the specific taxonomy indicated for each contracted service. If you don't submit the appropriate taxonomy codes, your claims may be rejected or denied, or result in reduced reimbursement.

Please be sure to file the two-digit qualifier with taxonomy.

## 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 the 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, you should use the PWK process to submit the attachments **the same day** the electronic claim is filed. Follow the instructions on the PWK cover sheet carefully to make sure we get your records 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, 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.**

## Update CAQH With All Credentialing/Recredentialing Documentation

Please be sure to update 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.

As of **Sept. 1, 2024**, we're no longer accepting 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.

# Commercial

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

## Focus on Appropriate Testing for Pharyngitis (CWP)

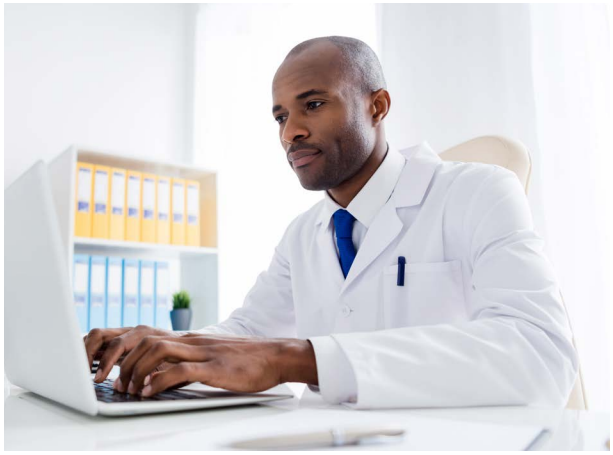
The CWP measure is focused on patients three years and older getting a strep test before receiving an antibiotic for a related pharyngitis diagnosis (acute pharyngitis, acute tonsillitis, streptococcal pharyngitis, etc.). It doesn't matter if the strep test result is positive or negative, as long as the test was performed. **Documentation on the claim form of an in-office strep test, the excluding comorbidity or the competing diagnosis is important in gap prevention for this measure.**

### Exclusions to the Measure

- Patients in hospice
- Comorbid conditions: (If the patient had a diagnosis during the 12 months prior to, or on, the episode date) HIV, cancer, emphysema, COPD, disorders of the immune system
- Competing diagnosis exclusion: The episode date and three days following the episode date when the member had claims/encounters with any competing diagnoses

## Verify Member Benefits before Submitting High-Tech Imaging Authorizations

Please be sure to check member benefits to see if a High-Tech Imaging prior authorization is necessary before submitting. This can save your practice time, as not all member plans require this. When looking up the member's benefits in Availity, click the **Prior Authorization Requirements** button and then look for the **High-Tech Imaging** section. If "yes" is listed, then an authorization is required, but if 'no' is listed, then an authorization is not required.



## Federal Employee Program (FEP) Implements Changes for U.S. Postal Service (USPS)

Starting **Jan. 1, 2025**, FEP is offering a new Postal Service Health Benefits (PSHB) plan for USPS employees and retirees, as well as their eligible family members. While PSHB will be part of the overall Federal Employees Health Benefits program, it will be a separate plan from those offered to other federal employees in the program.

Transitioning PSHB members will continue to use Blue Network P so there will be no network changes. Additionally, benefits/coverage will remain the same and members will still use their current FEP-branded Member ID cards. The only change will be a new group number. Network P providers could start seeing PSHB members as early as Jan. 1, 2025.

For questions prior to Jan. 1, 2025, please contact FEP customer service at **1-800-572-1003**. After Jan. 1, 2025, providers with questions about PSHB should call **1-866-780-7742**.

## Specialized Pregnancy Phone Line Discontinued

In Oct. 2022, we implemented a specialized phone line for providers with questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who were facing a non-viable pregnancy. We are now transitioning these calls back to our normal phone line.

Effective **Oct. 1, 2024**, we'll no longer have the specialized pregnancy phone line. Instead, you can call about pregnancy-related topics on our regular Provider Service line, **1-800-924-7141**.

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

As stated in earlier BlueAlert newsletters, please do not submit **Commercial** prior authorization requests through EviCore for high-tech imaging, genetic testing and radiation oncology. We've been managing these authorizations directly since **Sept. 1, 2024**.

To submit a prior authorization request, you can call us at **1-800-924-7141** or send it through Availity.

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

Please note: BlueCare Tennessee authorizations will still go to EviCore. The Availity prior authorization form will direct you regardless of line of business.

## 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 be automatically approved 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 on the authorization process, please contact your **eBusiness Regional Marketing Consultant**.

# BlueCare Tennessee

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

## 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 days** after receiving the other party's response to its inquiry/reconsideration. **If 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**.

## 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 **Documents and Forms** on the BlueCare website.

## Reimbursement Guideline Change: CPT® Code 36416

Beginning **Nov. 1, 2024**, we'll no longer provide separate reimbursement for CPT® procedure code 36416. This change aligns with guidelines from the Centers for Medicare and Medicaid Services (CMS), which has designated 36416 as a bundled code. This means procedure code 36416, associated with capillary blood specimen, will be considered part of a comprehensive service and included in the reimbursement for related procedures.

## Behavioral Health Provider Initiated Notice

The **Provider Initiated Notice (PIN)** form may now be attached to the Member Authorization on Availity. Simply look up the existing authorization, and attach the PIN form in the **Clinical Update** section. The **Quick Reference Guide** is housed on **Availity Payer Spaces** under the **Resources** tab. If you have Availity questions or would like training for your organization, please contact your **eBusiness Regional Marketing Consultant**.

## New Applied Behavior Analysis (ABA) Request Form and Program Description

On **Oct. 8, 2024**, a new ABA request form and program description will be added to the BlueCare Tennessee documents and forms page on **bluecare.bcbst.com/providers**. The universal ABA Request Form incorporates processes across the three managed care organizations (MCOs) for a universal approach to ABA service requests. This tool strengthens the necessary clinical data needed to render ABA utilization management decisions while reducing redundancies and multiple processes associated with the provider experience.

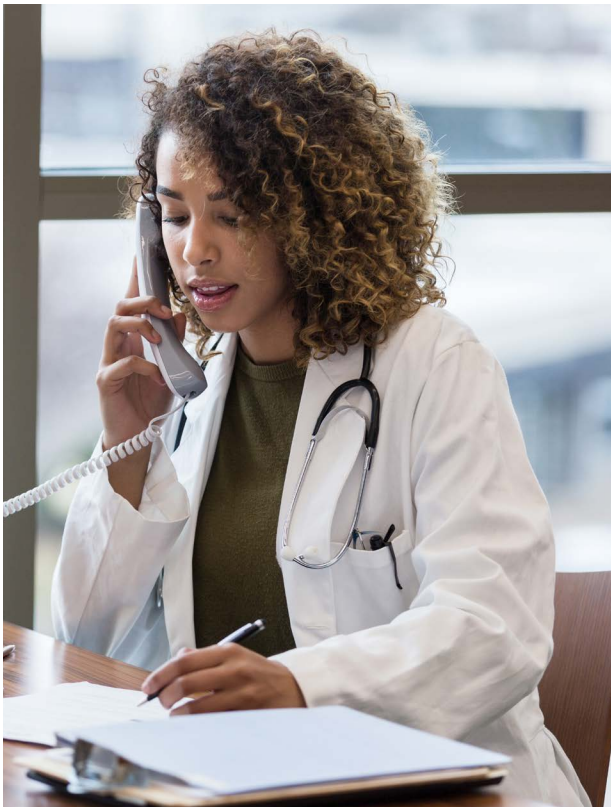
## Changes to Telehealth Coverage Take Effect

We've worked closely with the Division of TennCare and other managed care organizations (MCOs) to provide ongoing coverage for telehealth services. To better standardize coverage across all three MCOs, we made some changes to our telehealth policies that took effect **Oct. 1, 2024**.

We only cover the codes listed on the **Telehealth Approved Code list** published on the **Manuals, Policies and Guidelines** page of **bluecare.bcbst.com/providers**. Additionally, we've reduced 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**



## New Process for Member Roster Maintenance Starting Soon

The Division of TennCare and the three MCOs have worked together to update the process for member roster maintenance. The result of this collaboration is new criteria for member roster removal.

A small group of our network providers are currently using the new guidelines. All primary care providers caring for our BlueCare, TennCare*Select* or CoverKids members will need to adopt the new guidance beginning **Jan. 1, 2025**.

We'll share more about the criteria and new process in upcoming BlueAlert articles. In addition, we'll update the BlueCare Tennessee Provider Administration Manual for Jan. 1, 2025. Please stay tuned for more information.

## Electronic Visit Verification (EVV) System and Process Updates

Sandata recently updated the code for social workers in its system. For providers currently using a third-party EVV vendor, Sandata is working to update its BlueCare Tennessee Alternate EVV Specifications and Specification User Guide, which are both available **here**.

## Make Sure Your Claims Match EVV Data

Effective **Oct. 1, 2024**, we'll deny any claims for intermittent home health services that don't have matching EVV data.

If you have questions about the code update or EVV implementation for intermittent services, please contact your BlueCare Tennessee EVV representative by phone or email.

## Provider Orders for Home Health Services

When submitting orders for home health services to a patient's preferred home health agency, please only include the home health service(s), the amount and the frequency on the order. Including the name of a specific home health agency can lead to delays in care.

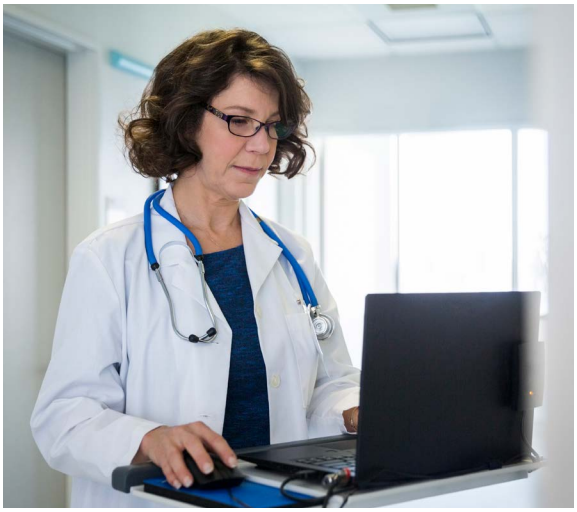
## Behavioral Health Screening: A Key Component of Perinatal Care

World Mental Health Day is Oct. 10. This is a great time to review your practice's policies related to maternal mental health screening and talk with patients about their behavioral health needs.

The American College of Obstetricians and Gynecologists lists perinatal mood and anxiety disorders among the most common complications during pregnancy and the first year after birth. If left untreated, maternal depression, anxiety and other behavioral health concerns can significantly impact the health and well-being of new moms and their babies.

Pregnant 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, consider following 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 mental health screening at least once during the perinatal period. For more information about the payment and billing guidance, please see the **Maternity Support page** of **bluecare.bcbst.com/providers**.



## Process Reminder: Timelines for Submitting Appeals

Providers may file a written appeal if they disagree with the results of an inquiry/reconsideration. For us to consider the appeal, providers must submit it within 60 days of getting the reconsideration response. If we don't get the appeal within that time frame, we'll uphold the original claim decision.

The written appeal should include the basis of the dispute, why the inquiry/reconsideration response wasn't satisfactory, and the proposed method of resolving the dispute. For more information about our Provider Dispute Resolution Procedure and filing appeals, please see the **BlueCare Tennessee Provider Administration Manual**.

## Review Recommendations for Pediatric Behavioral Health Screening

Assessing development and psychosocial/behavioral health is an essential part of well-child care and should be included in each EPSDT exam. At certain ages, specific screenings, including screening for depression, are also needed. Early detection and treatment of behavioral health conditions help improve outcomes for children and teens.

Our BlueCare and TennCare*Select* members, including *Select*Kids, are eligible for preventive care on the same schedule put forward by the American Academy of Pediatrics (AAP). In addition to developmental and autism screenings in young children, the AAP/Bright Futures Periodicity Schedule recommends:

- Depression screening at 12-21 years of age
- Alcohol and drug use assessment at 11-21 years of age

To view the screenings needed at each stage of development, please review our **EPSDT Provider Tool Kit**. You can find resources related to providing care for children in or at risk of entering state custody on the **Best Practice Network page** of **bluecare.bcbst.com/providers**. If you're concerned about substance use or your patient's behavioral health, call us at **1-888-423-0131**.

## 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.

# BlueCare Plus Tennessee

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

## Medicare Prescription Payment Plan

Beginning **Jan. 1, 2025**, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) will be eligible for the Medicare Prescription Payment Plan. This is a new payment option that works with current drug coverage to help manage out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January – December).

BlueCare Plus and BlueCare Plus *Select* plans charge $0 cost sharing for covered Part D drugs, so this plan wouldn't apply. However, in some cases, BlueCare Plus Choice members could incur some out-of-pocket expenses and would be eligible for this program. We anticipate that members may direct questions about this benefit to their primary care physicians.

Most BlueCare Plus Choice members don't pay out of pocket for prescription drugs. Those that do pay, likely don't have a high enough out-of-pocket expense to benefit from the program. If you have a BlueCare Plus Choice member who pays a portion for covered prescriptions and may benefit from the program, please refer them to Member Service line at **1-800-332-5762** for more information.

### 2024 Special Needs Plan Model of Care (MOC) Training Still 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 Tennessee and BlueCare Plus Tennessee Plans

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

### Billing Requirement for Professional and Institutional Claims

In the **August 2024 BlueAlert**, we published an article related to billing professional and institutional claims, and we wanted to provide some additional information. For BlueCare Tennessee and BlueCare Plus Tennessee claims with dates of service of **Oct. 1, 2024**, and after, the National Provider Identifier (NPI) submitted on professional and institutional claims for the secondary providers 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 and Department of Disability and Aging (DDA) 1915c claims 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.

# Medicare Advantage Plans

*This information applies to our BlueAdvantage (PPO)℠ plans unless specifically identified below.*

### Important Provider Assessment Form Reminders

Remember to complete Provider Assessment Forms (PAFs) 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 fax it to the number at the top of the form. **Providers are required to maintain a copy of the completed PAF from the QCR 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 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 a PAF completed in/exported from the QCR application is $225.

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

# Medicare Advantage and Dual Special Needs Plans

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

## Time-Based Documentation and Coding

Accurate documentation is essential when it comes to time-based coding for E/M (evaluation and management) office visits. To bill a time-based code, CMS requires time to be met or exceeded to report the service. Appropriate documentation should include start and stop times or total time spent providing the individual timed service, a detailed explanation of what was included in that time and a description of the screening process, including any standardized tools or questionnaires used, and the results of the screening.

Common time-based codes:

- G0442 - Annual alcohol misuse screening, 5 to 15 minutes
- G0444 - Annual depression screening, 5 to 15 minutes
- G0446 - Annual, face-to-face intensive behavioral therapy for cardiovascular disease, 15 minutes
- 99497 - Advance care planning, including the explanation and discussion of advance directives, first 30 minutes

Please refer to CMS guidance on when and how to bill these codes correctly. If you have questions, give us a call at **1-800-924-7141**. We're here seven days a week from 8 a.m. to 9 p.m. ET.

## Submitting Clinical Documentation in Availity for New Members

The 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 clearly demonstrating whether the request is for ongoing care or a new diagnosis when submitting initial authorization requests for new members.

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.*

## 2025 Drug List Changes

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

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links on the Pharmacy Resources & Forms page to view the 2025 drug list changes:

- **2025 Preferred Formulary Changes**
- **2025 Essential Formulary Changes**
- **2025 BlueAdvantage Formulary**
- **2025 BlueAdvantage Extra Formulary**
- **2025 BlueCare Plus Formulary**

## Refer to the TennCare Pharmacy Benefit Manager for Important Updates

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

# 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

Effective **Sept. 5, 2024**, providers are 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 the review of attestations is being performed, 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).

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

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

## Contact Us Through Availity

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

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

CAQH Solutions | PROVIEW™

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

## Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

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| **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**.