SEPTEMBER 2024

BlueAlert℠

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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How to Update Hospital Affiliations Quickly and Accurately

If your hospital admitting privileges have changed, please make sure your updates are captured in the CAQH provider data profile so members will have the correct information. If you follow the directions below, your new privileges will be displayed in our provider directory within two business days.

- Go to the **Hospital Affiliations** tab in your CAQH Provider Data Profile.
- Use the drop-down menu to find the hospital name rather than choosing **other** or typing in the name of the hospital. This assures that all the correct information for that hospital is automatically loaded and won't require manual corrections.
- Continue filling in the updated information on this tab (Primary Hospital, Admitting Privilege Status, etc.).
- Select **Reattest** to send the information to us.

If you have questions, please contact your provider service line, located on the last page of this newsletter.

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. Please carefully follow the instructions on the PWK cover sheet 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, 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.

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.

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'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.

Commercial

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

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.

Beginning **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

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

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** survey between June and September. Please be sure to share your feedback so we can continue to work to enhance our service to you.

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 on the authorization process, please contact your **eBusiness Regional Marketing Consultant**.

BlueCare Tennessee

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

Upcoming Changes to Telehealth Coverage

We've worked closely with the Division of TennCare and 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**.

We'll only cover the codes listed on the **Telehealth Approved Code list**. We'll publish this list in advance 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**

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.

Trauma-Informed Care: Best Practices for Pediatric Providers

Children and teens in state custody sometimes have complex behavioral and emotional needs. They may also have experienced traumatic events. Incorporating aspects of trauma-informed care (TIC) into your approach when caring for children and teens in state custody can help ensure they get the right level of care.

The **National Child Traumatic Stress Network** defines TIC as a treatment framework designed to understand, recognize and respond to the effects of trauma[1]. Its goal is to help support stable, safe and nurturing relationships that build resiliency. Tips for incorporating TIC in your practice include:

- **Recognizing the signs of past trauma.** These can include nightmares, trouble sleeping, headaches, fatigue, feelings of fear, anger or sadness, and stomach pain. Patients may also be irritable, highly reactive and guarded, or have trouble managing stress and emotion.
- **Approaching trauma as you would other conditions.** TIC in a medical setting may include triage, taking a complete medical history, surveillance and screening, diagnosis, care coordination, and management strategies, such as medication therapy, anticipatory guidance for foster parents and caregivers, referral to other providers and follow up.
- **Using active-listening skills and creating an emotionally safe space for discussing trauma.** Practicing empathy and listening to children and caregivers in an active, nonjudgmental way helps facilitate discussions about trauma and trauma management. **Cultural competency** is also an important component of TIC. Additionally, when performing an exam or asking sensitive questions, consider explaining why you need to do so.

For more tips and information about TIC, review these helpful resources:

- **American Academy of Pediatrics – Trauma-Informed Care**
- **The National Child Traumatic Stress Network – Health Care Providers**

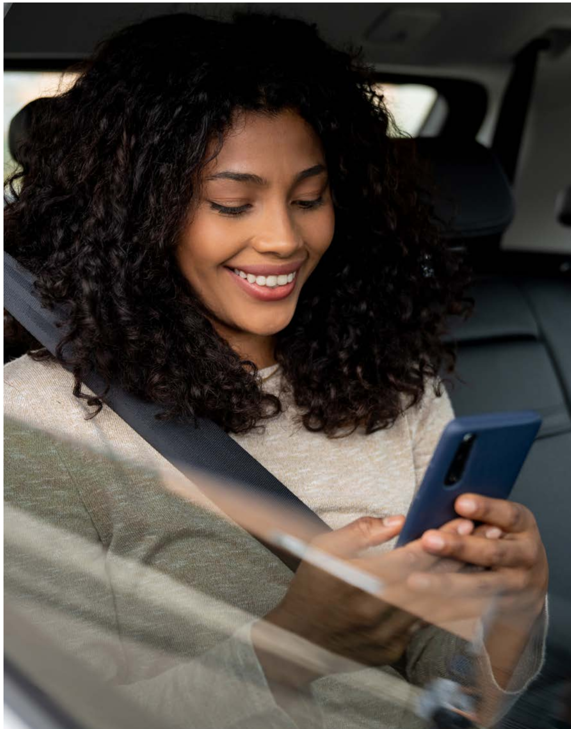
[1] nctsn.org/sites/default/files/resources//glossary_of_terms_related_to_trauma-Informed_integrated_healthcare.pdf

Make Sure All Patients Benefit From Well-Child Care

Children and teens with intellectual and developmental disabilities often have numerous visits to specialists or primary care practitioners. Even though they see their providers frequently, these young patients also need a TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exam every year. These checkups are an essential part of maintaining the health and well-being of all children and teens.

Your patients with BlueCare or TennCareSelect coverage are eligible for well-child care on the same schedule recommended by the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**. For more information about pediatric preventive care and to review a copy of the Periodicity Schedule, see our **EPSDT Booklet for Providers**.

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



Mileage Reimbursement for BlueCare Tennessee Members

We're working with Verida to provide non-emergency medical transportation to and from covered TennCare services. Depending on a member's location, transportation options may include:

- A shared ride service, such as Lyft, with multiple passengers in the vehicle
- A bus pass
- Mileage reimbursement

Mileage reimbursement is a convenient option for your patients with access to a vehicle or a friend or relative who's willing to drive them to their appointment. Our members who choose mileage reimbursement will get a form you'll need to sign confirming they visited your office. They'll then send the form to Verida, which will refund them for the miles traveled.

Note: This doesn't apply to CoverKids.

Transportation Available for Pharmacy Visits

BlueCare and TennCareSelect members can get a free ride to the pharmacy from our transportation vendor, Verida. If you plan to write a new prescription for a patient or know they'll need to get a prescription refill after their appointment, please remind them to plan ahead. Your patients can pick up prescriptions at the pharmacy on the same day as their visit if they've scheduled transportation for both for the same day.

In most cases, transportation requests must be made three days in advance. Your patients with BlueCare Tennessee coverage can schedule transportation online at **member.verida.com** or by calling Verida customer service for their plan:

- BlueCare Verida – **1-855-735-4660**
- TennCareSelect Verida – **1-866-473-7565**

You can also schedule transportation on a patient's behalf in the Verida facility/provider portal at **provider.verida.com**. To get started using the portal, call the appropriate number above for your patient's plan.

To learn more about these benefits, visit **bluecare.bcbst.com** and select **Get a Ride**.

Note: This information doesn't apply to CoverKids.

Use Quality Care Rewards to Refer Patients for Case Management

Primary care providers can now use the Quality Care Rewards (QCR) application in Availity to refer patients enrolled in BlueCare Tennessee and CoverKids for case management services. You can also use this application to see if a patient is already enrolled in case management, any previous case management history and the name of their case manager with contact information.

To start a referral, click **Case Management** from the Availity home screen. Then, select the patient you'd like to refer for services, choose **Case Manager Referrals** and click **Make a Referral**. To complete the referral, you'll need to share your contact information and details about support your patient may need. Referral reasons may include:

- Medical and behavioral health coordination
- Medical and behavioral health peer-to-peer support
- Utilization management assistance
- Help with appointment scheduling
- Pharmacy coordination needs
- Social needs/connection to community resources

Once you've submitted the referral, you'll get a confirmation. You'll also be able to view the referral on the **Case Management Referrals** tab. When we get the referral, we'll contact the patient or reach out to you with follow-up questions if needed.

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

Encourage BlueCare Patients to Engage with Spiras Health

We're partnering with a vendor called Spiras Health to provide at-home care for BlueCare members with complex health needs. With Spiras, your patients can:

- Receive ongoing, specialized care while getting help managing conditions more closely at home.
- Get help staying on track with their medication.
- Call their Spiras Care Team 24/7 to answer their health questions.

As a provider, Spiras can work with you to create a care plan tailored to each patient's health goals. A nurse will meet with patients in their home to get to know them and their health needs. The program won't replace any existing primary or home health care but will provide an additional layer of support.

Spiras Health will begin working with a select group of our members on **Sept. 1, 2024**. If your patients ask you about Spiras Health, please encourage them to sign up for a customized care plan.

Note: Spiras Health will only be working with BlueCare members. For BlueCare, TennCareSelect and CoverKids members who need additional support, we also offer a population health program that's available any time. Additionally, our members with specific needs may qualify for one of these four programs: SelectKids, SelectCommunity, CHOICES, and Employment and Community First CHOICES. For more information about our plans and programs, visit **bluecare.bcbst.com/providers**.

Promoting Prenatal Vaccination

Vaccines during pregnancy help protect pregnant patients and their babies against illnesses and potentially serious complications. Consider informing your patients about the benefits of getting these vaccines during pregnancy:

- **Tetanus, diphtheria and pertussis (Tdap)** – Vaccination between weeks 27 and 36 of gestation during each pregnancy offers babies some short-term, early protection against whooping cough.
- **Respiratory syncytial virus (RSV)** – Encourage patients to consider getting an RSV vaccine between 32 and 36 weeks if they're pregnant between September and January. **Please note:** Abrysvo™ is currently the only RSV vaccine approved for use during pregnancy.
- **Influenza** – A flu vaccine is particularly important for pregnant patients during flu season.

If your patients have concerns about vaccine safety, efficacy and necessity, try these tips to help decrease vaccine hesitancy:

- Let your patients know vaccines during pregnancy help protect young babies who are particularly vulnerable to infections like the flu, whooping cough and RSV.
- Consider using presumptive statements when discussing the vaccines needed at each visit. Here's an example: "You're 32 weeks pregnant and can get these vaccines today."
- Acknowledge the patient's concern, be respectful and consider sharing any personal experiences you've had with vaccination during pregnancy.
- Make educational information about each vaccine available to your patients and offer vaccine training to your staff. Everyone – from the front office to the billing staff – should be able to positively talk about vaccines.

New TennCare Benefit: Diapers for Members Under Age 2

Your patients' BlueCare Tennessee and CoverKids benefits now include diapers and training pants at no cost to them. The benefit covers up to 100 diapers per month from an approved list of products until age 2. To view the list of participating pharmacies and approved diapers, which include different types and brands, please visit **tn.gov/tenncare/diapers**.

To get the diapers, parents and guardians will simply need to present their child's pharmacy ID card at the pharmacy counter of participating locations. There's nothing required from you. Patients don't need a prescription, and diapers don't have a copay or count against our members' monthly prescription limit. If a newborn doesn't have a pharmacy ID card yet, parents can present the mother's pharmacy ID card or the child's Social Security Number.

Please let your patients know about this exciting benefit. If they have questions, please ask them to call the Customer Service number on the back of their member ID card or visit **tn.gov/tenncare/diapers**.

Medicare and Dual Special Needs Plan Crossover Process Updates

As a reminder, the Medicare and Dual Special Needs Plan (D-SNP) crossover claims transition took effect for dates of service on and after Jan. 1, 2024, earlier this year. Most claims billed to Medicare or D-SNP cross over to us with no issues, so please wait at least 60 days for claims to cross over before submitting a claim for cost-share reimbursement.

To help address instances where providers must submit a secondary claim because the Medicare or D-SNP claim is delayed or doesn't cross over to us, we implemented an automation feature in July. This feature automatically copies the provider-submitted secondary claim to a different claim prefix (SPX) so we can process cost-share amounts. **Please note:** In this case, we define a secondary claim as a claim filed for reimbursement of unpaid Medicaid services that traditional Medicare or a D-SNP considers patient responsibility. We don't process the cost-share amounts (patient copay, coinsurance or deductible) on secondary claims.

Please file secondary claims for Qualified Medicare Beneficiaries (QMB) members to TennCareSelect with the appropriate explanation of benefits (EOB) when a claim doesn't cross over from Medicare or a D-NSP. Similar to the process outlined above, we'll copy the claim to a different claim prefix and process any applicable cost-share amounts. We'll deny Medicaid services billed on these claims because these members don't have Medicaid benefits.

Lastly, the timely filing limit for crossover claims is different than other claims. For crossover claims, providers have the greater of one year from the date of service or 180 days from the Medicare/D-SNP EOB date to submit a claim for cost-share amounts. If a claim is incorrectly denied for timely filing, please contact the Provider Service line for your patient's plan:

- BlueCare – **1-800-468-9736**
- TennCareSelect – **1-800-276-1978**

Note: The processes outlined in this article only apply to crossover claims. The timely filing limit for all other claims is still 120 days from the date of service for standard claims and 120 days from the date of the primary payer's EOB for secondary claims. We'll continue to deny non-crossover claims submitted outside of the 120-day time limit.

BlueCare Plus Tennessee

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

PCP Changes are Made in Real Time in Availity

When you look up a member's eligibility and benefits to verify the assigned PCP, if the PCP listed (in the **Eligibility & Benefits** application in Availity) is a provider in your practice or covers for your office, you won't need to make any updates. If the PCP isn't a provider in your practice or a provider covering for your office, you'll need to use the **PCP Change Maintenance** application to make a PCP change. If you make the PCP change in Availity, it's not necessary to fax in the confirmation page. The PCP change is made in real time.

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**.

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

You can now submit wound care authorizations 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.

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, the Centers for Medicare & Medicaid Services (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.

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.

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.

Submit Drug Coverage Reviews Digitally for a More Efficient Process

Please submit all new or continuation of care drug prior authorization requests digitally for faster service for you and your patients. Here's the best way to submit drug coverage reviews:

- **Self-Administered Drugs** – Submit through CoverMyMeds OR SureScripts
- **Provider-Administered Drugs** – Submit through Availity

With this process, we can make decisions on cases more quickly, provide faster feedback and request additional information much more easily. And you can check case statuses in real time via the provider dashboard. Faxing can lead to longer turnaround times and delays in care for your patients.

If you have questions about how to submit digital prior authorization requests, we'll be happy to help.

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).

BlueCross BlueShield of Tennessee

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Federal Employee Program	1-800-572-1003
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BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
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Monday–Friday, 8 a.m. to 6 p.m. (ET)	

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Benefits & Eligibility	1-800-676-2583
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Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
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If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice or facility:

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