of Tennessee

MARCH 2025

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.

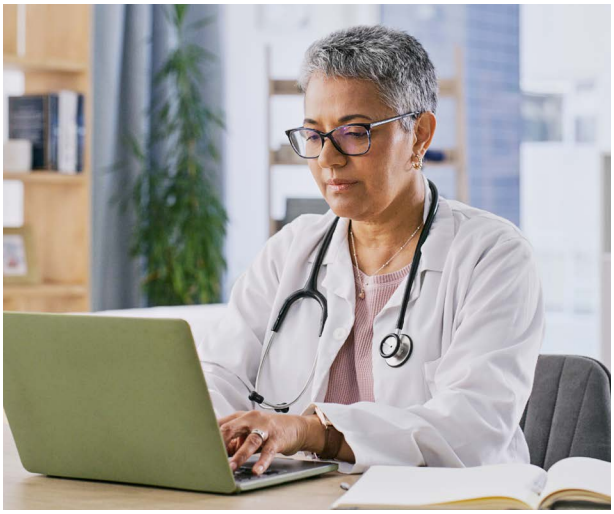
INSIDE THIS ISSUE

Announcing the Updated Quality Care Rewards (QCR) Attestation Audit Process

We're introducing a new auditing process using the QCR application in Availity®. It streamlines the way providers submit medical records for attestation audits, which enhances security and efficiency, and supports our shared commitment to quality care.

Key Changes

- **Regular audits:** All attestations entered in the QCR application are subject to verification audits.
- **Record requests:** If your QCR attestation is selected for audit and it doesn't have a record attached, you'll receive a request within the QCR application for the record to be uploaded within seven business days.
- **Provider queue:** You can regularly check the provider queue under Audited Attestations: Requested Medical Records to find any medical record requests.
- **Easy uploads:** You'll be able to upload the record directly from the QCR application to your attestation.



Important Note: During the internal audit, if any errors are found, we'll delete the incorrect attestations. You can see what errors were made and why. This allows for transparency and continuous improvement.

Inclusive or Exclusive Billing for Behavioral Health Psychiatric Facilities

Please review the following guidelines for institutional and professional providers to ensure you're billing for inclusive services correctly.

Institutional providers (psychiatric hospital, residential treatment center, other psychiatric outpatient facility)

Your contract with BlueCross includes details about inclusive or exclusive service billing. You can find the information under each section of your contract addressing your rates for each service, such as inpatient, intensive outpatient and partial hospitalization.

If the language about the rate for a particular service denotes it as inclusive, all professional or physician services must be provided as part of that rate. Another claim shouldn't be submitted for professional or physician services rendered in your facility as part of the service you're providing. Please ensure providers supporting these services are aware of the inclusive agreement.

Professional providers (psychiatrists, nurse practitioners, psychologists, therapists, primary care physicians)

When providing services at a psychiatric hospital, residential treatment center or other psychiatric outpatient facility, please confirm with the facility if professional services should be billed separately. If you're providing services at a facility whose rates are inclusive of professional services, a separate claim can't be filed. Any amount you receive from BlueCross for your service with this facility is subject to an overpayment recovery.

If you have questions, please contact your provider network manager.

CAHPS® Surveys Starting Soon

Gaining insight into how your patients feel about their health care experience can benefit you and your patients. Most patients will be more engaged, have higher adherence rates and feel more confident in the care they receive when they're highly satisfied with their provider's customer service, communications and coordination of care.

That's why the Consumer Assessment of Healthcare Providers & Systems (CAHPS) annual survey, conducted by an outside entity, is important to providers and health plans. The National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) use this survey to evaluate care and services provided to your patients.

All our lines of business measure member experience using some version of the CAHPS survey. Each year between March and June, randomly selected members are asked to complete a survey about their experience. Please encourage your patients to participate in all surveys from us and outside organizations so we're better able to identify opportunities for improvement.

Simple Tips to Improve Quality Care for Patients

When patients are trying to understand medical conditions and recommended treatments, the information can sometimes feel overwhelming. Building a trusted relationship with their provider is a key component that can affect treatment success. Here are some easy tips to help you make sure your patients get the information they need.

1. **Explain things in ways that are easy to understand.** Try to avoid medical jargon when talking with patients about a medical condition or treatment plan. Consider using shared decision-making tools to help patients learn more about their conditions and options for treatment.
2. **Make eye contact with your patients and spend time listening carefully to them.** Ask your patients or their caregivers if they have questions or concerns. These actions help build trust and foster engagement. The National Institutes of Health (NIH) recommends asking open-ended questions that require patients to answer more than a simple yes or no.
3. **Be considerate of patients' thoughts and beliefs and try to continue conversations at the next visit if they refuse care.** For example, if patients don't want their child to receive a needed vaccination, work with them to find one action that you can agree on, like scheduling a follow-up appointment.
4. **Use the teach-back method, which involves asking patients to explain what they need to do in their own words.** According to the NIH, this technique lets you see if patients need additional information or if they understand the information you presented.
5. **Coordinate care by talking with patients about services they get from other providers.** When you see your patients, ask if they've recently been to the ER or a specialist. Also, discuss any services or medications they've received elsewhere and contact their other providers to request information about test results and treatment plans.

Commercial

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

Find Upcoming Prior Authorization Changes

You can easily find the latest changes to prior authorizations under **Upcoming Prior Authorization Changes** in the **News & Updates** section of our **Documents & Forms** page. Prior authorization changes are published at least 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)**.

Save Time With High Tech Imaging Prior Authorizations

Please be sure to find out if your patients have High Tech Imaging (HTI) prior authorization requirements before starting the authorization process. Not all our commercial plans require HTI authorization and checking on this can save you some time.

You can check when you log in to Availity to verify patient benefits. Just click the blue button labeled **Prior Authorization Requirements**, then look for the **High Tech Imaging** category. If **Yes** is listed, an authorization is required and you should continue with the process. If **No** is listed, an authorization isn't required.

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

Understanding the Financial Responsibility Form and Prior Authorizations

Sometimes our members choose to pay for services their plan doesn't cover. To make sure they understand potential financial commitments, have them sign the **Acknowledgement of Financial Responsibility Form**. Your patients must sign this form before requesting a non-covered service.

Even if patients agree to pay out-of-pocket, you'll still need to complete the prior authorization process. The form doesn't waive this requirement. And it's important for you to complete the prior authorization process to make sure members don't self-pay if they have benefits available under their plan.

If you need more information on how to use this form, contact your provider network manager.

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

Effective **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 is still part of the overall Federal Employees Health Benefits program, it's a separate plan from those offered to other federal employees in the program.

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

If you have questions, call PSHB at **1-866-780-7742**.

Commercial and BlueCare Tennessee

This information applies to both Commercial and BlueCare Tennessee lines of business.

Behavioral Health Authorization Update

Effective **April 1, 2025**, if you're requesting behavioral health authorizations after business hours, you must use Availity or call us during regular business hours.

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

Peer-to-Peer Requests

You can now submit peer-to-peer requests for Commercial and BlueCare℠/TennCare*Select* members in Availity:

- Log in to Availity.
- Click on **Payer Spaces** and select the BlueCross BlueShield of Tennessee logo.
- Select the **Authorization Submission/ Review** application.
- Go to the **Auth Inquiry/Clinical Update** drop-down arrow then select **BCBST** to search for the existing authorization.
- Select **Peer-to-Peer Review** from the **Service Information, Note Type** drop-down list.

A Peer-to-Peer request gives providers the opportunity to speak directly with a medical director and provide clinical information to dispute an adverse determination. Providers will be required to give two dates and times they're available to speak with the medical director. Peer-to-Peer requests can be scheduled Monday through Friday, excluding holidays.

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

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

BlueCare Tennessee

*This information applies to BlueCare℠, TennCare*Select* and CoverKids plans unless specifically identified below.*

Coverage for Complex Rehab Technology Maintenance

Effective **July 1, 2024**, BlueCare, TennCare*Select* and CoverKids cover and reimburse medically necessary repairs on complex rehab technology (CRT) annually for at least one preventive maintenance visit. The repairs must be provided by an authorized CRT equipment supplier.

CRT providers are required to complete the **Tennessee Department of Commerce and Insurance's CRT Attestation Form** and submit it with their claim. All paid claims are subject to provider audit and recoupment if no attestation form is on file.

For questions about billing for CRT maintenance, please refer to this grid:

Approach to Identify Wheelchair Device	**Use Wheelchair code + MS modifier** for Data Reporting/Segmentation of device (No payment)
Approach to Identify and Reimburse for Maintenance Service Only	Line 1 Billed on Claim— Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim—K0739MS (Indicates Maintenance; Results in Payment)
Approach to Identify and Reimburse for a Combined Visit of Repair and Preventative Maintenance Services	Line 1 Billed on Claim—Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim—K0739 + MS modifier (Indicates Maintenance; Results in Payment)
	Line 3 Billed on Claim—K0739 (without modifier) (Indicates Repair; Results in Payment)
Approach to Identify and Reimburse for a Repair Services Only	Line 1 Billed on Claim—Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim—K0739 (without modifier) (Indicates Repair; Results in Payment)

Updated Sickle Cell Disease Resource

We recently updated our **Caring for Patients With Sickle Cell Disease** provider guide. We encourage you to review it if you care for patients with sickle cell disease. The guide includes information about:

- Covered medications, other sickle cell-specific services and additional support
- Prior authorization requirements
- Gene therapy
- Our care team
- Transportation and dental benefits

We hope you find it useful. If you have questions about the information covered, please call the applicable provider line on the back cover of the guide.

Help Ensure Children in State Custody Get Well-Child Care

When a child enters the Department of Children's Services' (DCS) custody, we may not know much about their medical history, including immunization history, past trauma and prescribed medications. Performing an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening when children and teens enter state custody is an essential step in identifying medical, behavioral health and dental care needs. We need your help to make sure they get these important visits.

Within 72 hours of entering DCS custody, children and teens must have a medical exam. This exam should then be followed by a comprehensive EPSDT checkup within 30 days. (The exam performed within the first 72 hours may serve as the EPSDT exam if it contains all necessary components.) Following these checkups, children and teens in state custody should continue to get preventive care according to the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**.

For more information about caring for children in state custody, click **here**. To review the components of EPSDT visits, please see our **EPSDT Provider Booklet**.

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

Well-Care Visits, Sports Physicals and Transportation Benefits

Many young patients go several years between checkups. This is especially true for teens and young adults. Because an office visit for an illness, shots, prescription refills or other reason may be the only chance you have to conduct a well-care check, TennCare Kids Screening Guidelines allow reimbursement for both a "sick" and "well" visit on the same day. More than one well visit is allowed per year.

Additionally, stand-alone sports physicals and their corresponding codes aren't covered services. However, by converting that appointment into a complete well-care visit, you can meet all requirements of the sports physical and receive reimbursement for a covered service.

Spring is a great time to schedule sports physicals and/or well-care exams. For more information about combining visits, view our **EPSDT Provider Guide**.

Is transportation a barrier to care?

If you have patients who can't get to covered medical services or pick up prescriptions because they don't have transportation, let them know we can help. Our transportation vendor, Verida, can get them to and from their covered medical visits or the pharmacy at no charge.

Your BlueCare and TennCare*Select* patients can arrange transportation through Verida's member portal or by calling the Verida toll-free customer service number for their plan, regardless of the distance they need to travel. The Verida Call Center is open 24 hours a day, 365 days a year.

- BlueCare: **1-855-735-4660**
- TennCareSelect: **1-866-473-7565**
- Member portal: **member.verida.com**

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

Save the Date: Lunch and Learn Event for Maternal Health Providers

We're hosting a Maternal Health Substance Use Disorder/ Opioid Use Disorder Lunch and Learn for providers located in Middle and East Tennessee. The event is tentatively scheduled for Monday, April 7, 2025, at 12 p.m. ET and will include:

- BlueCare Tennessee Behavioral Health
- ReVIDA® Recovery Center
- Vanderbilt's Firefly program
- Q&A

Keep an eye on your email for more information coming soon.

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**.

Your New Source for Division of TennCare Announcements

You can now view announcements from TennCare in the **News and Updates** section of **bluecare.bcbst.com/providers**. These announcements replace the TennCare Provider Experience newsletter. We'll update them quarterly, so check back frequently for news you need.

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Dental Benefit Changes

BlueCare Plus (HMO D-SNP)SM dental coverage has changed for 2025. The plan still covers routine and comprehensive dental services. However, members no longer use their FlexCard benefit to pay for comprehensive dental services. Instead, BlueCare Plus Tennessee covers these services as part of the member's dental benefits.

If you see BlueCare Plus members, you'll need to submit claims for comprehensive dental services to BlueCare Plus Tennessee for coverage and payment.

2025 Special Needs Plan Model of Care (MOC) Training 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 afterward. 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 by **clicking here**.

BlueCare Plus Tennessee and Medicare Advantage

This information applies to both BlueCare Plus Tennessee and Medicare Advantage lines of business.

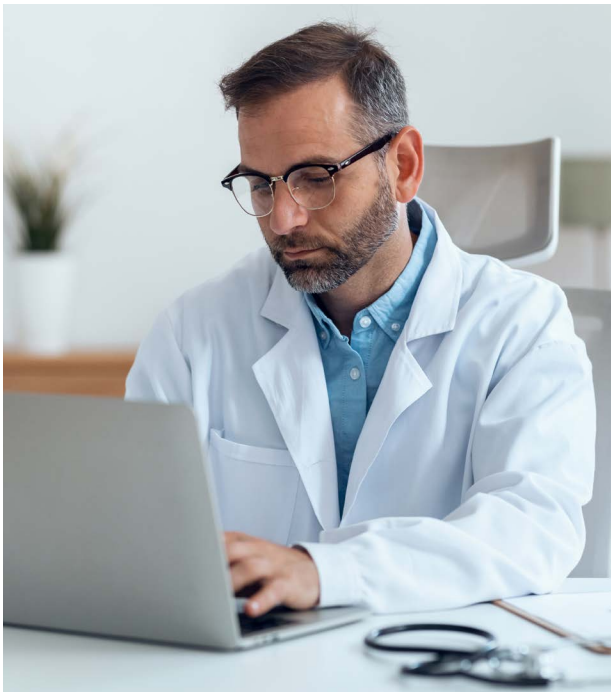
Master Prior Authorization List Review and Upcoming Updates

In preparation for the 2025 CMS proposed prior authorization rule changes, we're reviewing the Master Prior Authorization List to identify opportunities to reduce the number of services requiring prior authorization.

Effective **April 1, 2025**, we're removing prior authorization requirements for several additional codes.

To help, we've created a Master Prior Authorization List Code Removals document, which includes all codes that no longer require prior authorization. We'll update this list as we remove prior authorization requirements from additional codes.

You can access the Master Prior Authorization List and the Prior Authorization Removal list at **provider.bcbst.com/tools-resources** in the **Authorization & Appeals** section.



Medicare Advantage

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

Provider Reimbursement Rates Changing April 1

Stars ratings adjustments for each provider's reimbursement rates go into effect April 1, 2025.

The Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement to providers that achieved quality scores of 4 Stars and above with coding accuracy during the 2024 measurement period of Jan. 1 through Dec. 31, 2024.

Participating providers will receive a rate adjustment notification letter and a rate attachment with the new fee schedule by April 1, 2025. Your contract amendment will include information about your base rate, the quality escalator and total earning potential.

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Attestations for patients in the Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) measure are only permitted for telephone visits completed on the day of or within the seven days after discharge that aren't billed.

- Attestations for office or telephone visits that are billed aren't needed as the claim will satisfy the requirement of the measure if it was completed in the appropriate time frame.
- Please allow a minimum of four to six weeks for the claim data to process and close the gap.
- Attestations for telephone visits require documentation of the telephone visit from the medical record to be submitted.

FMC measure attestations without proper supporting documentation and/or unnecessary attestations are subject to removal from the QCR application.

Please contact your Provider Quality Outreach Consultant for questions or assistance with the FMC measure.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Attestations for patients in the Statin Therapy for Patients with Cardiovascular Disease (SPC) measure are available in the Quality Care Rewards (QCR) application in Availity. Please note that attestations are only permitted for measure exclusions and statins filled through cash pay, the Veteran's Administration (VA) and Patient Assistance Programs (PAPs).

- Attestations for statins filled at the pharmacy using the patient's Part D benefit aren't needed as the pharmacy claim data will satisfy the requirement if the medication fill meets all other requirements (minimum dosage of a specific statin filled during the measurement year).
- Please allow a minimum of four to six weeks for the pharmacy claim data to process and close the gap.
- Attestations for statins filled through cash pay, VA and PAPs require a photocopy of the prescription bottle or pharmacy receipt that includes the full label with patient identification, medication name, dose, route and dispensed date to be submitted with the attestation.
- Attestations for SPC exclusions require documentation from the medical record to support the exclusion to be submitted with the attestation.

SPC measure attestations without proper supporting documentation and/or unnecessary attestations are subject to removal from the QCR application.

Please contact your Provider Quality Outreach Consultant for questions or assistance with the SPC measure.

Complete 2025 Provider Assessment Forms

Please complete provider assessment forms (PAFs) for your patients. PAFs can be completed during face-to-face or telehealth visits that use both video and audio components. These forms can be completed once per year in conjunction with a Medicare annual wellness visit or any other office visit type.

To complete a PAF, use the hierarchical chronic condition (HCC)-focused PAF in the **Quality Care Rewards (QCR) application** in Availity. You can complete it in the QCR application or export it for manual completion and upload it to the QCR. Or you can fax it to **1-877-922-2963**. A copy of the PAF is required to be kept in the medical record.

Please note that office notes aren't accepted as the PAF and won't be reimbursed.

Submit CPT® code 96161 on your claim once the PAF is complete and submitted, in addition to the appropriate visit evaluation and management code. No modifier is needed. Reimbursement for completion of a PAF completed in the QCR application is $225.

Please contact your provider quality outreach consultant for questions or assistance with PAFs.

Pharmacy

This information applies to all lines of business unless specifically identified below.

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 specifically identified below. 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**).

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**.