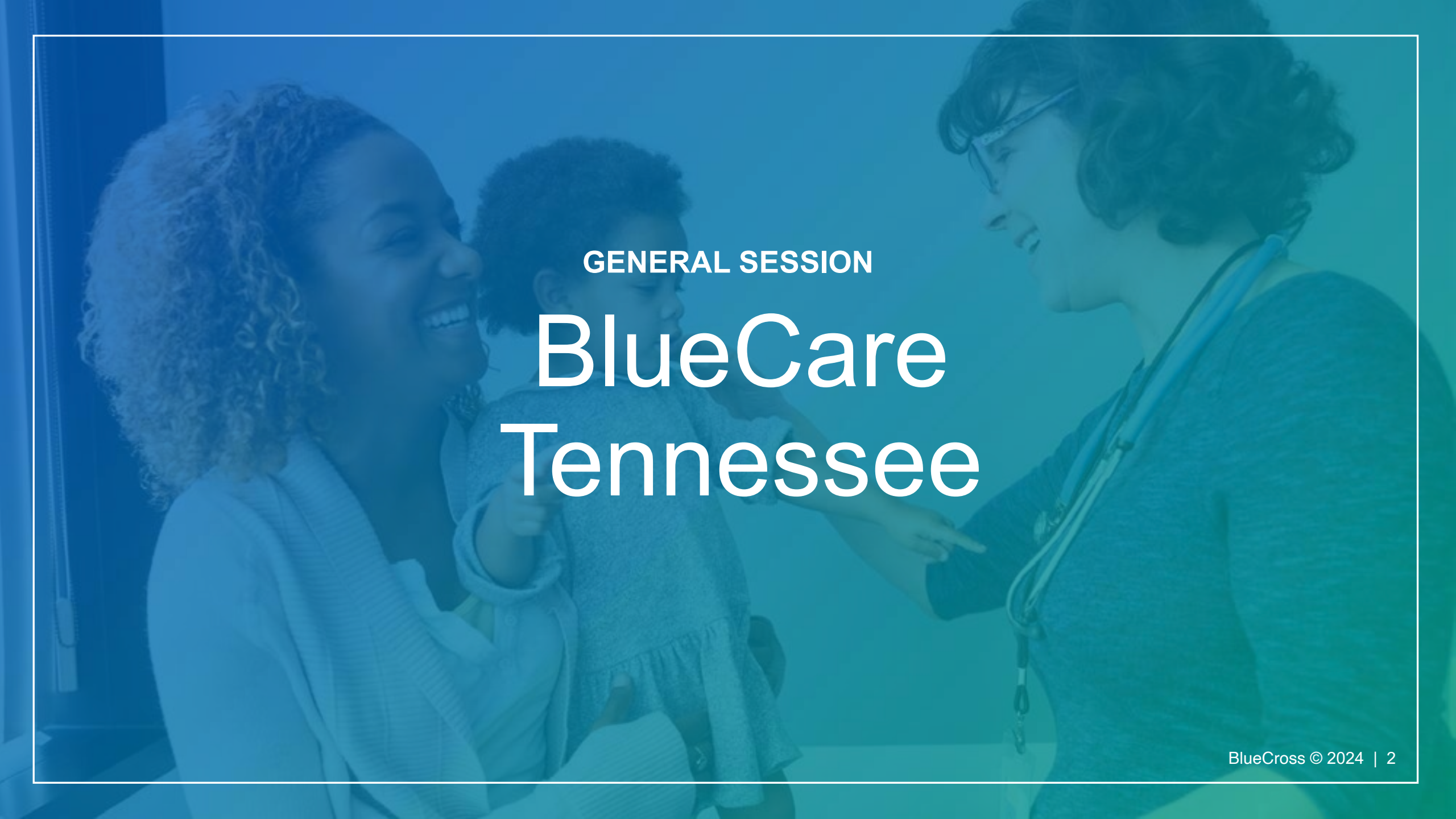
To get credit for attending today, please email your name, group/provider and Tax ID to **ABW_QA_feedback@bcbst.com**



GENERAL SESSION

BlueCare Tennessee

TennCare Kids

TENNCARE KIDS GOALS

Promoting Well-Child Care

- Kids, teens and young adults enrolled in a BlueCare Tennessee health plan often have a high risk of developing health issues, and they're most in need of the preventive care you provide.
- Since the COVID-19 pandemic, fewer children and teens have been getting well-child care.
- Our goal is to ensure all children and adolescents in our state get appropriate health care, including checkups and developmental screenings.
- We're asking for your help in encouraging your patients to get preventive care.

EPSDT Components

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits have seven components:

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Hearing and vision screening
- Age-appropriate developmental/behavioral screening
- Lab tests/procedures
- Immunizations
- Health education

Assess Your Patients' Development at Key Ages

In addition to regular hearing and vision assessment, screening recommendations related to healthy development include:

- Developmental screening at ages 9,18 and 30 months
- Autism spectrum disorder screening at ages 18 and 24 months
- Behavioral/social and emotional screening at each wellness exam, from the newborn visit to age 21

When scheduling EPSDT visits, let parents and guardians know if their child will be getting a developmental screening at their upcoming visit and discuss the importance of these services.

Tennessee Early Intervention System

If a child has a developmental delay or disability, consider referring families to the Tennessee Early Intervention System (TEIS). This program offers therapy and other services to families of infants and young children.

For more information about TEIS, visit **tn.gov/didd/for-consumers/tennessee-early-intervention-system-teis.html**. To refer a patient younger than age 3, complete the online referral form. To refer older patients, contact their local school district.

If you have questions or would like to make a referral over the phone, please call **1-800-852-7157**.

Mature Minor Doctrine Clarification Act

- In 2023, the Tennessee legislature passed the Mature Minor Doctrine Clarification Act. It requires providers to get informed consent from a parent or legal guardian before administering vaccines to minors under age 18.
- The law applies to all vaccines, including the COVID-19 immunization. Additionally, such consent should be in written form for the administration of the COVID-19 vaccine. Proof of consent for each vaccine should be included in each patient's medical record.
- During appointments, consider talking with parents about the vaccines their child may need during the visit and the benefits of vaccination. Then, get the appropriate consent for each vaccine before administering the shots.

TENNCARE KIDS TIPS

Completing EPSDT Exams

1. Preschedule all six visits during the first 15 months of life at the infant's first appointment. This helps keep a plan for care in place if a visit is missed.
2. Convert sports physicals to well-child exams.
3. Combine a well-child visit with visits for other types of services, such as acute care.
4. Use electronic health/medical record tools to manage appointment scheduling and patient reminders.
5. Schedule the next EPSDT appointment at the end of each visit.
6. Tailor outreach for patients ages 18-21. Encourage them to complete their EPSDT exams and help them transition to adult care.

Office Workflow Considerations

Sometimes, adjusting office processes or hours can help promote EPSDT visits. Consider these suggestions:

- Designate specific staff members to perform and manage well-child care.
- Offer alternate or extended office hours.
- Make a daily huddle part of your office's morning routine. During this time, review the day's schedule and identify any patients coming into the office who are past due for preventive services.
- Promote care coordination by talking with patients about care they may be receiving from other providers. Make this discussion a standard part of each visit.

Review Our EPSDT Tool Kit

We created our tool kit to make it easier for providers to find information about EPSDT and well-child care. It includes:

- The American Academy of Pediatrics periodicity chart and coding information
- Contact information
- Best practices shared by providers across the state
- Details about transportation and community outreach
- An inside look at our claims processes

Find the Tool Kit Online

bluecare.bcbst.com/providers/BlueCare_EPSDT_Provider_Booklet.pdf

Transportation Benefits

What's Covered?

BlueCare and TennCare*Select* member benefits include transportation to and from the pharmacy and TennCare-covered services.*

- This service option is available to patients at no cost.
- Verida, our transportation vendor, is open 24 hours a day, seven days a week.
- Transportation options may include a bus pass, shared ride or mileage reimbursement.
- In most cases, patients must schedule their transportation at least 72 hours before their appointment.

* **Note:** CoverKids and TennCare*Select* / QMB only members **don't** have transportation benefits.

Scheduling Transportation

BlueCare

Our members can call Verida at **1-855-735-4660** or use the online portal at: **member.verida.com**.

Providers scheduling transportation on their patient's behalf can use the facility portal at: **facility.verida.com**.

TennCare*Select*

Our members can call Verida at **1-866-473-7565** or use the online portal at: **member.verida.com**.

Providers scheduling transportation on their patient's behalf can use the facility portal at: **facility.verida.com**.

Member PCP Assignment and ID Cards in Availity

AVAILITY PCP CHANGE MAINTENANCE APPLICATION

Changing PCP Assignment in Availity

We've developed this application to make our primary care provider (PCP) assignment process more efficient and improve the turnaround time on requests.

- Providers can change a patient's PCP in Availity by using the **BlueCare PCP Change Maintenance application**.
- As of **April 1, 2024**, we no longer accept PCP change requests by fax or email.

Using the application:

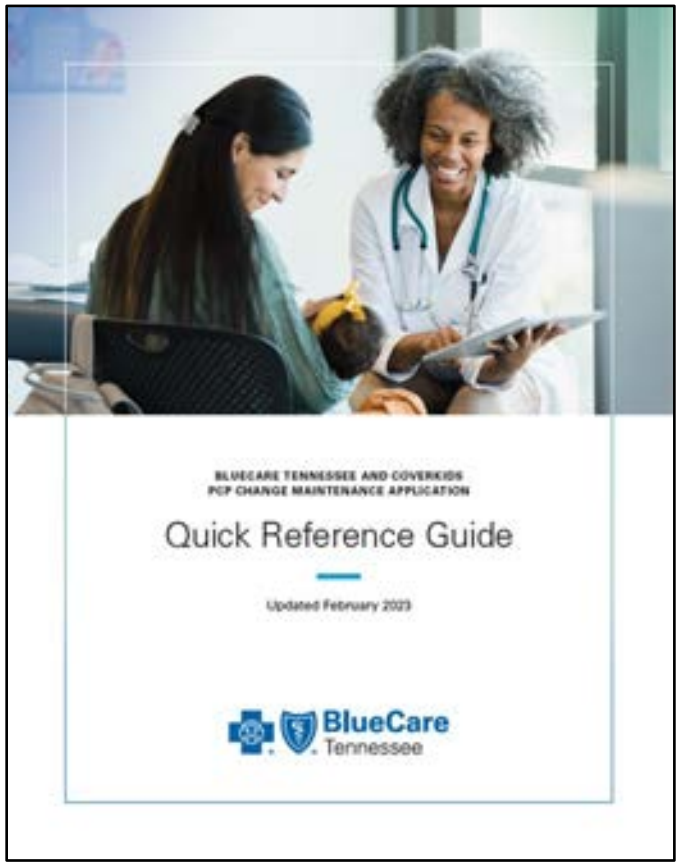
- Updates are made in real time.
- Once you submit a PCP change, you'll see the patient in your assigned member roster and can view their Member ID card in Availity. Your patient will be able to access their updated digital ID card in their online account. A new Member ID card will also be mailed to your patient automatically.

REVIEW OUR QRG

Step-by-Step Instructions

You can find the **BlueCare Tennessee and CoverKids PCP Change Maintenance Application Quick Reference Guide (QRG)** in the **Resources** section of Availity **Payer Spaces**.

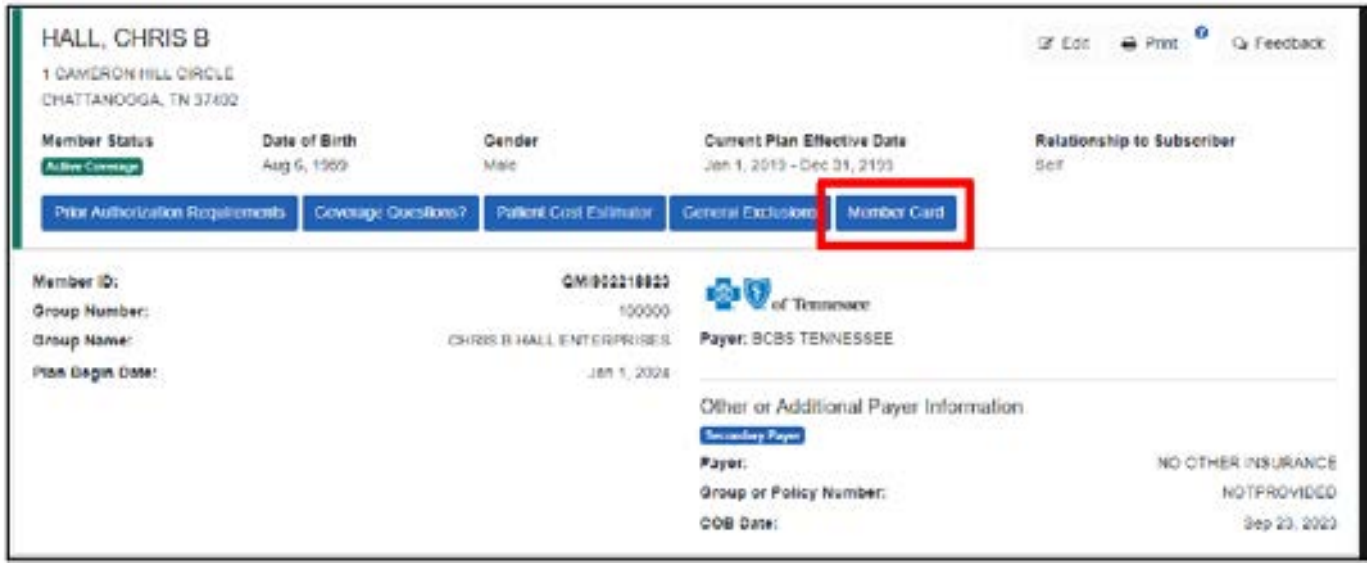
If you have questions or would like to schedule training for your practice, please contact your eBusiness Regional Marketing Consultant. You can find the name of your contact here: **provider.bcbst.com/contact-us/my-contact**.



AVAILABLE IN AVAILITY

Member ID Cards

We've enhanced the Availity **Eligibility & Benefits** section to include the Member ID card for BlueCross BlueShield of Tennessee members.



Benefits Reminder: Lactation Consultant Services

LACTATION CONSULTANT SERVICES

Member Benefit

As of June 1, 2023, lactation consultant services are covered through patients' Medicaid and CoverKids benefits. Providers in our network may bill for outpatient lactation services.

- Members with BlueCare, TennCare*Select* and CoverKids coverage may get medically appropriate lactation consultant services during pregnancy and through the extended postpartum period.
- Parents can receive services:
  - In a one-on-one or small group setting
  - In person or through telehealth (including the appropriate Place of Service code)
- There's no limit on the number of visits allowed.*

* We may request additional information after 15 units are billed in one calendar year.

Who Can Provide Services?

Providers who can offer lactation services include:

- Physicians, nurse practitioners, physician assistants or certified nurse midwives for whom lactation counseling, education or consultation is within their scope of practice
- International Board-Certified Lactation Consultants/Registered Lactation Counselors (IBCLCs/RLCs) with a Medicaid ID who are in network with a TennCare managed care organization (MCO)
- Certified Lactation Counselors (CLCs), Certified Lactation Educators (CLEs), Certified Lactation Specialist (CLSs) and Certified Breastfeeding Specialist (CBSs)

LACTATION CONSULTANT SERVICES

Coding

Claims for lactation services should include the appropriate CPT® codes and modifiers:

- 98960 U8 (single individual per 30 min.)
- 98961 U8 (2-4 patients per 30 min.)
- 98962 U8 (5-8 patients per 30 min.)

Coding (cont.)

Please also use the appropriate number of units to signify the length of the visit:

- 1 unit = visit 16-45 min.
- 2 units = visit 46-75 min.
- 3 units = visit 76-105 min.

LACTATION CONSULTANT SERVICES

Breastfeeding-Related Patient Resources

Resources that complement lactation support include:

- No-cost electric breast pumps and related supplies (storage bottles and tubing)
- Digital education tools and online communities
- Care management
- Referrals to lactation providers, including the Tennessee Breastfeeding Hotline, WIC, La Leche League and designated breastfeeding experts in local health departments

Benefits Reminder: Adult Dental Benefits

Dental Care Eligibility

As of Jan. 1, 2023, TennCare covers dental services for members of all ages.*

- Adults who are pregnant or have recently given birth have the same benefits as other adults.
- Those enrolled in Employment and Community First CHOICES will continue to get supplemental covered dental benefits for waiver members.
- DentaQuest manages dental benefits for our members. You can verify member eligibility through DentaQuest's member portal here: **govservices.dentaquest.com/**.

* Adults enrolled in CoverKids don't have dental benefits. Only CoverKids members under age 19 have dental benefits.

DENTAL BENEFITS

Covered Services

Covered dental services include:

- Regular exams
- Cleanings
- Fillings
- Crowns
- Other medically necessary services

DENTAL BENEFITS

Connect Your Patients to Care

To help your patients with BlueCare Tennessee coverage find a dentist participating with their plan:

› Visit **dentaquest.com** and select **Find a Provider**.

Crossover Claims

CROSSOVER CLAIMS

Effective January 2024

Effective Jan. 1, 2024, we began processing Medicare crossover claims. The start date for Dual Special Needs Plan (D-SNP) crossover claims was changed to March 1, 2024. Previously, the Division of TennCare processed these claims for the Medicare and D-SNP copay, coinsurance and deductible amounts.

For all claims with a date of service of Jan. 1 and beyond, providers no longer need to submit a crossover claim for Medicare or D-SNP cost-share amounts. Providers can submit one claim to Medicare or the member's D-SNP. That claim will automatically cross over to us, and we'll process the copay, coinsurance and deductible amounts using pricing methods defined by the Division of TennCare.

FAQs

We've developed these FAQs to share more information about the crossover claims transition and what it means for you.

When will we begin processing Medicare and Dual Special Needs Plan (D-SNP) crossover claims?

We began processing claims from traditional Medicare on Jan. 1, 2024. We began processing claims from D-SNP on March 1, 2024.

How much will BlueCare Tennessee pay toward the Medicare/D-SNP copay, coinsurance and deductible amounts?

We're using the same pricing methods used by TennCare before the transition to price the copay, coinsurance and deductible amounts.

FAQs (cont.)

Who will be responsible for the coinsurance and deductible amounts if a patient is a Qualified Medicare Beneficiary (QMB) member?

QMB members will be assigned to TennCare*Select*, and the claims will cross over from Medicare or the D-SNP to TennCare*Select* for processing of the copay, coinsurance and deductible amounts.

If I don't get a response on the primary claim submitted to Medicare or the patient's D-SNP, should I submit a crossover claim? How long should I wait for that response?

Please wait at least 30 days before submitting a crossover claim.

Crossover Claim Prefixes

We've developed several prefixes to process Medicare crossover claims:

- BBX, WBX, XBX, YBX, ZBX
  - Medicare crossover claims submitted to BlueCare/TennCare*Select* from a D-SNP plan
- CCX, WCX, XCX, YCX, ZCX
  - Medicare crossover claims submitted to BlueCare/TennCare*Select* from Coordination of Benefits Agreement (COBA) (directly from Medicare)
- SPX, WPX, XPX, YPX, ZPX
  - A provider submitted the claim to BlueCare/TennCare*Select*

TennCare*Select*
QMB Only

QMB Only Benefits

TennCare*Select* is only responsible for processing the Medicare/D-SNP copay, coinsurance and deductible amounts.

- QMB Only members **don't** have Medicaid benefits under the TennCare Program.
- QMB Only members **don't** have non-emergency medical transportation (NEMT) benefits under the TennCare Program.

Telehealth

Telehealth Billing Requirements

We reimburse services provided through telehealth in accordance with BlueCare Tennessee, the Centers for Medicare & Medicaid Services (CMS), and TennCare guidelines.

- Telehealth claims should be billed with the correct place of service:
  - POS 02: Telehealth Provided Other than in Patient's Home
  - POS 10: Telehealth Provided in Patient's Home or
- Telehealth service modifiers used for informational purposes include GT, 93, 95, G0 or GQ.

Third-Party Liability

Third-Party Liability (TPL) Billing Guidelines

We've established a new denial code to deny claims filed with the incorrect Other Insurance Indicator.

› XLM – Other Insurance Indicator Incorrect

- When traditional Medicare, a D-SNP or a Medicare Advantage Plan is the primary payer, the Other Insurance Indicator "16"(Health Maintenance Organization [HMO] Medicare Risk) should be filed.
- If you get an XLM denial, please refile the claim with the correct Other Insurance Indicator.
- We shared more information in the June BlueAlert℠.

Provider Resources

Crossover Claims

- BlueCare Tennessee Provider Page: bluecare.bcbst.com/providers
- Medicare Crossover Claims FAQs: **bluecare.bcbst.com/Providers/Medicaid_Crossover_Claims_Provider_FAQs.pdf**

Telehealth

- Provider Administration Manual: **bcbst.com/providers/manuals/BCT_PAM.pdf**

Third-Party Liability

- BlueCare Tennessee Provider Manuals, Policies and Guidelines: **bluecare.bcbst.com/providers/tools-resources/manuals-policies-guidelines/**

Behavioral Health

BEHAVIORAL HEALTH

Focus on Transition of Care

We work with inpatient psychiatric facilities and our outpatient providers. Our Transition of Care program ensures members receive appropriate member outreach, education and support for:

- Readmissions
- Discharge Planning
- Seven-Day Follow Up After Discharge

Focus on Transition of Care

Why It Matters

- **Reducing readmissions** means members have longer community tenure and reduces adverse events.
- **Streamlining discharge planning** helps members understand next steps in their care and proactively address any barriers or gaps in care.
- **Increasing seven-day follow up after discharge** connects members to needed care and bridges potential gaps between providers or services.

BEHAVIORAL HEALTH

Discharge Summaries Available in Availity

Save time by adding discharge summaries directly in Availity.

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

For more information:

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

BEHAVIORAL HEALTH

Behavioral Healthcare in Pediatrics (BeHIP)

- Behavioral Healthcare in Pediatrics (BeHiP) is a collaborative training program with the Tennessee Chapter of the American Academy of Pediatrics. It gives pediatric providers tools and strategies for screening, assessing and managing patients with behavioral health and substance use disorders.

Behavioral Healthcare in Pediatrics (BeHIP) (cont.)

- Online modules, as well as virtual and in-person training, are available. Free CME credits are awarded upon completion.
- For more information, visit **tnaap.org** and select **BeHiP** under the **Programs** tab.

BEHAVIORAL HEALTH

Foster Care Medical Home

- This program provides specialized training for pediatric providers caring for members in Department of Children's Services custody. It allows children to get TennCare Kids Screenings (EPSDT) as well as comprehensive primary care in a setting that facilitates collaboration with DCS and behavioral health community providers.

Foster Care Medical Home (cont.)

- It includes the BeHiP training information with additional training in the following areas:
  - Focus on trauma-informed care models
  - Documentation requirements for children in custody
  - Connection with and training provided by DCS health unit staff
  - Access to a psychiatric consultation line
  - Participation in an ECHO model learning collaborative
- For more information, visit **tnaap.org**, click **BeHiP** from the **Programs** menu and then **Foster Care Medical Home ECHO Project** on the BeHiP page.

Provider Resources

- BlueCare Tennessee Provider Page: **bluecare.bcbst.com/providers**
- Behavioral Health Provider Page: **provider.bcbst.com/working-with-us/behavioral-health**
- Behavioral Health Consultation and Referral Line: **1-800-367-3403**
- Find Your Provider Network Manager: **provider.bcbst.com/contact-us/my-contact**
- Telehealth Guide: **bcbst.com/docs/providers/quality-initiatives/BlueCare_Tennessee_Telehealth_Guide.pdf**
- Tennessee Redline: **1-800-889-9789**
- Tennessee Statewide Crisis Phone Line: **1-855-274-7471 or 988**

BlueCare Tennessee Quality Priorities

BLUECARE: MY 2022

Path to a 4-Star Health Plan

Child & Adolescent Well-Care Visits

› Achieved 4 Stars

- Well-Care Visits for Children & Adolescents
- Well-Child Visits in the First 15-30 Months of Life
- Weight Assessment & Counseling for Nutrition in Children & Adolescents

Diabetes Care

› Achieved 4 Stars

- Eye Exam for Patients with Diabetes

BlueCare 4-Star Health Plan

BLUECARE: MY 2022

Path to a 4-Star Health Plan (cont.)

Cancer Screening

- Achieved 4 Stars
  - Cervical Cancer Screening

Behavioral Health

- Achieved 5 Stars
  - Follow-Up Care After Treatment for Substance Use and Use of Opioids
- Achieved 4 Stars
  - Initiation & Engagement of Alcohol & Other Drug Abuse Treatment
  - Metabolic Monitoring for Children & Adolescents on Antipsychotics
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics

Path to a 4-Star Health Plan (cont.)

Member Experience

- Achieved 5 Stars
  - Rating of Health Plans
- Achieved 4 Stars
  - Getting Care Quickly & Easily

BLUECARE 2023

Identified Opportunities

- Child & Adolescent Well-Care Visits
- Immunizations
- Diabetes – Chronic Care Management
- Behavioral Health
- Continuity & Coordination of Care

BlueCare 4-Star Health Plan

2024 Priorities

Priority Measures	BlueCare Interventions
Immunizations › Childhood Immunization Status (CIS) › Immunizations for Adolescents (IMA)	› Continue member outreach and provide education on vaccine hesitancy with immunizations › HPV Pilot
Well-Child › Early and Periodic Screening, Diagnostic and Treatment (EPSDT) › Well-Child Visits in the First 30 Months of Life (W30) › Child and Adolescent Well-Care Visits (WCV)	› Foster our strong community partnerships and focus on activities to support our providers.
Diabetes › Eye Exam for Patients With Diabetes (EED) › Kidney Health Evaluation for Patients With Diabetes (KED) › Blood Pressure Control for Patients With Diabetes (BPD) › Glycemic Status Assessment for Patients With Diabetes (GSD)	› Support our providers and members with chronic conditions, specifically diabetes and hypertension. › Explore coverage of blood pressure cuffs for high-risk pregnant members and high-risk adults that will give you the ability to monitor your patients' readings. › We'll continue our partnership with Retina Labs, which does in-home retinal eye exam screenings. In addition, Retina Labs partners with us and attends community outreach events to complete these screenings, including collection of Hemoglobin A1C testing.
Behavioral Health › Follow-Up After Hospitalization for Mental Illness (FUH) › Continuity and Coordination of Care	› For members with medical and behavioral health needs, we'll continue to enhance care transitions to address and support continuity and coordination of care between practitioners and across settings.

BLUECARE 2024

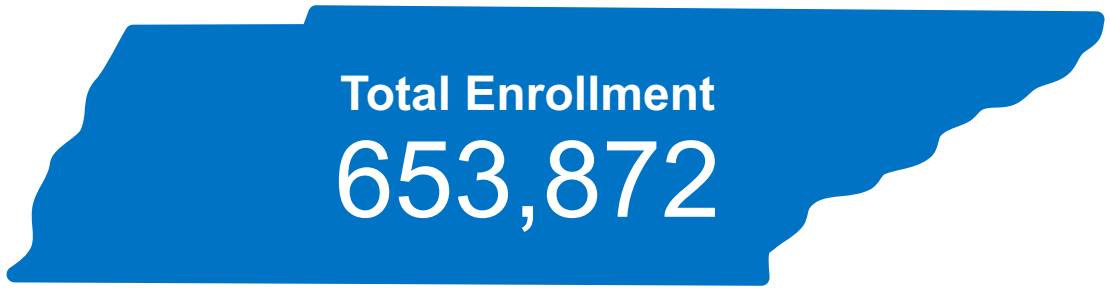
2024 Priorities

Priority Measures	Interventions
Cardiovascular Conditions › Controlling High Blood Pressure (CBP)	› Explore coverage of blood pressure cuffs for high-risk pregnant members and high-risk adults that will give you the ability to monitor your patients' readings.
Maternal Health › Prenatal and Postpartum Care (PPC)	—
Long-Term Services & Supports › Comprehensive Assessment and Update (CAU) › Comprehensive Care Plan and Update (CPU) › Reassessment/Care Plan Update after Inpatient Discharge (RAC) › Shared Care Plan with the Primary Care Practitioner (PCP)	› Perform well in these measures. › We'll continue our ongoing activities to identify these members for timely follow-up and assessment completion.
TennCare Outcome Metrics › Emergency Department Utilization per 1,000 member months › Inpatient Utilization per 1,000 member months › Plan All-Cause Readmissions › PCP Utilization per 1,000 member months › Specialist Utilization per 1,000 member months › Per-term Birth Rate	› For Outcome/Utilization metrics, we'll continue to improve data feeds to assist with appropriate and timely follow-up care. › Enhancing care transitions for members with behavioral health and medical needs.

BlueCare Member Demographics & Language Profile

BLUECARE

Member Demographics



Race

61.3 % White
26.4% Black
4.3 % Other
8.1% Unknown

Ethnicity

88.1 % Non-Hispanic
11.9% Hispanic

Gender

67.3 % Female
32.7% Male

Language

92.9 % English
4.9% Spanish
2.2% Other*

* Top “Other” languages include: Arabic, Vietnamese, and Kurdish

Internal Strategic Analytics and Reporting – 1/2024

Presentation of this information is intended to meet NCQA standard Health Equity 3 Element C Factor 2

Appeals

APPEALS

What's a Provider Appeal?

- A provider appeal is a request for reconsideration of an **adverse action** for a physical or behavioral service that's already been provided to the member.
- We'll send a response to the reconsideration to the provider and member **within 30 calendar days** of getting the request for appeal. If the 30-day timeline can't be met, we'll notify the provider.
- If the provider is still dissatisfied with the decision, providers may appeal pursuant to the Provider Dispute Resolution Procedure described in the Provider Administration Manual.

APPEALS

When and Where?

Standard Provider Appeals for denied services must be received within 60 calendar days from the date of the initial denial notification. You may submit appeals by fax or mail.

- **Fax:** BlueCare Tennessee UM Appeals, **1-888-357-1916**

  OR

- **Mail:** BlueCare Tennessee

  Attention: BlueCare/TennCare*Select* Provider Appeals Manager

  1 Cameron Hill Circle, Ste 0020

  Chattanooga, TN 37402-0020

Home Health Critical Incidents

What is a Home Health Critical Incident (HHCI)?

A critical incident is an adverse event that occurs during the provision of home health services. It's not an incident that results from the individual's underlying health condition or diagnosis. HHCIs include:

- Unexpected Death
- Major/Severe Injury
- Medication Error
- Theft
- Neglect
- Life-threatening Medical Emergency
- Financial Exploitation
- Safety Issues
- Suspected Physical Abuse
- Suspected Mental Abuse
- Suspected Sexual Abuse

Reporting an HHCI to APS and CPS

All suspected incidents of abuse, neglect and exploitation must be reported to Adult Protective Services (APS) within 24 hours.

- Phone: **1-888-277-8366**
- Fax: **1-866-294-3961**
- Online: **reportadultabuse.dhs.tn.gov/**

All reports of abuse, neglect and exploitation must be reported to Child Protective Services (CPS) within 24 hours.

- Phone: **1-877-237-0004**
- Online: **Child Abuse Referral And Tracking (tn.gov)**

How to Report an HHCI

HHCIs must be reported to our Quality of Care department as quickly as possible upon discovery using the HHCI form here: **bluecare.bcbst.com/providers/tools-resources/documents-forms**

- Please complete all applicable fields and provide as much detail as possible.

HHCIs must be submitted to BlueCare Quality of Care Oversight by email or fax:

- Email: **BlueCareQOC@bcbst.com**
- Fax: **1-855-339-3022**

BlueCare Plus (HMO D-SNP)[SM]

BlueCare Plus Tennessee

D-SNP is a special needs Medicare Advantage plan serving people who are eligible for both Medicare and Medicaid

› Individuals are eligible for D-SNP if they:

- Live in the plan service area of Tennessee
- Have both Medicare Part A and B
- Are eligible for full Medicaid/TennCare benefits or Medicaid cost-sharing assistance under Medicaid/TennCare. This includes:
  - FBDE (Full Benefit Dual Eligible)
  - QMB+/Only (Qualified Medicare Beneficiary)
  - SLMB+ (Specified Low Income Medicare Beneficiary)

BlueCare Plus Tennessee

Benefit Description	BlueCare Plus	BlueCare Plus Choice (FIDE)	BlueCare Plus *Select*
OTC/Healthy Food	$230 Allowance / monthly (combined)	$280 Allowance / monthly	$300 Allowance / monthly (combined)
Housing Utilities		$100 / monthly	
Dental Services			
2 routine cleanings and x-rays on dental	$0 copay	Medical Benefit Only	Medicaid Benefit Only
Routine and Preventive Services	Combined Flex Card $3,900 Yearly		
Hearing Services			
Routine Hearing Exams Hearing aid fitting / evaluation, hearing aid	Combined Flex Card $3,900 Yearly	Combined Flex Card $3,300 with Vision Yearly	Combined Flex Card $3,000 with Vision Yearly
Vision Services			
Routine Exam	Combined Flex Card $3,900 Yearly ($800.00 max benefit)	Combined Flex Card $3,300 with Hearing Yearly ($800.00 max benefit)	Combined Flex Card $3,000 with Hearing Yearly
Glasses / Frames / Contacts			

HOW DO I IDENTIFY A BLUECARE PLUS TENNESSEE MEMBER?

BlueCare Plus Tennessee

BlueCare Plus Tennessee

Health Care Service	2024 Incentive
Annual Wellness Visit (AWV)	$50
Colorectal Cancer Screening (COL)	
› Sigmoid / Colonoscopy	$50
› Fecal Occult Blood Test / FIT Kit	$15
Breast Cancer Screening	$25
Diabetic Retinal Eye Exam	
› Eye Care Professional	$50
› Non-Eye Care Professional	$15
Annual Health Needs Assessment (HNA)	$25

BlueCare Plus Tennessee

Service	Codes	Coverage Notes	Amount
PACF	96160 96161	› Submitted once **per calendar year** › Completed with the “Welcome to Medicare” Exam or AWV	$155
ICT	99366- 99368	› Bring the plan and providers together to promote healthy outcomes › Completed and returned PACF, medical records, or conversations with the plan care coordination team	$54

BlueCare Plus Tennessee

How to submit PACFs

- In Availity® under the Quality of Care Rewards (QCR) Tool Availity.com.
- Fax: **(423) 591-9504**

Need training or help?

- Call eBusiness **(423) 535-5717, option 2**
- Email ebusiness_service@bcbst.com

BlueCare Plus Tennessee

Who?

- All participating physicians in the BlueCare Plus network
- Noncontracted providers in cases of continuity of care

When?

- New physicians: Upon completion of contracting and credentialing
- Required annually
- Encourage to complete at the beginning of each year

MODEL OF CARE (MOC) TRAINING

BlueCare Plus Tennessee

Online Training

- Each individual physician can complete training on their own
- Access via Availity or BlueCare Plus Website
- BCP Model of Care Attestation (bcbst.com)
- Physician attestation automatically captured and tracked

Group (HV) Training

- Completed in a group setting (Staff meeting, QI meeting, etc.)
- High Volume attestation form must be completed and returned
- Compliance tracked via attestation form
- Form available from assigned network manager or sam_hatch@bcbst.com

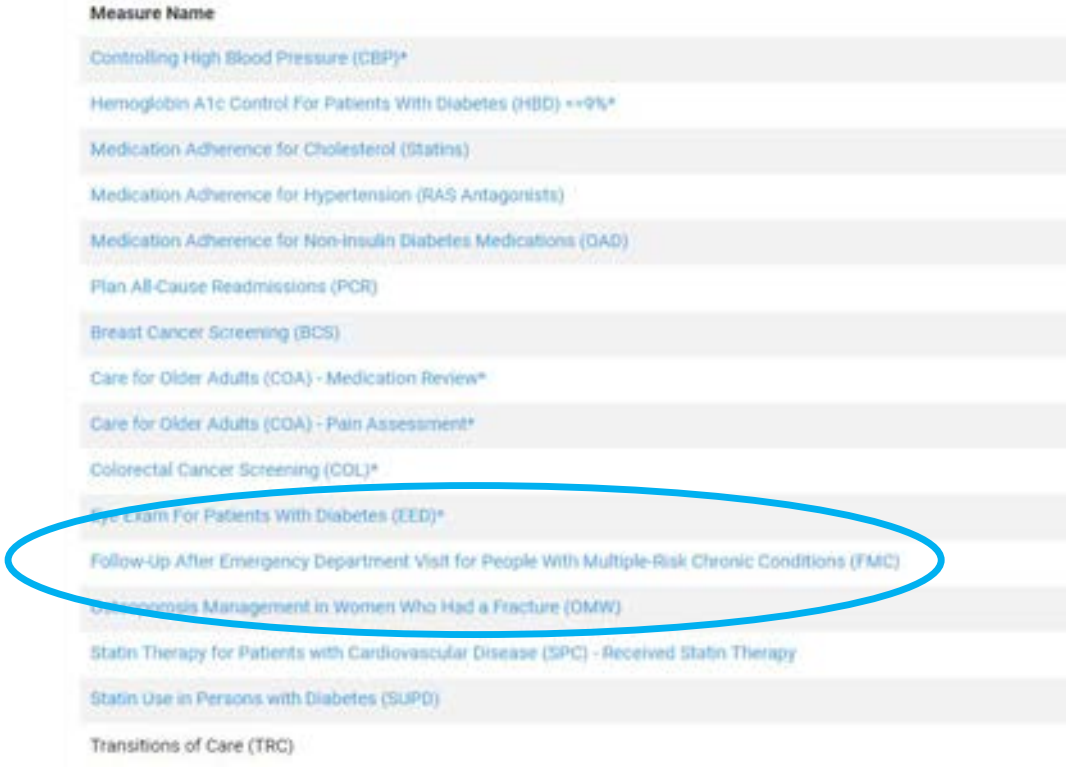
VALUE-BASED PROGRAM MEASURES

BlueCare Plus Tennessee

Measure Name	# Elig.	# Comp.	Your Rate	Region Rate	Quality Score	To 1 Star	To 2 Stars	To 3 Stars	To 4 Stars	To 5 Stars	Weight
Controlling High Blood Pressure (CBP)*	306	89	29.08%	45.99%	★☆☆☆☆	0	68	101	141	162	3
Hemoglobin A1c Control For Patients With Diabetes (HBD) <=9%*	167	36	21.56%	45.94%	★☆☆☆☆	0	40	73	93	101	3
Medication Adherence for Cholesterol (Statins)	144	135	93.75%	93.36%	★★★★★	-19	-12	-7	-2	0	3
Medication Adherence for Hypertension (RAS Antagonists)	152	145	95.39%	93.34%	★★★★★	-26	-15	-10	-6	0	3
Medication Adherence for Non-Insulin Diabetes Medications (DAD)	88	83	94.32%	93.83%	★★★★★	-11	-7	-5	-2	0	3
Plan All-Cause Readmissions (PCR)	51	4	7.84%	9.67%	★★★★☆	4	3	2	0	-1	3
Breast Cancer Screening (BCS)	180	133	73.89%	62.37%	★★★★☆	-33	-15	-2	0	10	1
[illegible] Older Adults (COA) - Medication [illegible]*	318	73	22.96%	34.29%	★★☆☆☆	-64	0	106	198	226	1
Care for Older Adults (COA) - Pain Assessment*	318	53	16.67%	28.26%	★☆☆☆☆	0	81	196	240	259	1
[illegible] Cancer Screening (COL)*	345	233	67.54%	62.07%	★★★☆☆	-48	-10	0	19	47	1
Eye Exam For Patients With Diabetes (EED)*	167	90	53.89%	54.47%	★★☆☆☆	-10	0	12	29	42	1
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	51	22	43.14%	50.72%	★☆☆☆☆	0	5	10	11	14	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	5	1	20.00%	35.29%	★☆☆☆☆	0	1	2	2	3	1
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Statin Therapy	44	36	81.82%	75.10%	★★☆☆☆	-1	0	2	3	4	1
Statin Use in Persons with Diabetes (SUPD)	110	79	71.82%	73.71%	★☆☆☆☆	0	11	15	17	22	1
Transitions of Care (TRC)					★★☆☆☆						1

VALUE-BASED PROGRAM MEASURES – FOLLOW UP AFTER ED VISIT

BlueCare Plus Tennessee



Eligible Chronic Conditions

COPS and asthma	Alzheimer's disease and related disorders
Chronic Kidney Disease	Depression
Heart Failure	Acute myocardial infarction
Atrial fibrillation	Stroke and transient ischemic attack
Follow up service office visit within 7 days after an ED visit (8 total days)	—

Same Day Visits as the ED visit included, but not limited to:

Telephone	Transitional Care
Case Management	Telehealth
E-visit or Virtual Check-in	Community Mental Health Center

REMINDER FOR MY 2023 – TRANSITION OF CARE

BlueCare Plus Tennessee

- CMS retired the stand-alone Medication Reconciliation Post-Discharge (MRP) HEDIS® measure
- Replaced with new Transition of Care (TRC) measure, which incorporates three additional components:

Notification of Inpatient Admission › Receipt of Discharge Information › Patient Engagement after Inpatient Discharge › Medication Reconciliation Post-Discharge

REMINDER FOR MY 2023 – TRANSITION OF CARE

BlueCare Plus Tennessee

Transitions of Care (TRC)					★★☆☆☆						1

Measure Name	# Elig.	# Comp.	Your Rate	Region Rate	Quality Score	To 1 Star	To 2 Stars	To 3 Stars	To 4 Stars	To 5 Stars	Weight
Transitions of Care (TRC) - Medication Reconciliation Post-Discharge (MRP)	45	17	37.78%	21.95%	★☆☆☆☆	0	4	10	15	21	0.25
Transitions of Care (TRC) - Patient Engagement After Inpatient Discharge (PED)*	45	34	75.56%	73.98%	★★★★★	-22	-14	-13	-8	0	0.25
Transitions of Care (TRC) - Notification of Inpatient Admission (NIA)*	45	0	0.00%	0.00%	★☆☆☆☆	0	13	21	22	27	0.25
Transitions of Care (TRC) - Receipt of Discharge Information (RDI)*	45	0	0.00%	0.00%	★☆☆☆☆	0	13	21	22	27	0.25

TRANSITION OF CARE – SOURCES

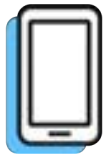
BlueCare Plus Tennessee

- Medical Records review only
  - Notification of Inpatient Admission (NIA)
  - Receipt of Discharge Information (RDI)
- Medical Records and Claims data
  - Patient Engagement after Inpatient Discharge
  - Medication Reconciliation Post-Discharge (MRP)

For more details regarding coding and documentation, refer to the Transition of Care booklet provided through MA or BCP quality programs team.

IMPORTANT CONTACTS

BlueCare Plus Tennessee



Provider Service Line

1-800-299-1407
8 a.m. – 6 p.m. (ET) Monday – Friday

BlueCare Plus TN website

bluecareplus.bcbst.com

PACF/Medical Records Fax

(423) 591-9504

Utilization Management

Phone: **1-866-789-6314**
Fax: **1-866-325-6698**

Hayley Copeland, Stars Quality Manager

Phone: **(423) 535-1739**
Fax: hayley_copeland@bcbst.com

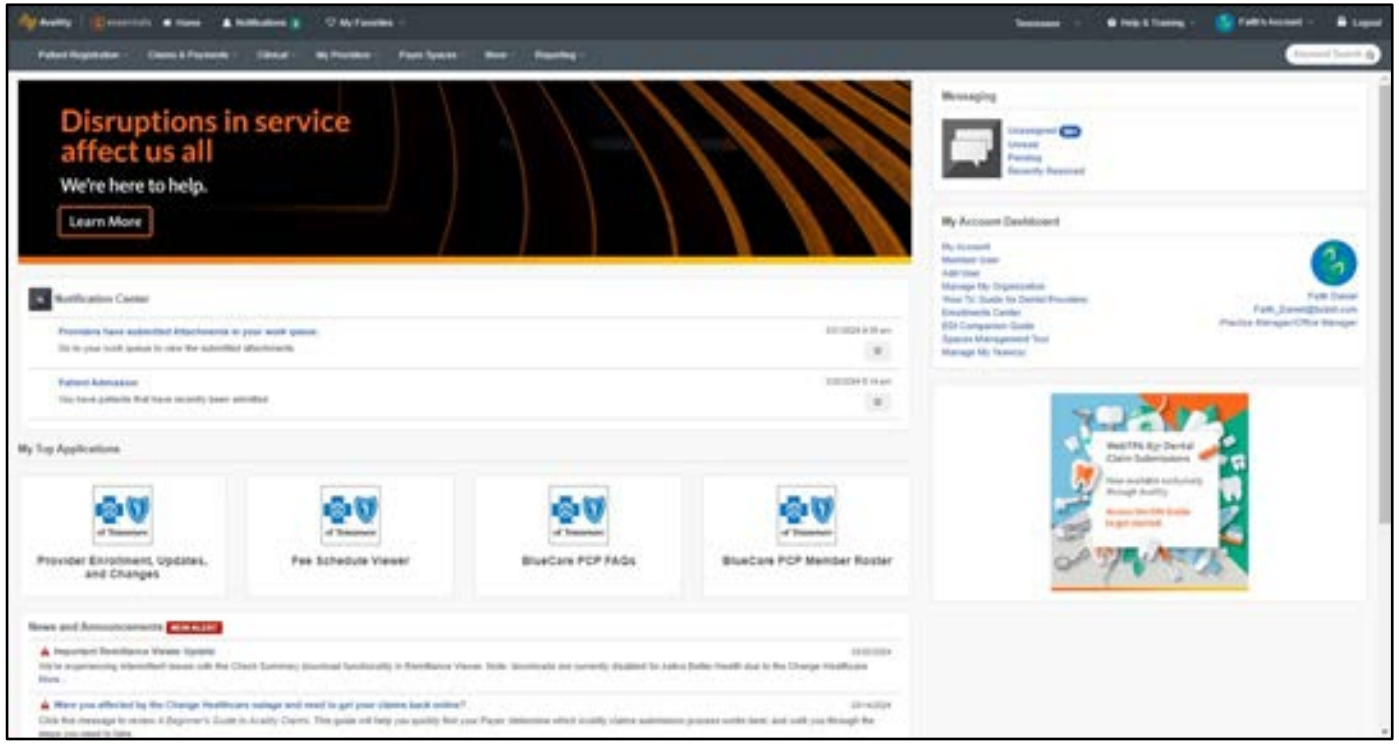
Thank You

GENERAL SESSION

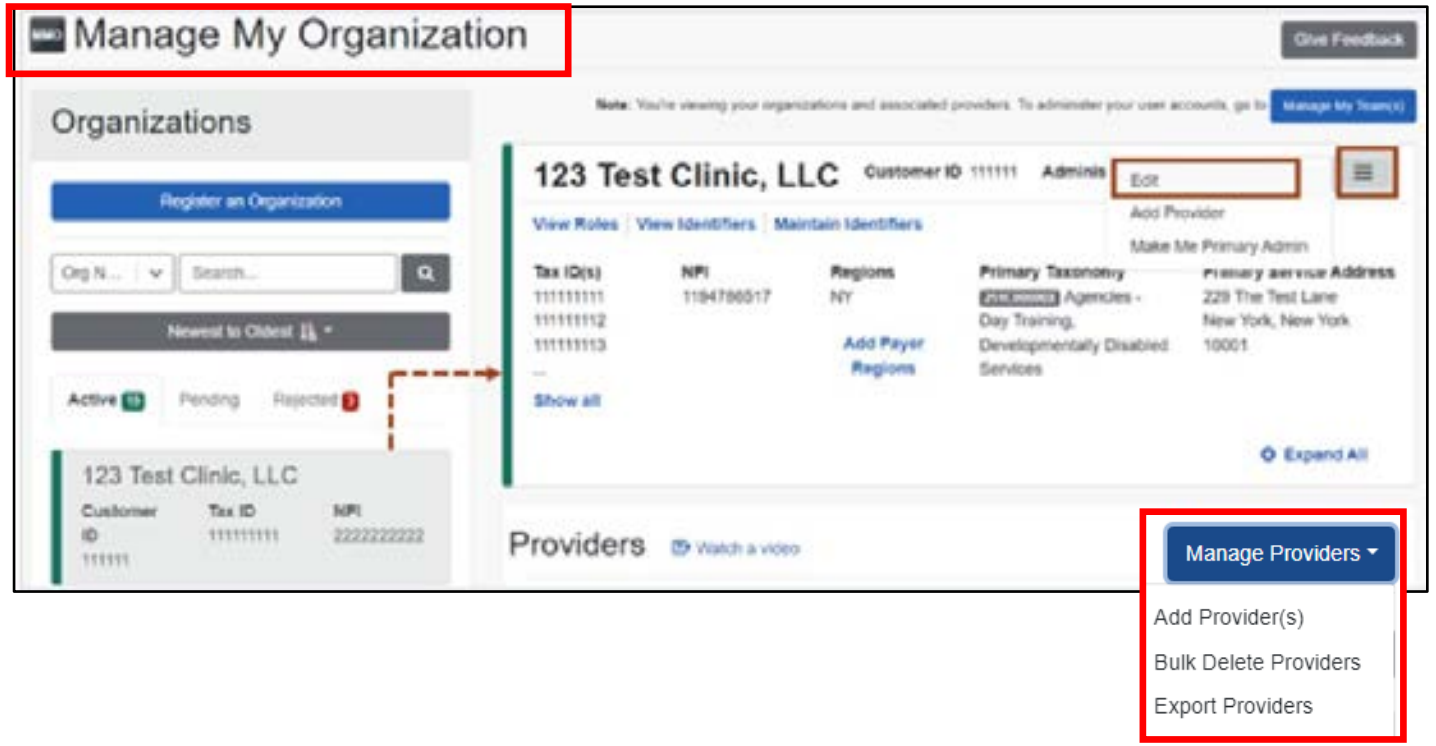
eBusiness

Home

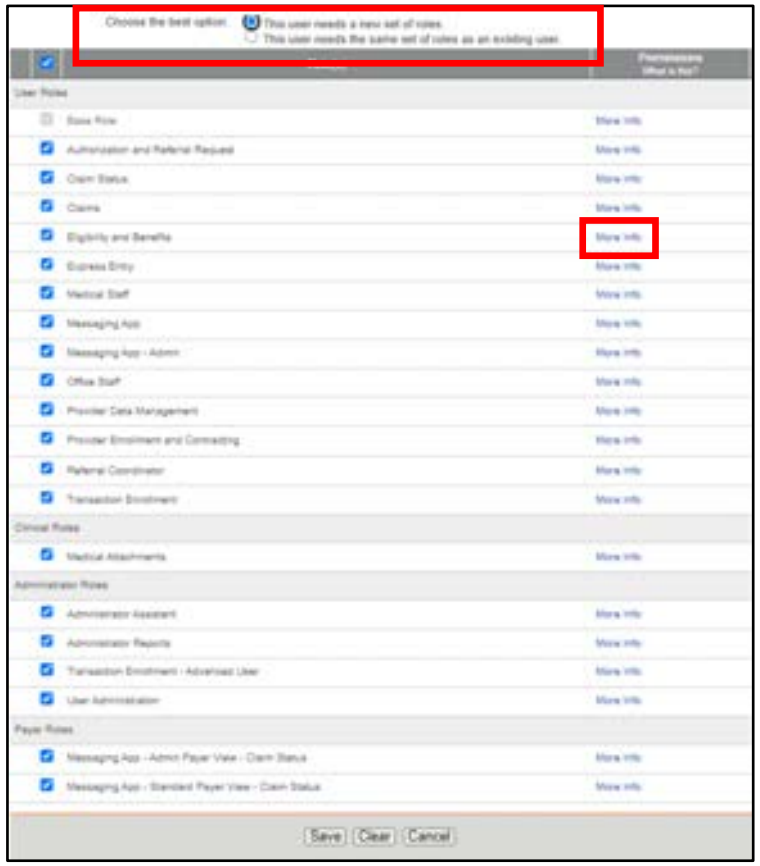
- Messaging
- My Account Dashboard
- Notification Center
- News and Announcements



Manage My Organization



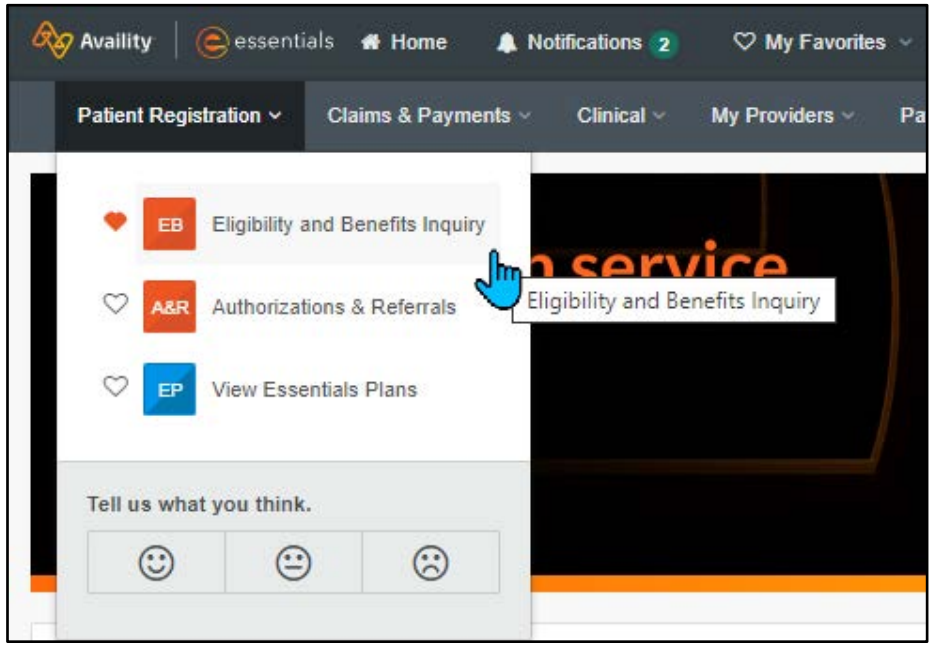
User Roles



- Access can mirror existing user in Organization.
- Clicking More Info defines level of access for each role.

AVAILITY® MULTI-PAYER

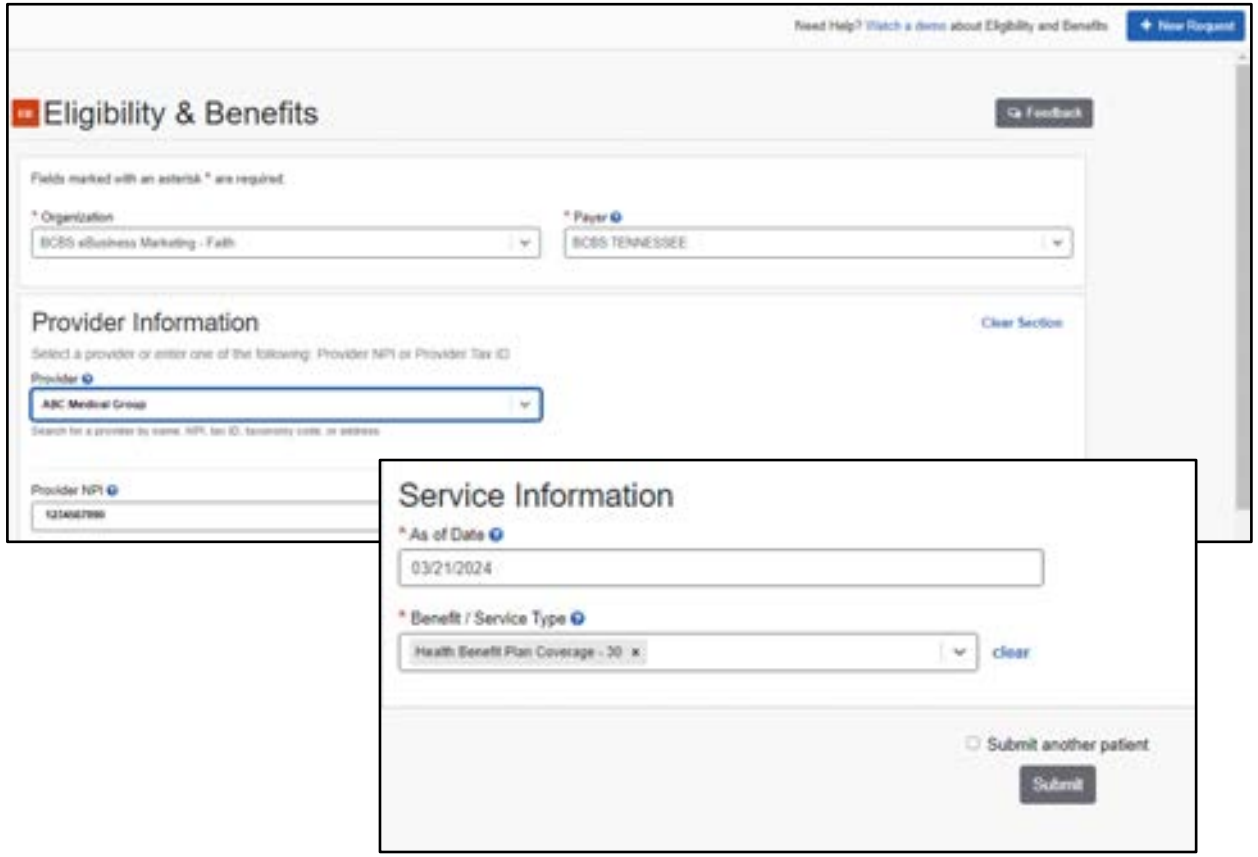
Patient Registration



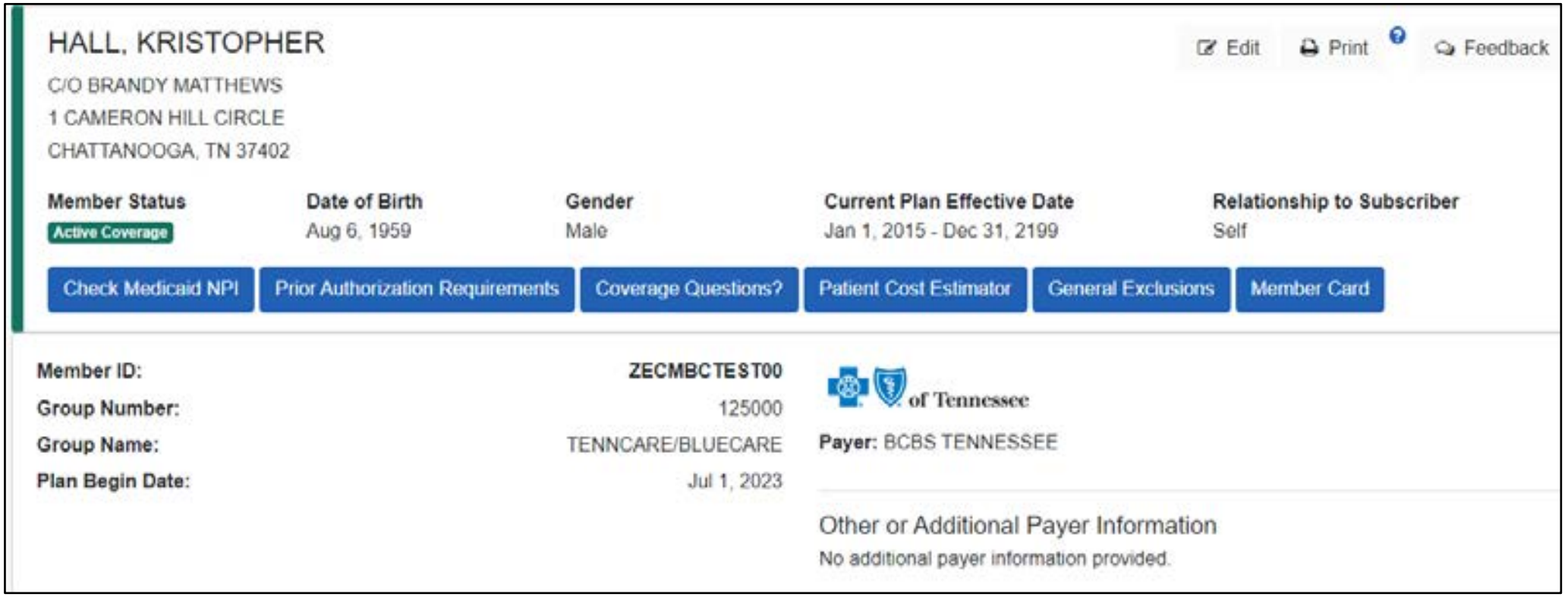
- Eligibility and Benefits Inquiry
- Authorizations & Referrals
  - Authorization Request (BlueCard)
  - CoverMyMeds – Pharmacy Benefit Drugs
- Tell us what you think
  - Feedback

AVAILITY® MULTI-PAYER

Eligibility & Benefits



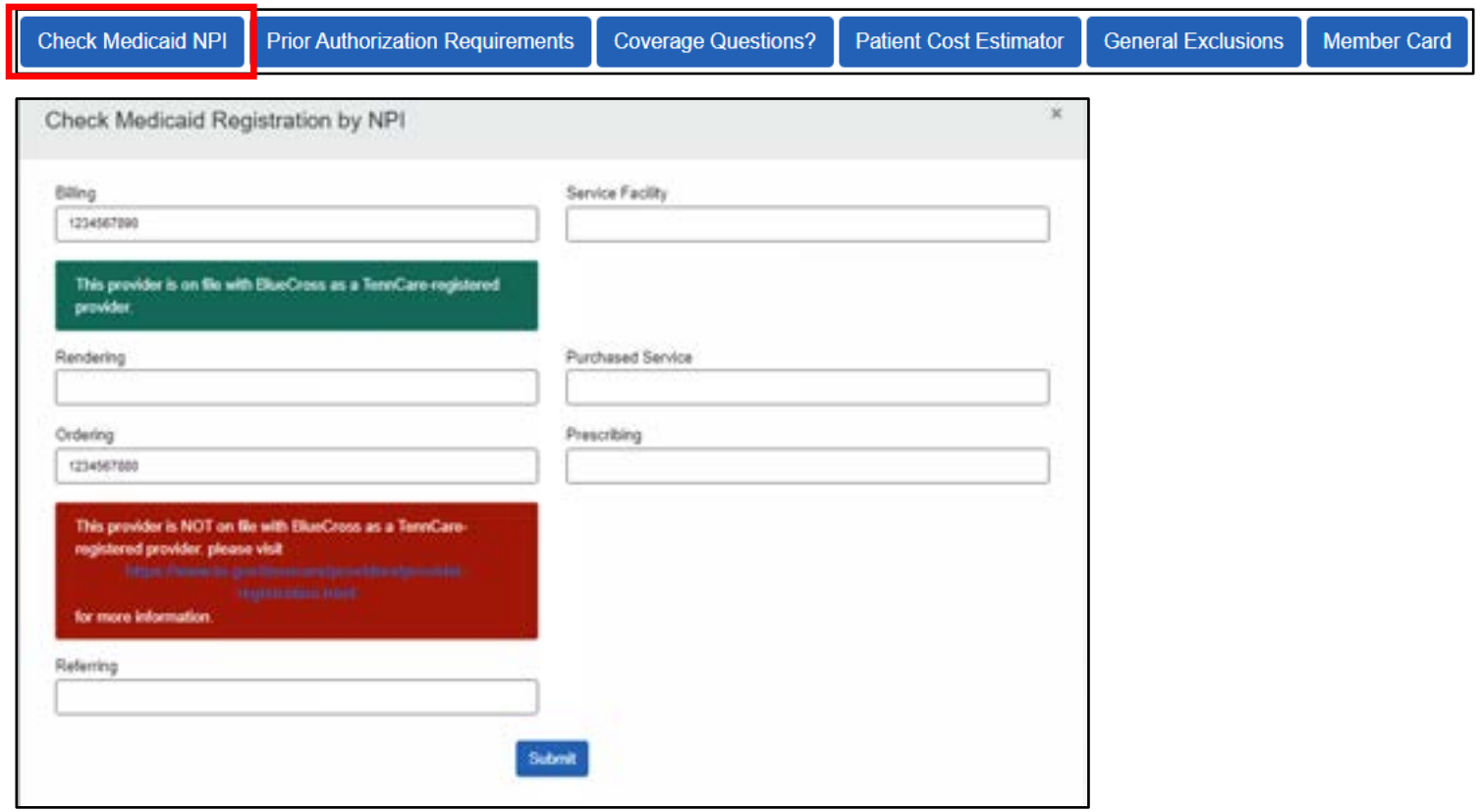
BlueCare Member Eligibility & Benefits



* None of these slides depict actual member information.

Check Medicaid NPI

- All NPI(s) billed on a claim must be on file with TennCare.
- NPI(s) not on file will result in rejected claim.



Prior Authorization Requirements Coverage Questions?

Prior Authorization Requirements

Coverage Questions? “Fast Path”

- Prior Authorization Requirements
- Coverage Questions / Fast Path

AVAILITY® MULTI-PAYER

Member Card

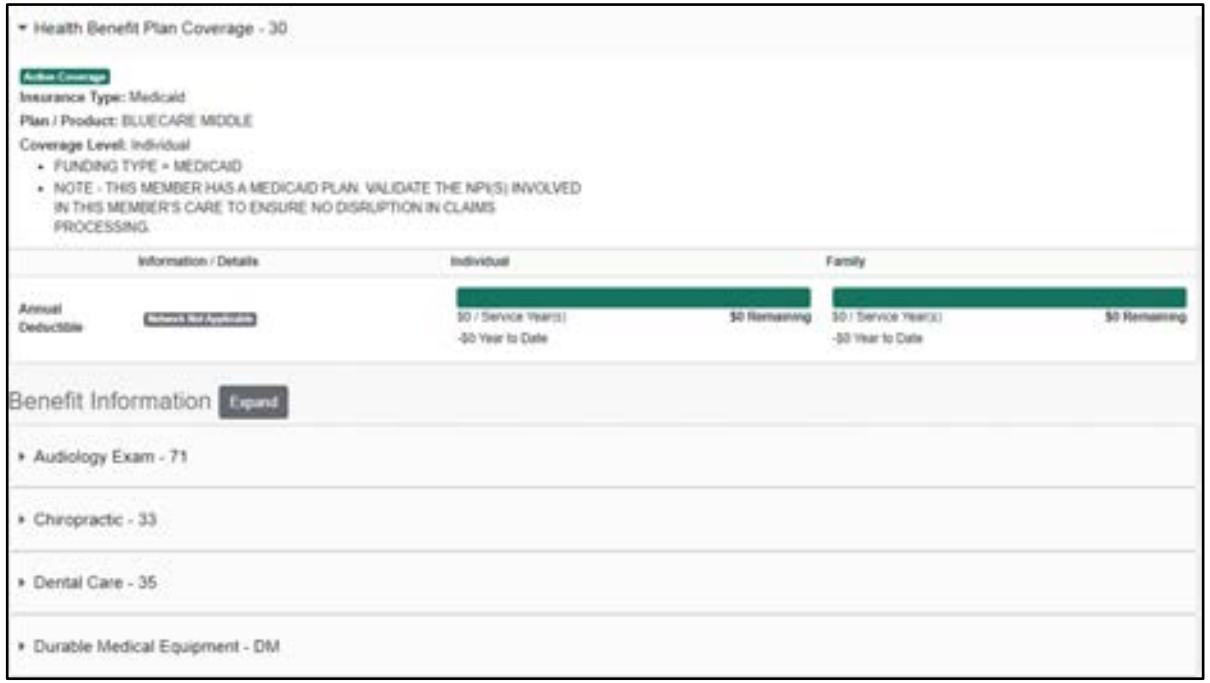
Check Medicaid NPI | Prior Authorization Requirements | Coverage Questions? | Patient Cost Estimator | General Exclusions | **Member Card**

Member Card

Additional Information

- Patient Cost Estimator (Real Time Claim Adjudication)
- General Exclusions

BlueCare Member Eligibility & Benefits



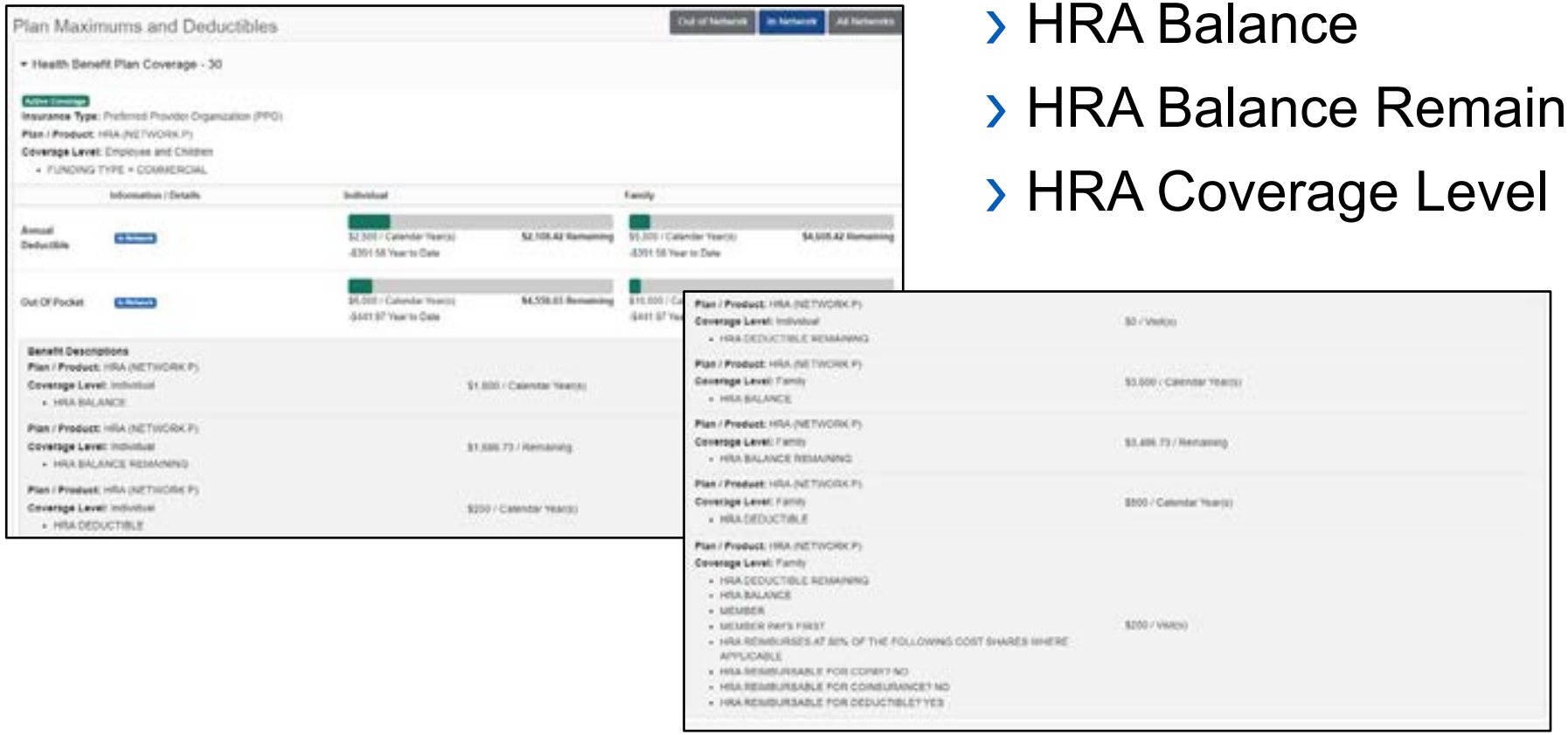
- Coverage Level
  - Funding Type = Medicaid
  - Note – Validate the NPI(s) involved
    - Check Medicaid NPI button on previous slide
- Deductible
- Benefit Information

AVAILITY® MULTI-PAYER

Commercial Member Eligibility & Benefits

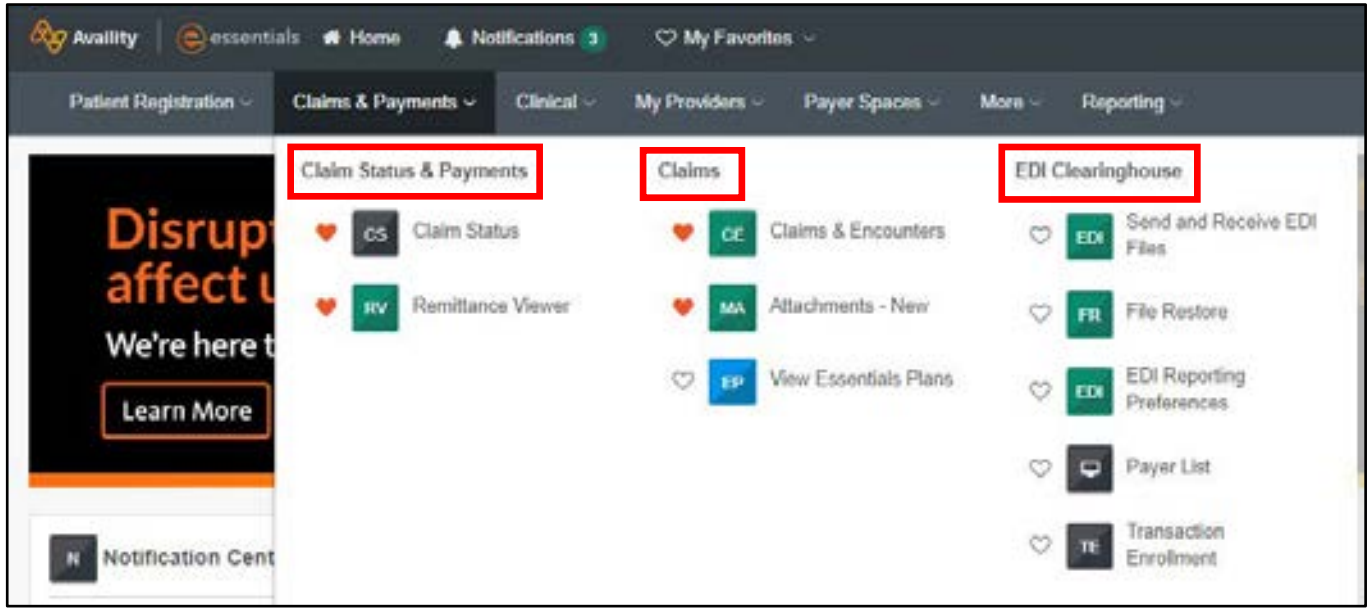
- Prior-Authorization Requirements
- Coverage Questions? (Fast Path)
- Patient Cost Estimator (RTCA)
- General Exclusions
- Member Card
- Coordination of Benefits (COB)

Health Reimbursement Account (HRA)



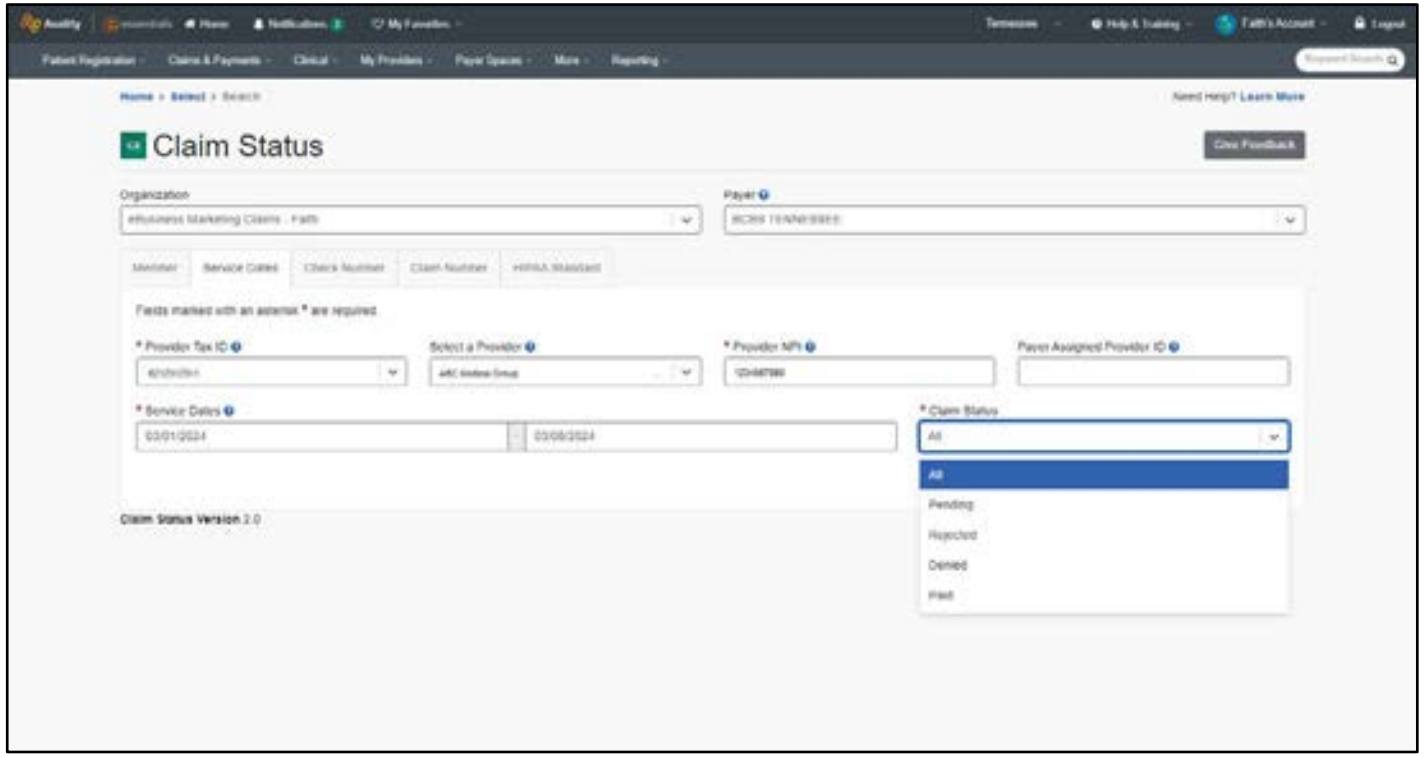
- HRA Balance
- HRA Balance Remaining
- HRA Coverage Level Details

Claims & Payments



- Claims Status & Payments
  - Claim Status
  - Remittance Viewer
- Claims
  - Claims & Encounters
  - Attachments – New
- EDI Clearinghouse
  - Send & Receive EDI Files
  - File Restore
  - EDI Reporting Preferences

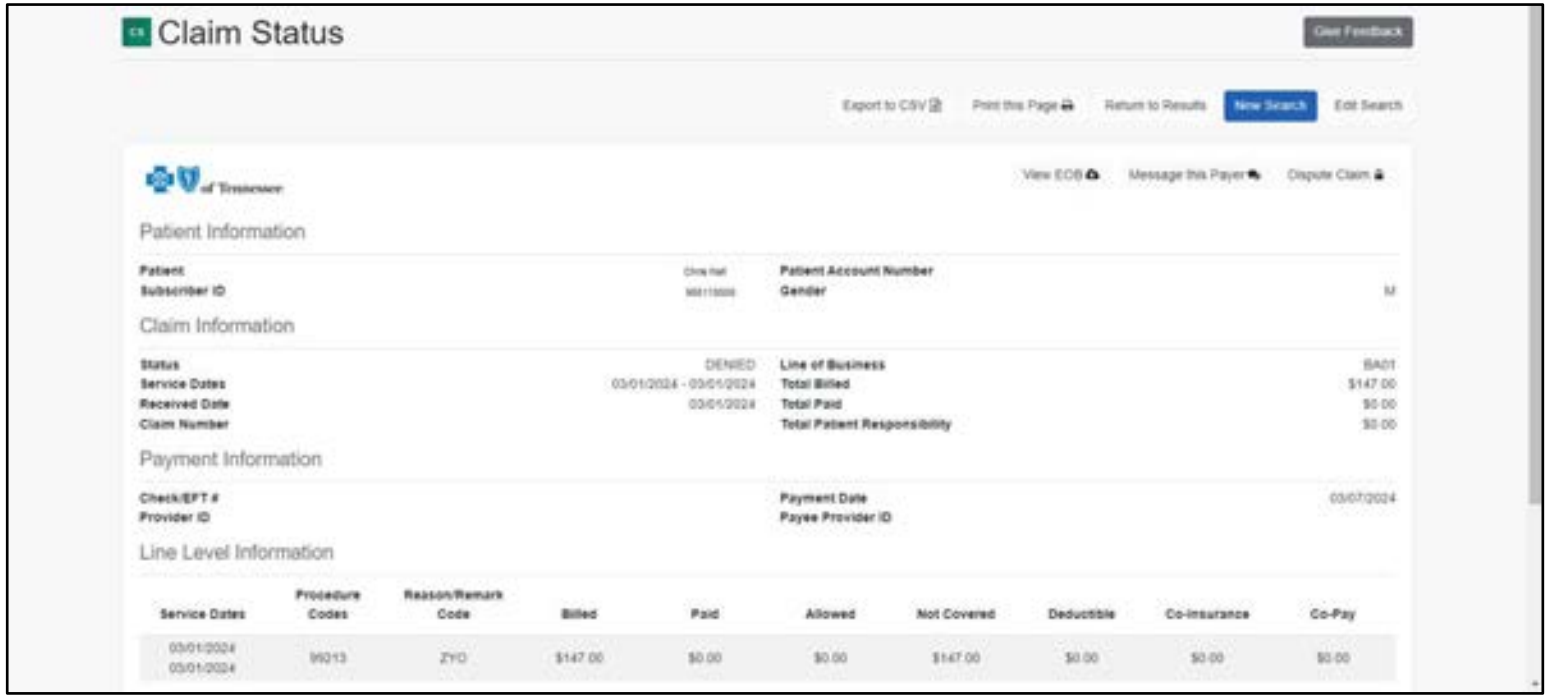
Claim Status



Search By:

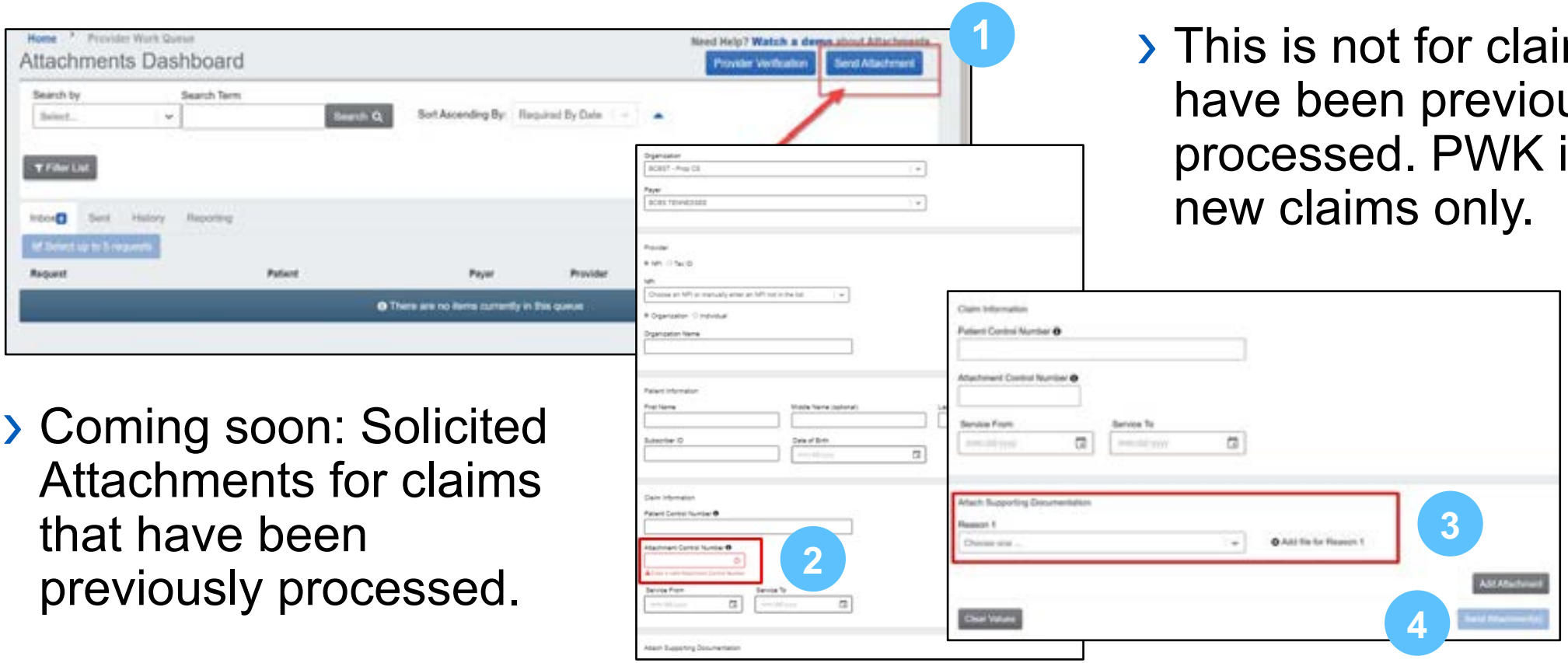
- Member
- Service Dates
  - Allows search by specific Claim Status
- Check Number
- Claim Number
- HIPAA Standard

Claim Status



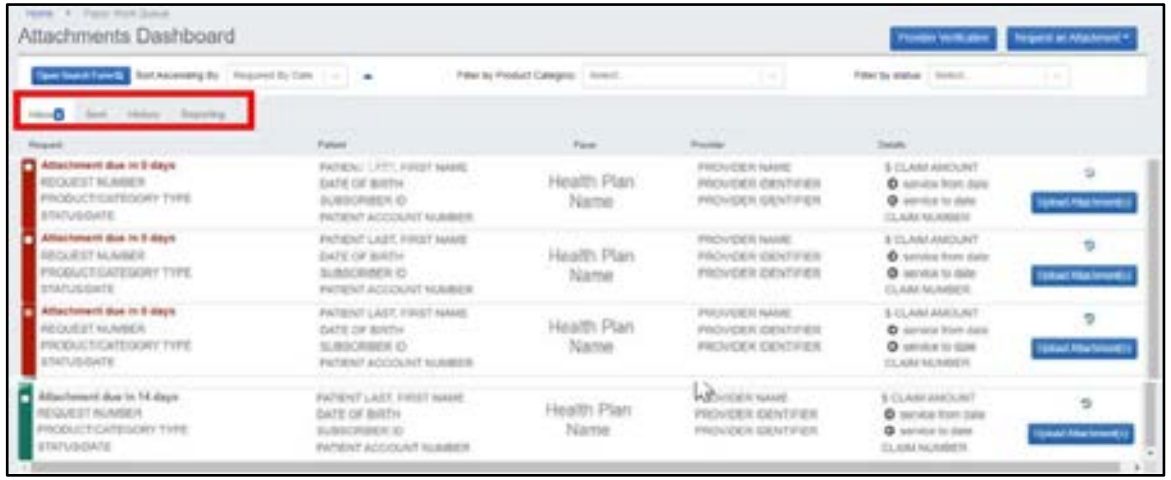
- Export to CSV
- Return to Results
- View EOB
- Message this Payer
- Dispute Claim

PWK Attachments – New Claims Submission



- This is not for claims that have been previously processed. PWK is for new claims only.
- Coming soon: Solicited Attachments for claims that have been previously processed.

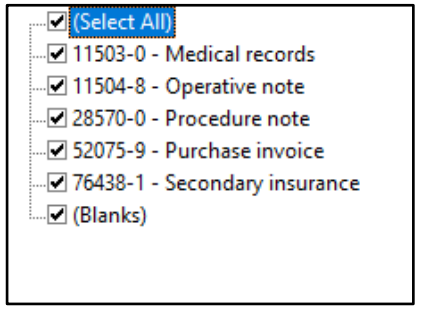
Solicited Attachments



- Inbox is for incoming attachment requests.
  - Each row has a claim number listed and an attachment request assigned.
- Sent shows the submitted requests.
- History provides the history of submissions.
- Reporting allows filtering of data and will be shown on the next slide.

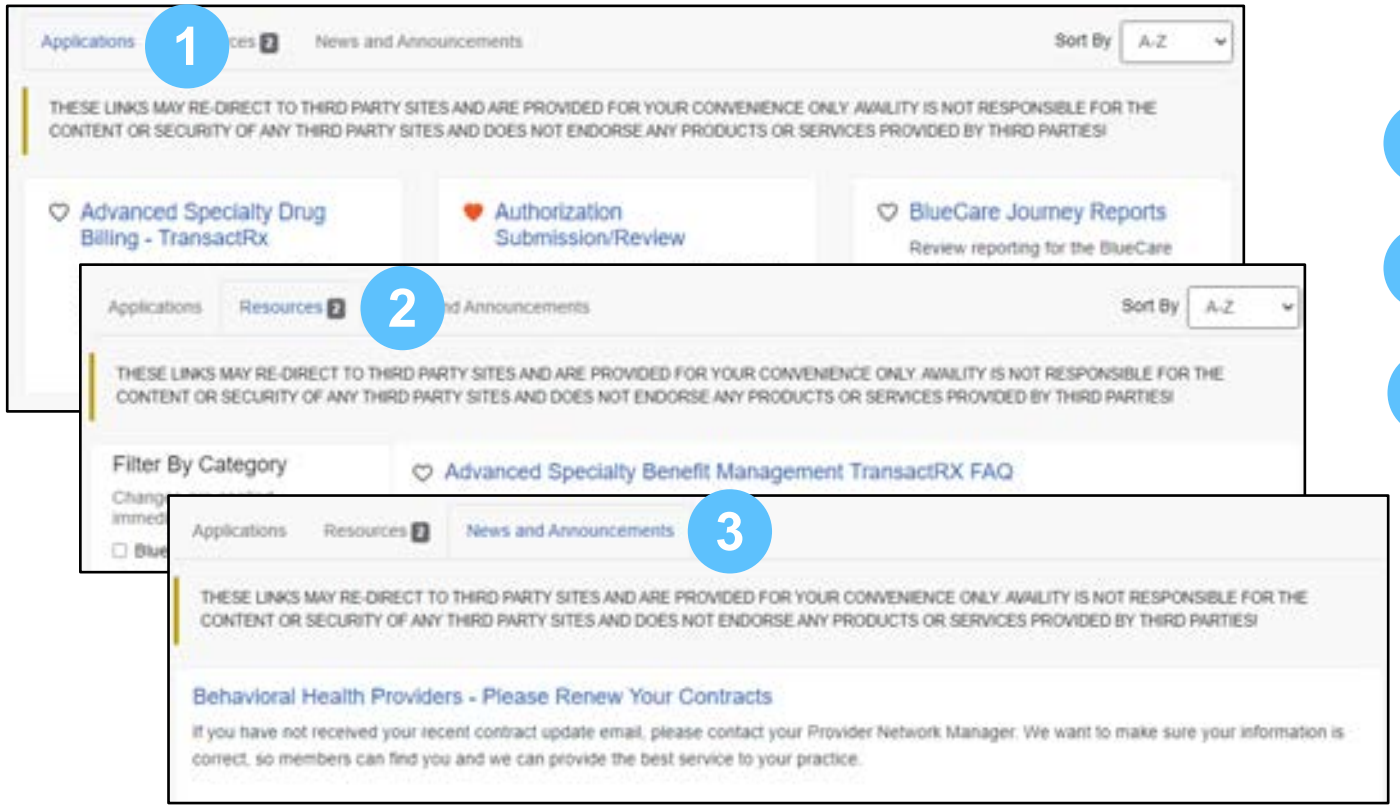
Solicited Attachments, Reporting

- Click the Export CSV button to generate report.
  - If desired, put a filter onto the exported report (csv file) to specifically drill down to the reason for the record request.
  - Column K on the exported report has a heading of “LOINCS.” Within this column, the filter options are as shown below:



PAYER SPACES

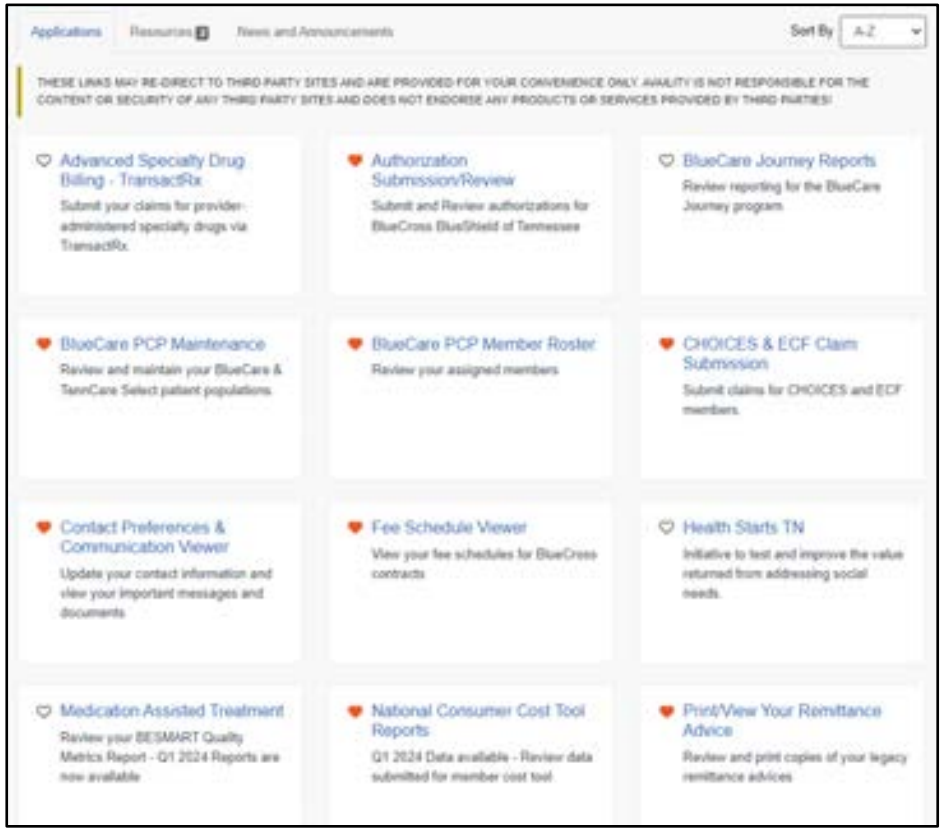
Introduction to Payer Spaces

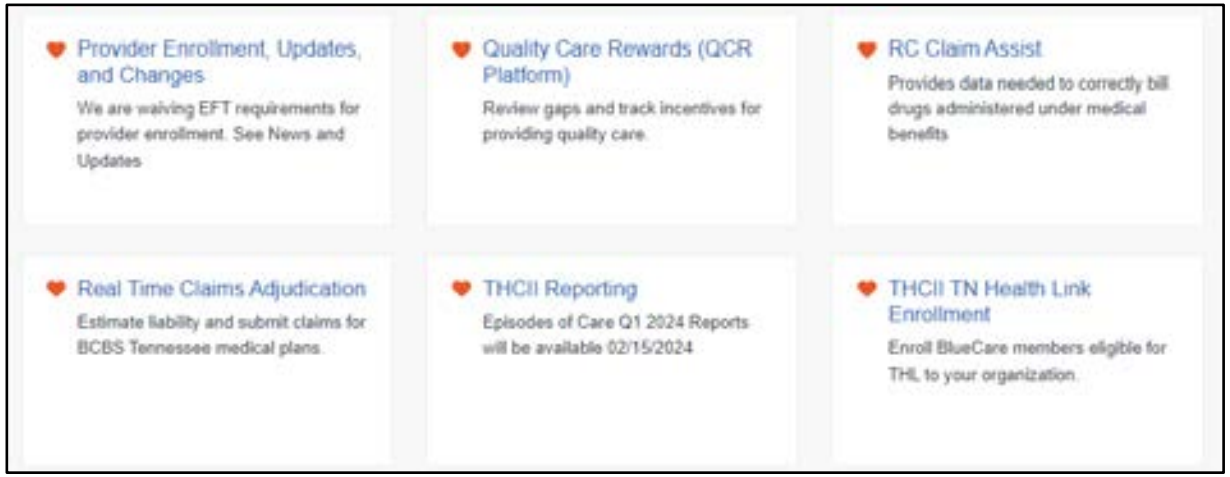


1. Applications
2. Resources
3. News and Announcements

PAYER SPACES

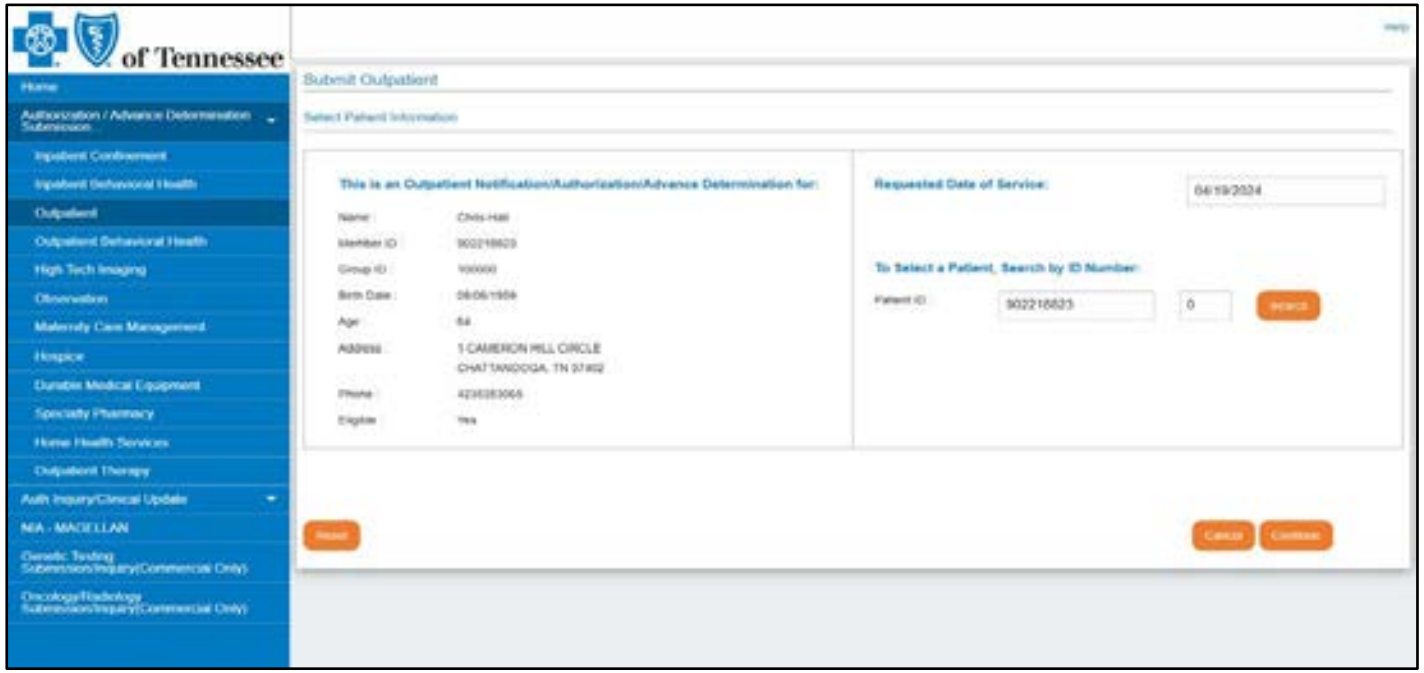
Applications





PAYER SPACES

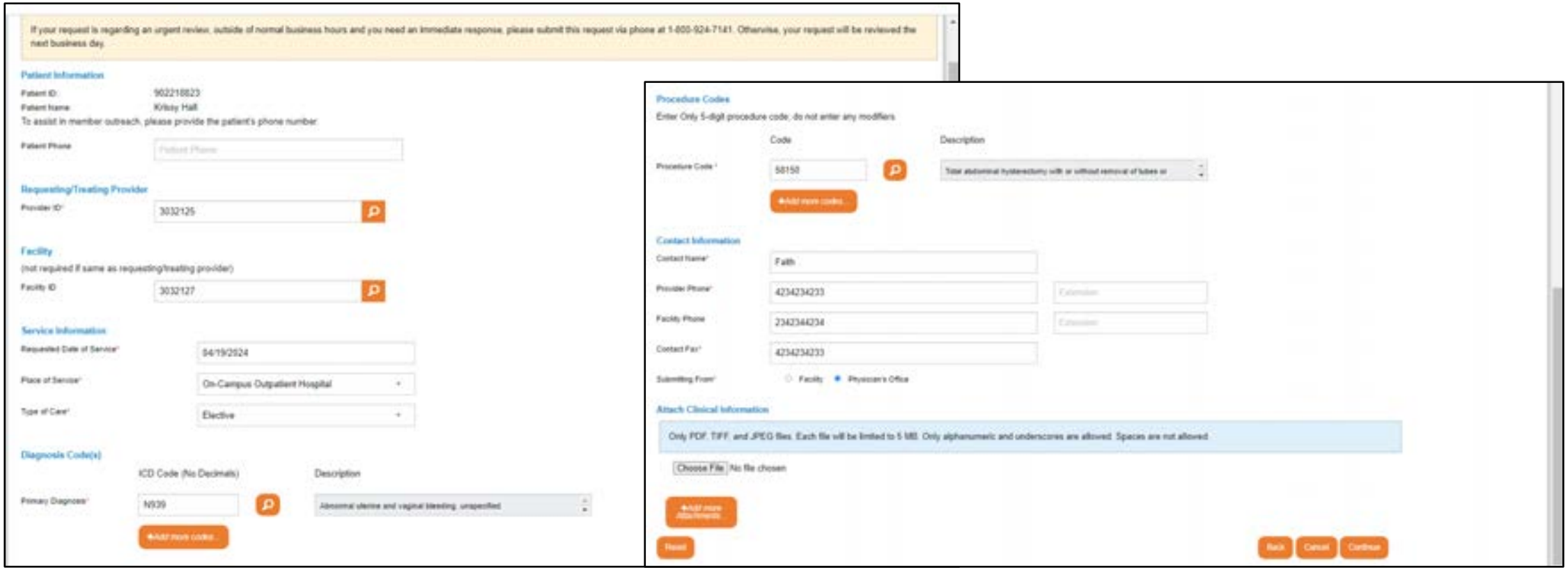
Authorization Submission/Review



- Requested Date default is current date.
- Do Not Enter ID Prefix.
- Only Enter 9-Digit ID Number.

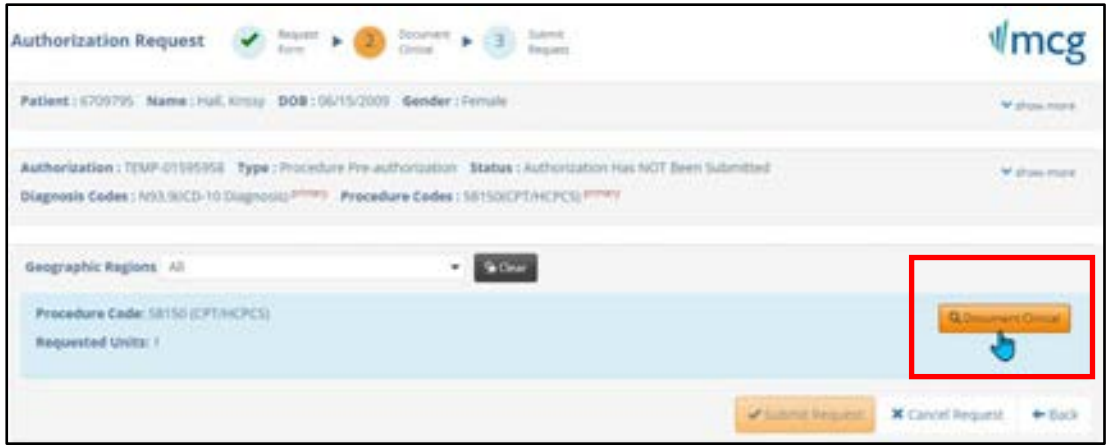
PAYER SPACES

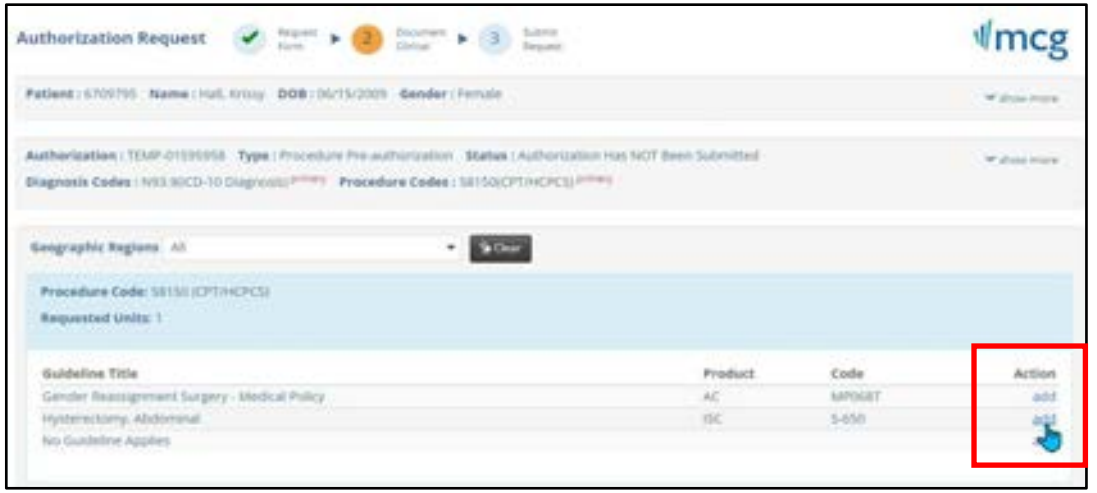
Initial Authorization Submission



PAYER SPACES

Milliman Care Guidelines (MCG)





- Click Document Clinical.
- Click Add Guideline.

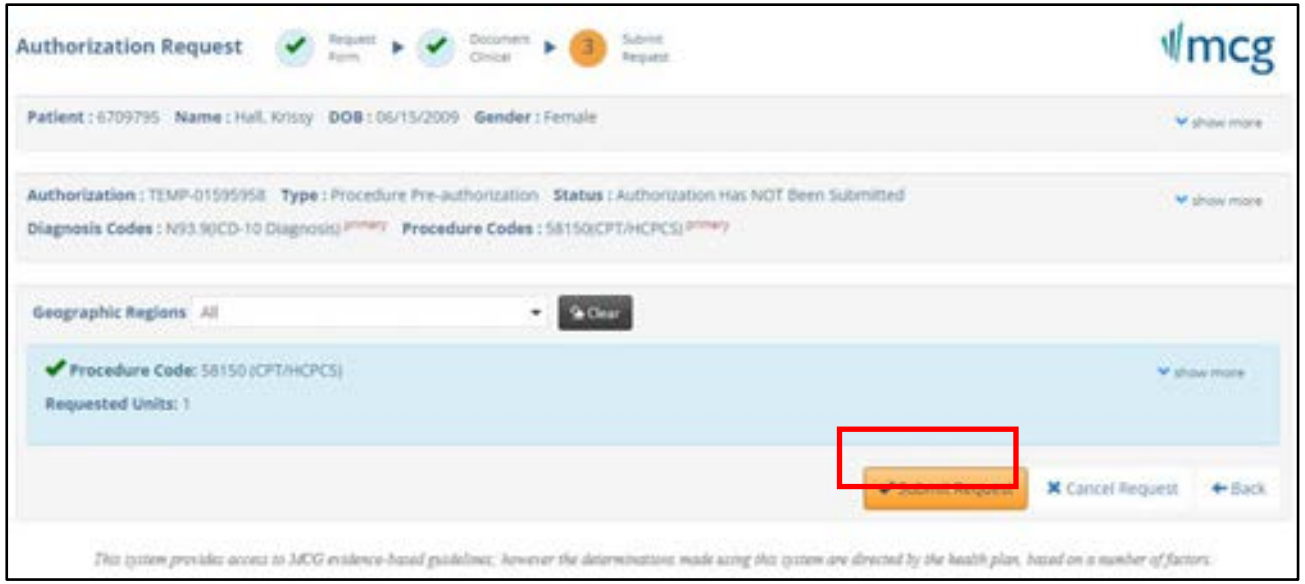
PAYER SPACES

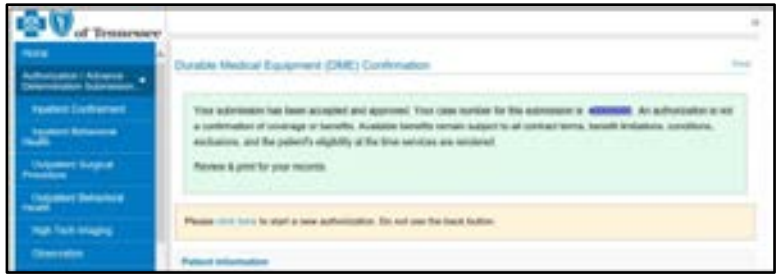
Milliman Care Guidelines (MCG)

- Select all clinical criteria.
- Click Save.

PAYER SPACES

Milliman Care Guidelines (MCG)

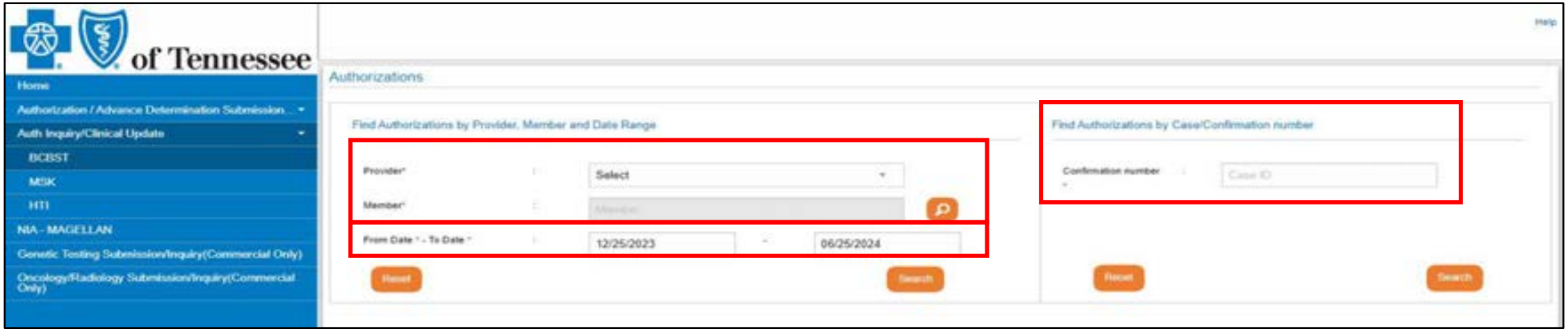




- Submit Request.
- Confirmation including Authorization number.

PAYER SPACES

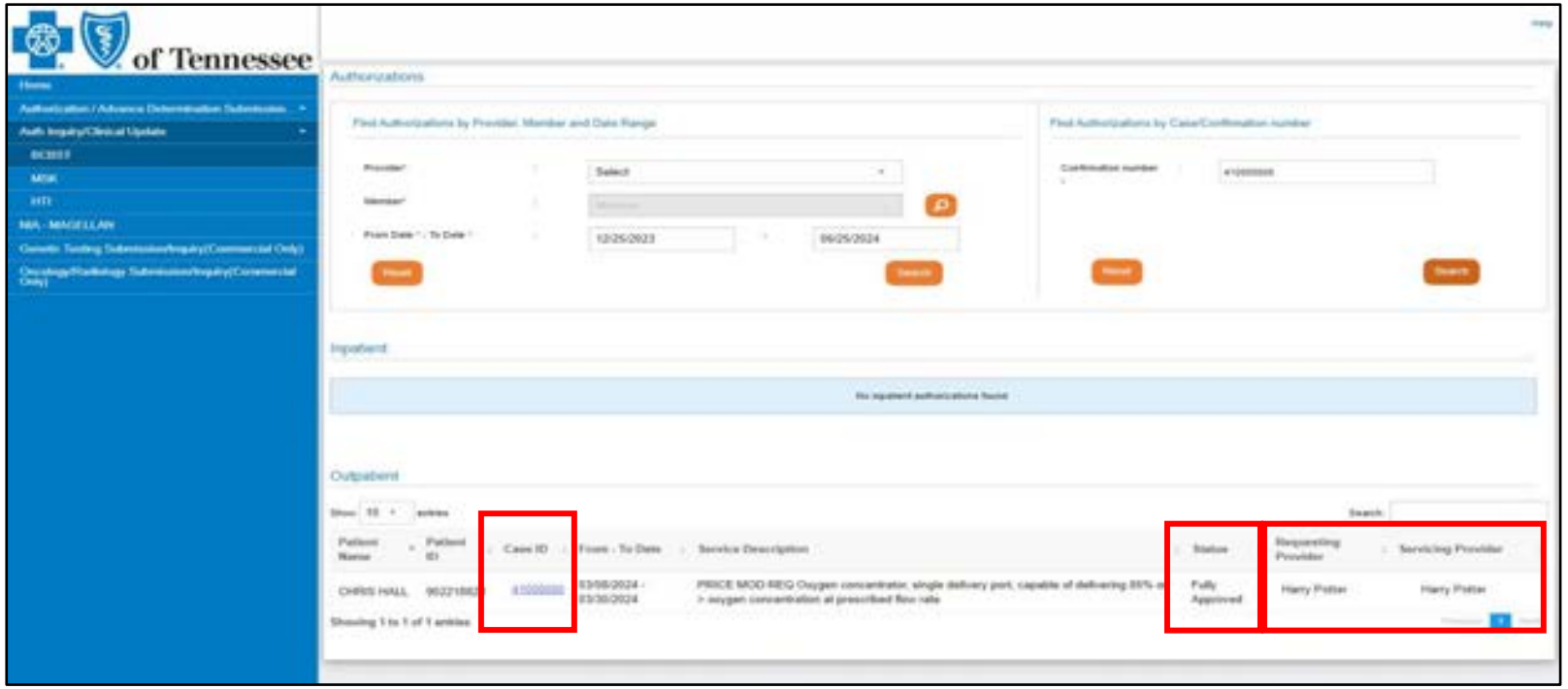
Auth Inquiry / Clinical Update Search



- Search by Confirmation (Authorization) Number.
- Search by Member.
- From Date – To Date may be expanded.

PAYER SPACES

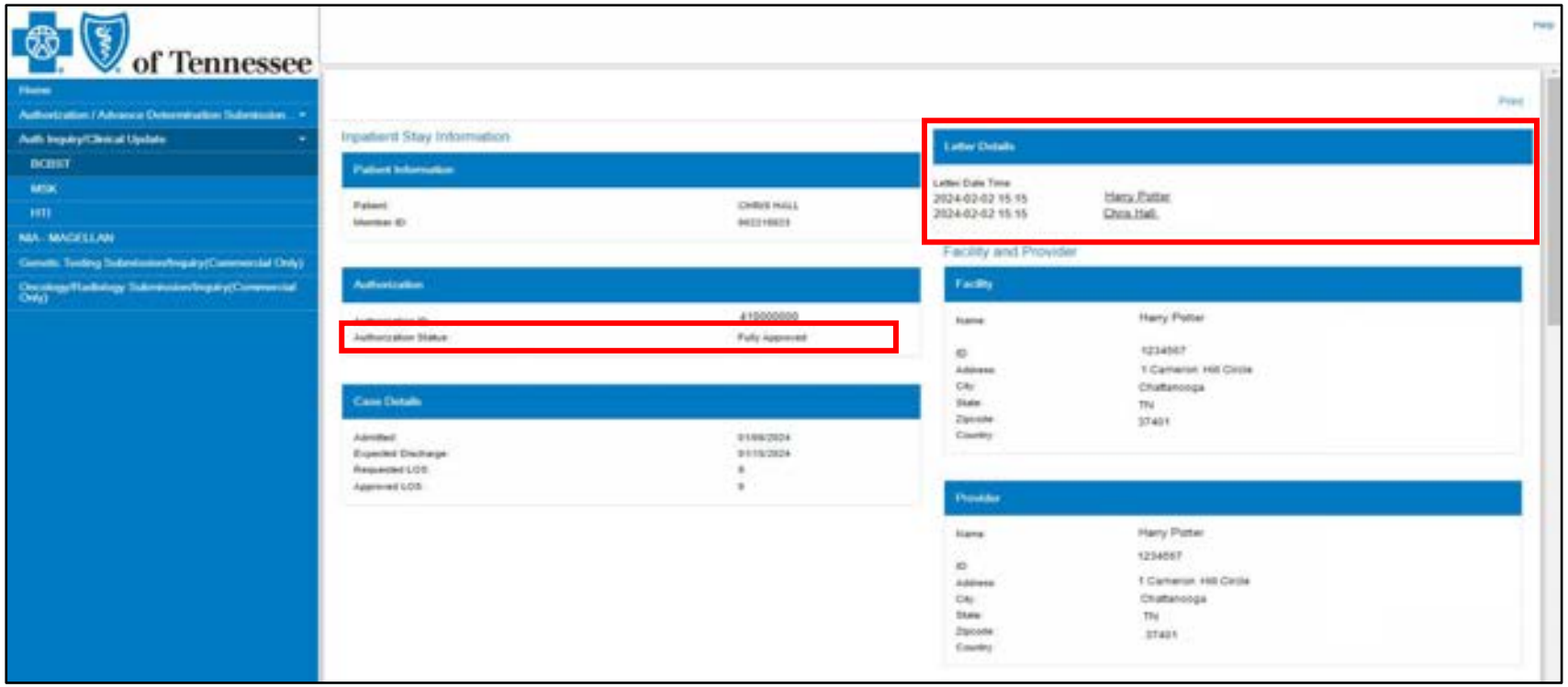
Auth Inquiry / Clinical Update Search



- Authorization Status
- Requesting & Servicing Provider
- Click Case ID to view Authorization Details.

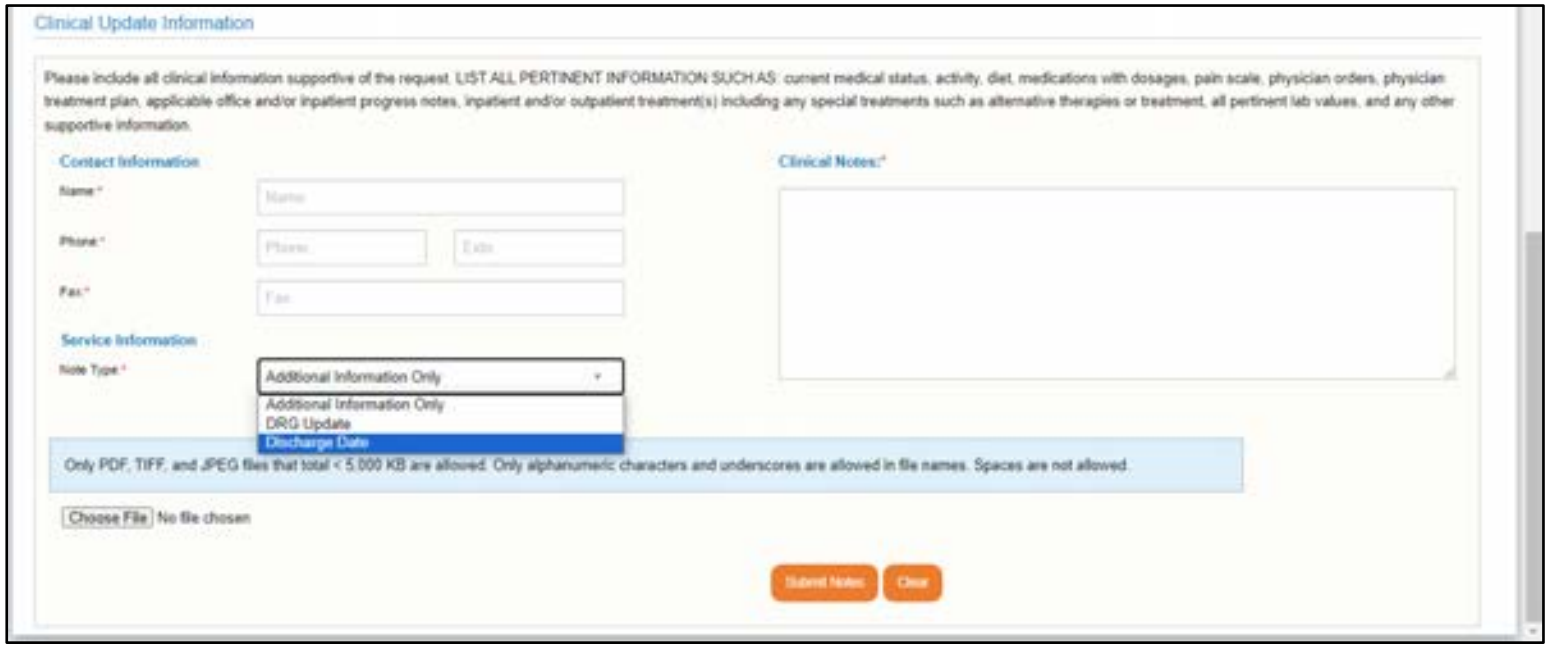
PAYER SPACES

Auth Inquiry / Clinical Update Search



- Letter Details
- Authorization Status

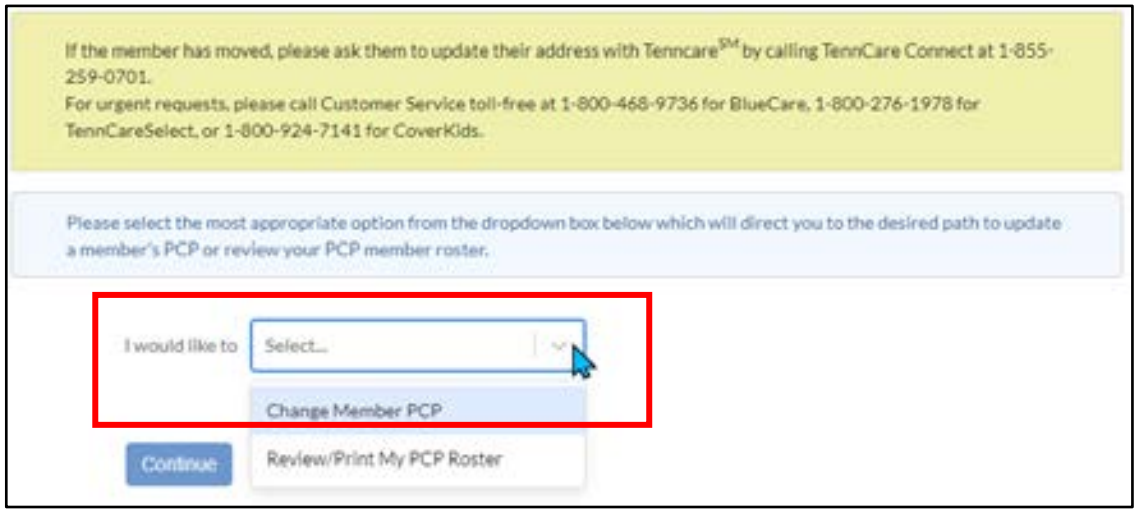
Clinical Update



- Update Existing Authorizations
  - Discharge Date/Summary
  - Update / Extend Treatment
  - BlueCare Home Health allows missed visits to be reported.

BlueCare PCP Maintenance

- BlueCare, TennCare*Select* and BlueCare Plus patient populations

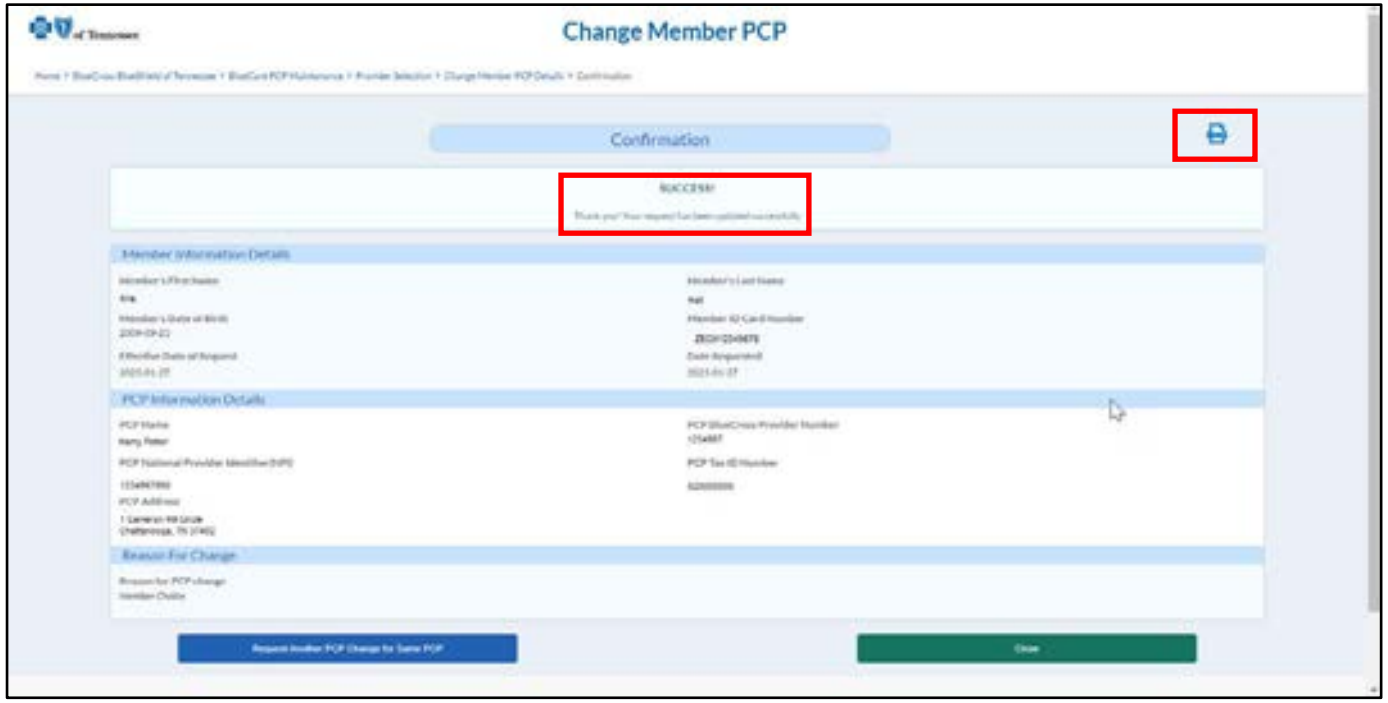


Change Member PCP Details

1. Enter Member ID with Prefix.
2. Enter Effective Date for Change.
3. Click Find Member.
4. Select Reason for Change.
5. Click Submit.

Important: Effective Dates may be backdated three business days.
Use capital alpha characters when entering Member ID number.

Change Member PCP Confirmation



- Changes are made in real time.
- Verify PCP was changed by looking up Eligibility & Benefits.

Change Member PCP Error

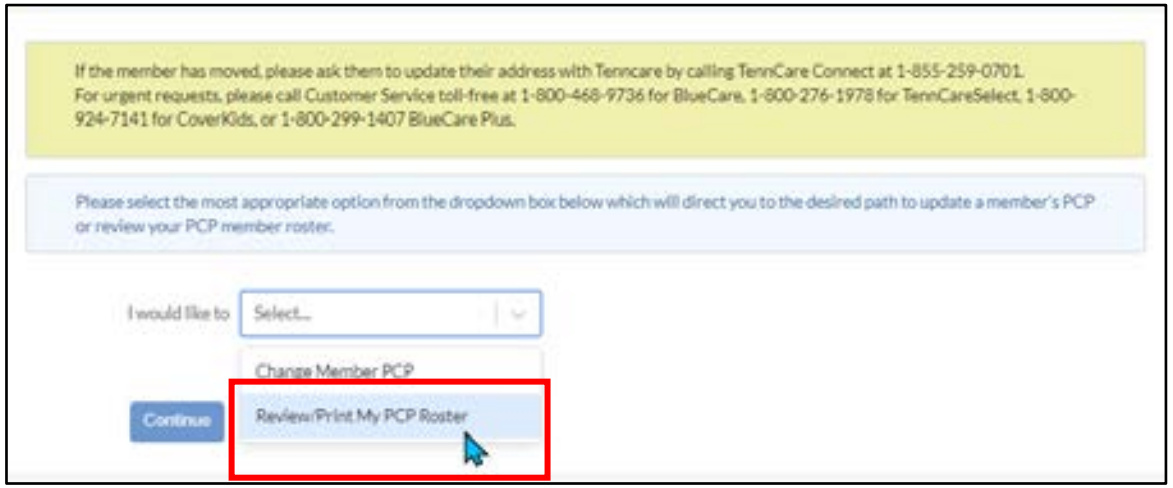
If an error is received on the confirmation page, do this:

- Click Printer icon to save the error page.
- Send the error information along with the reason for the PCP change to the email address in the red banner: **Fax_pcp@bcbst.com**

Payer Spaces

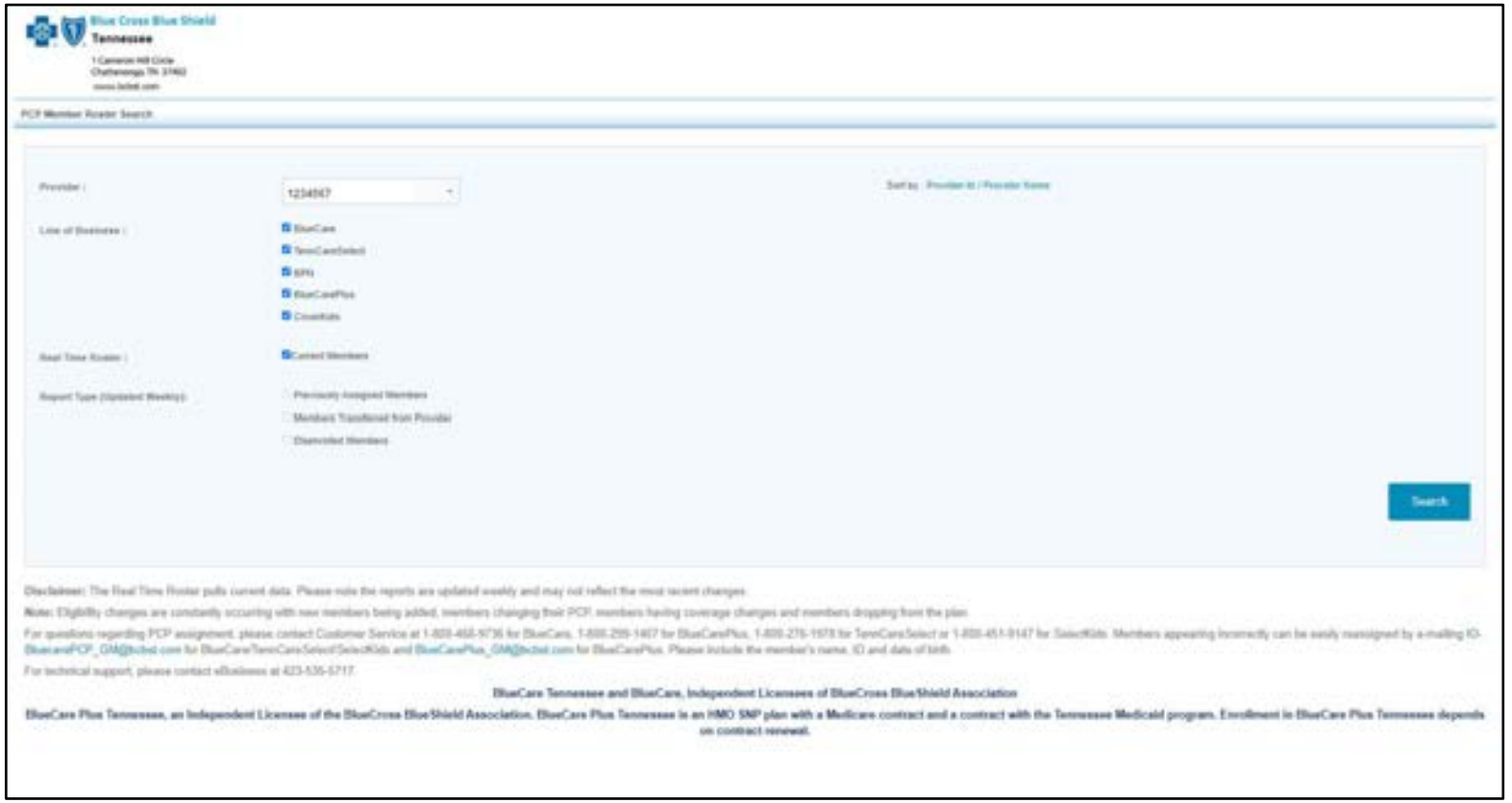
Review/Print My PCP Roster

- BlueCare, TennCare*Select*, BPN, BlueCare Plus and CoverKids lines of business



Payer Spaces

BlueCare PCP Roster



PAYER SPACES

Print / View Your Remittance Advice

View statements as early as Monday of each week to see payments deposited later in the week.

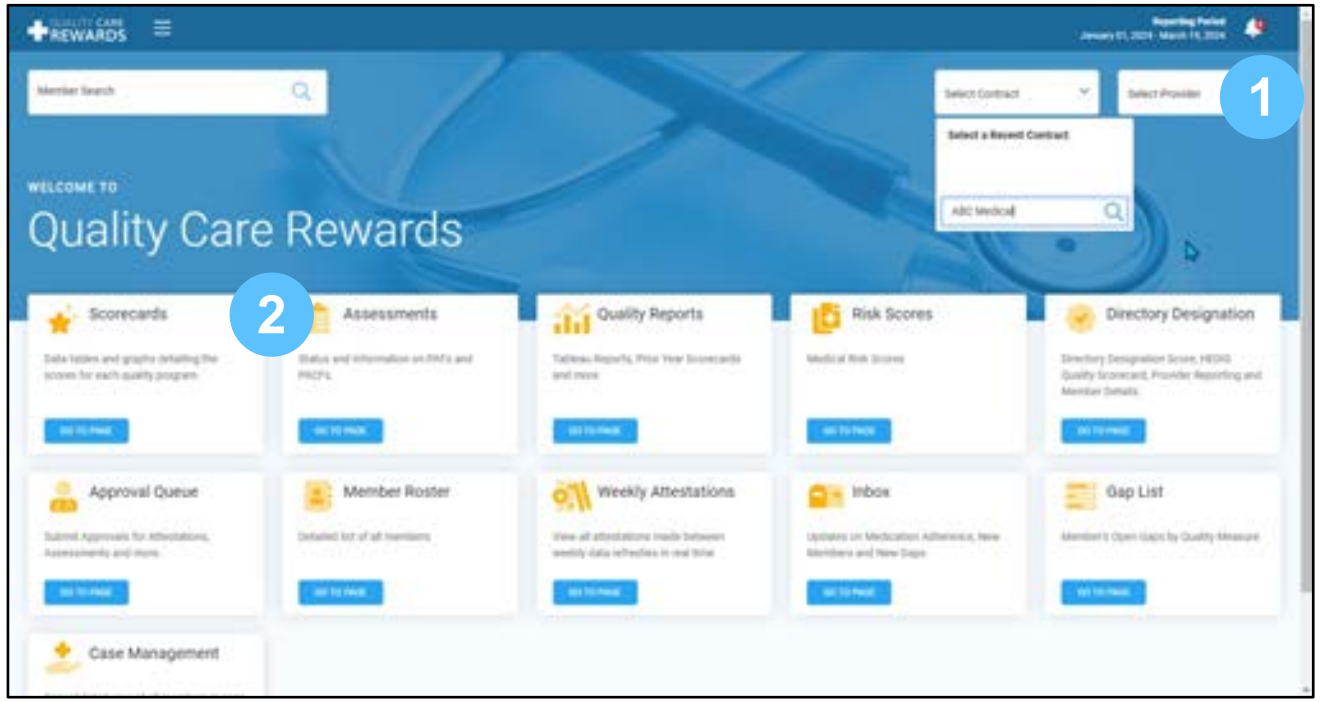
PAYER SPACES

Provider Enrollment, Updates and Changes

- CAQH is the source of truth, not the Availity Provider Data Management Application.
- Quarterly Data Verification
- Group/Individual Enrollment Form
  - Enroll up to 15 providers on one form
- Group/Individual Change Form
  - Update practice address or add location.
  - Supervising/Covering Physician changes
  - Remove practitioner from group & reassign members.

PAYER SPACES

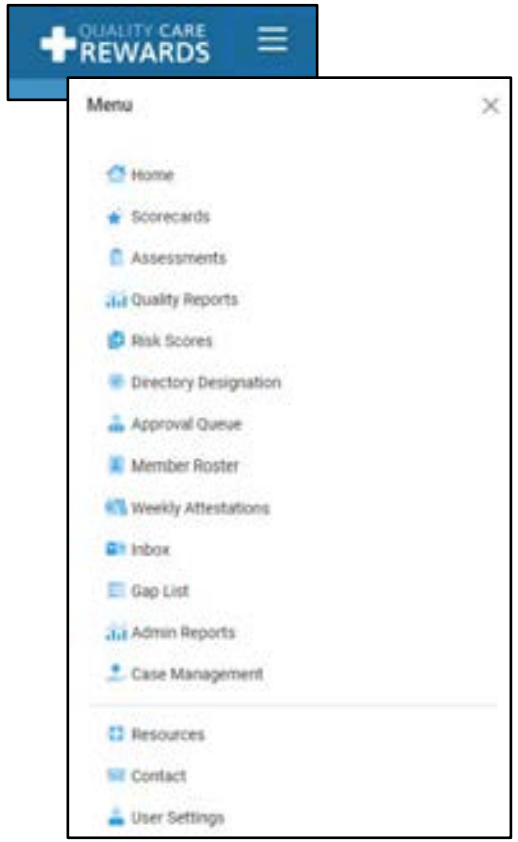
Quality Care Rewards (QCR)



1. Search provider name in Contract Search field.
2. Select desired tile to view data.

PAYER SPACES

QCR Navigation



- Three horizontal lines allow for navigation within QCR.
- Assessments for PAF and PACF
- Quality reports (Discharge, ADT, PCMH, etc.)
- Member Roster includes csv export.
- Inbox provides information about Medication Adherence, New Members, New Gaps and New Discharges.
- Gap List allows csv export where pivot tables can be created to show all open gaps for each member.

PAYER SPACES

THCII Reporting

- Episodes of Care website: **Episodes of Care (tn.gov)**
- Sign up for newsletters: **State of Tennessee (formstack.com)**

› Reports issued November, February, May and August.

› Typically, the third Thursday of each quarter

eBusiness Contacts

Technical Support
(423) 535-5717, Option 2

Vivian Williams

West Tennessee
Jackson and Memphis

(901) 544-2622
Vivian_Williams@bcbst.com

Faye Mangold

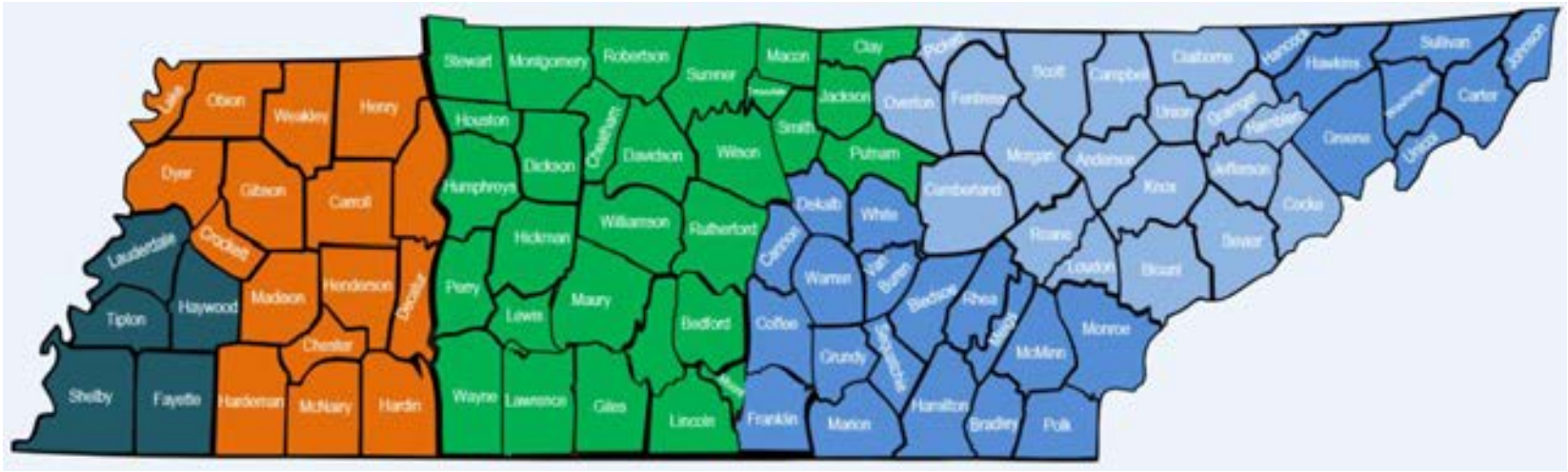
Middle Tennessee
Nashville

(615) 426-9122
Faye_Mangold@bcbst.com

Faith Daniel

East Tennessee
Chattanooga, Knoxville, Tri-Cities

(423) 535-6796
Faith_Daniel@bcbst.com



Thank You

GENERAL SESSION

Provider Network Operations

PROVIDER NETWORK OPERATIONS

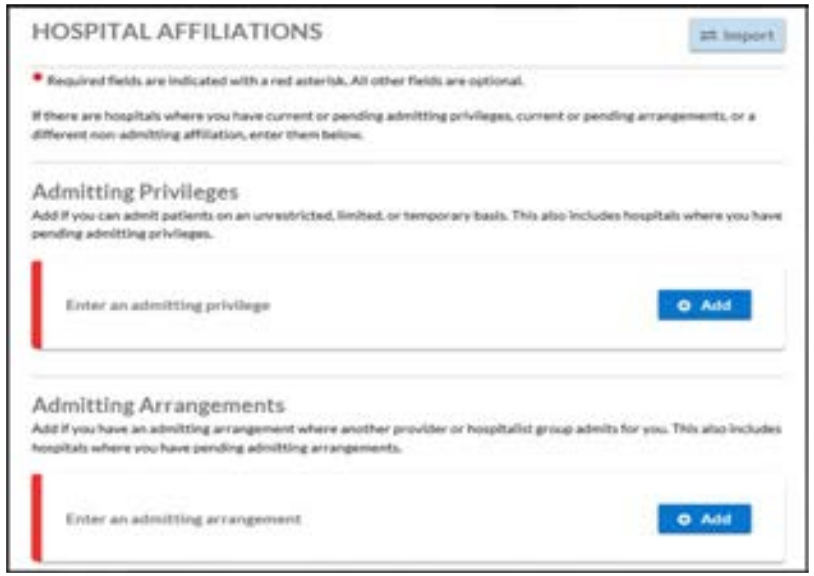
Discussion Topics

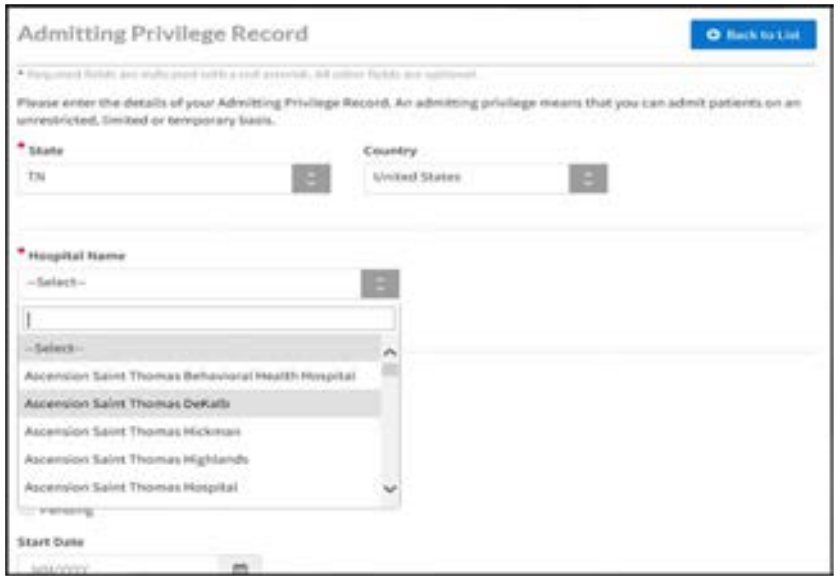
- CAQH / Provider Network Verification
- Directory Suppression
- Enrollment Process
- Navigating the Persona Page and accessibility
- Enrollment Applications Suite and Contact Preference
- Application Status Tracker
- Reference page

Directory Topics

- CAQH Hospital Affiliations and Practice Locations
- Consolidated Appropriation Act – Directory Suppression
- Network Verification

Hospital Affiliation





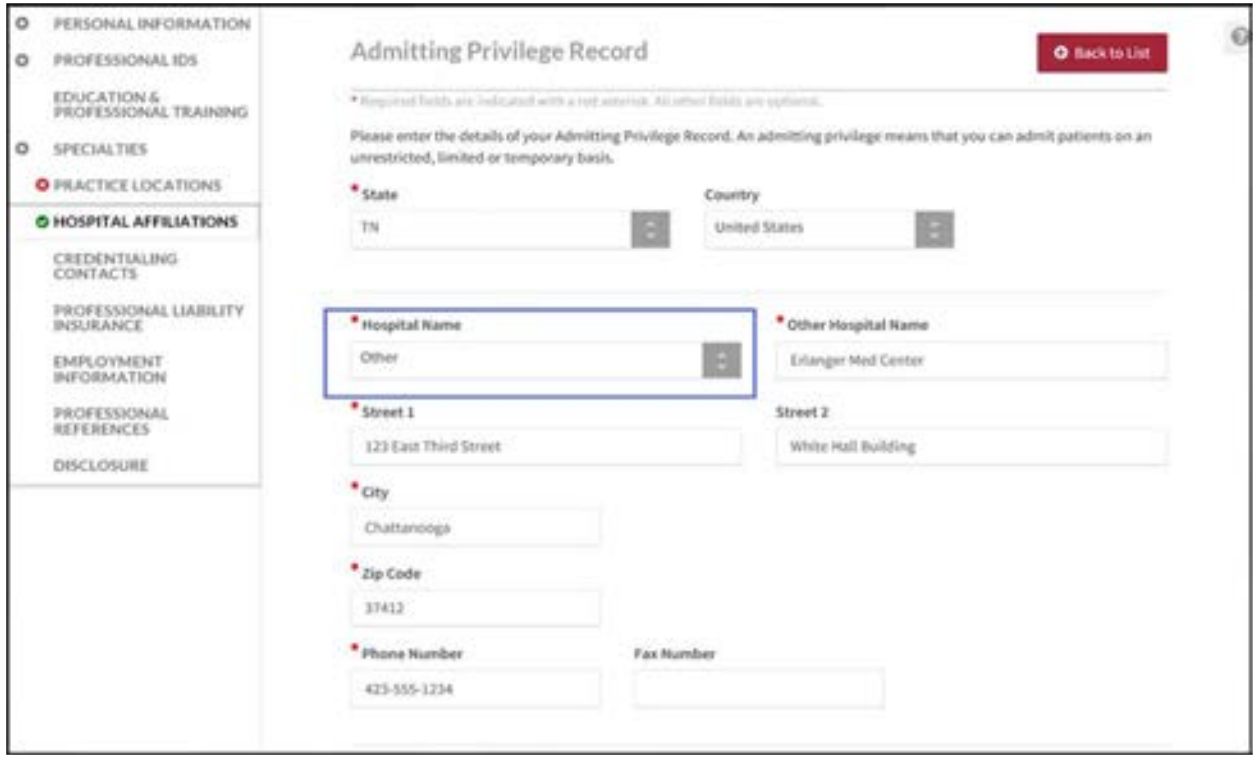
Please Review

- Review options for Hospital Affiliation and choose the appropriate State selection to drive the dropdown menu options for the accurate Hospital Name selection.
- Hospital names shown in the drop down are as the hospital is registered with the American Hospital Association (AHA)

Hospital Affiliation (cont.)

Please Review

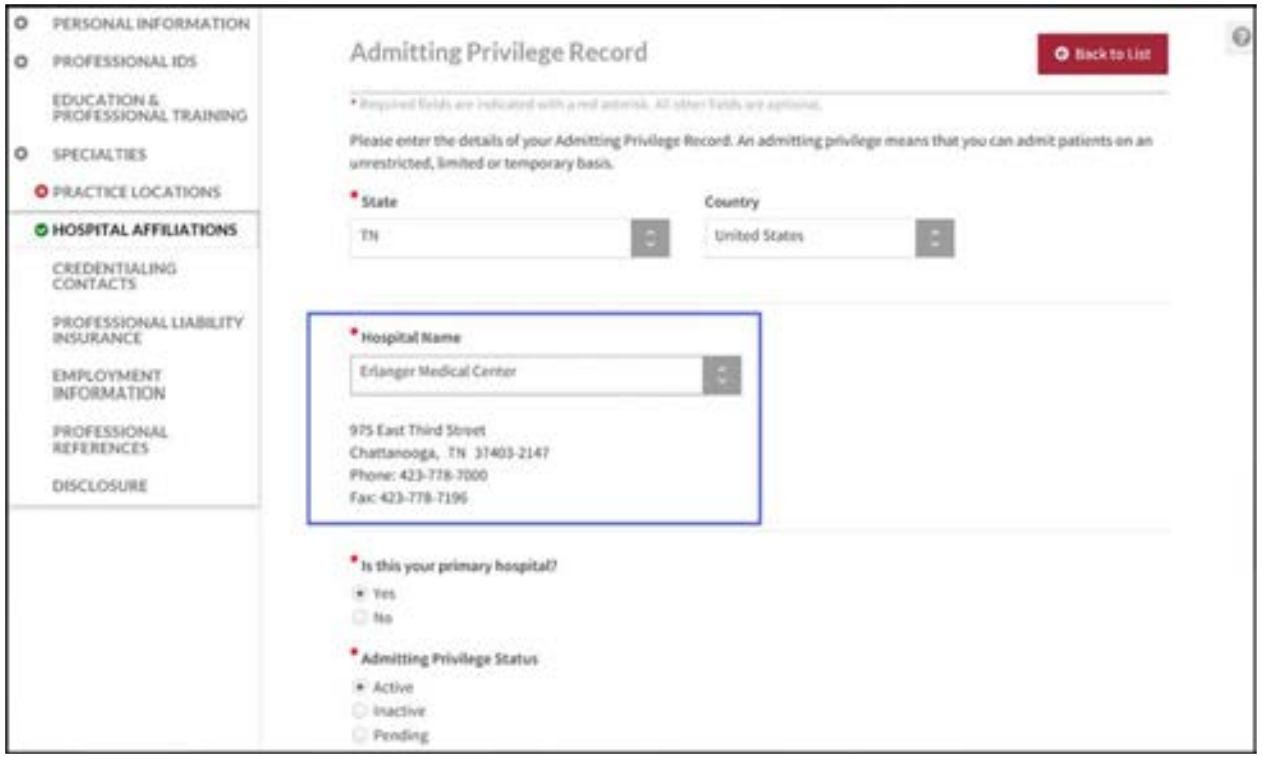
- If “Other” is selected, free form fields will be available, but is not best practice.
- By using the dropdown option, selecting the AHA Hospital Name and not “Other” will save you time looking up required fields and align with our data more accurately.



CAQH PROVIEW HOSPITAL AFFILIATION

Best Practice

1. Standardized hospital name
2. Standardized address
3. Fewer keystrokes



CAQH PROVIEW PRACTICE LOCATION

Practice Details

Please Review

- Location address
- Appointment phone number
- Business identifiers (Tax ID)
- Organization (Type 2) NPI
- Office hours
- Practice Affiliation

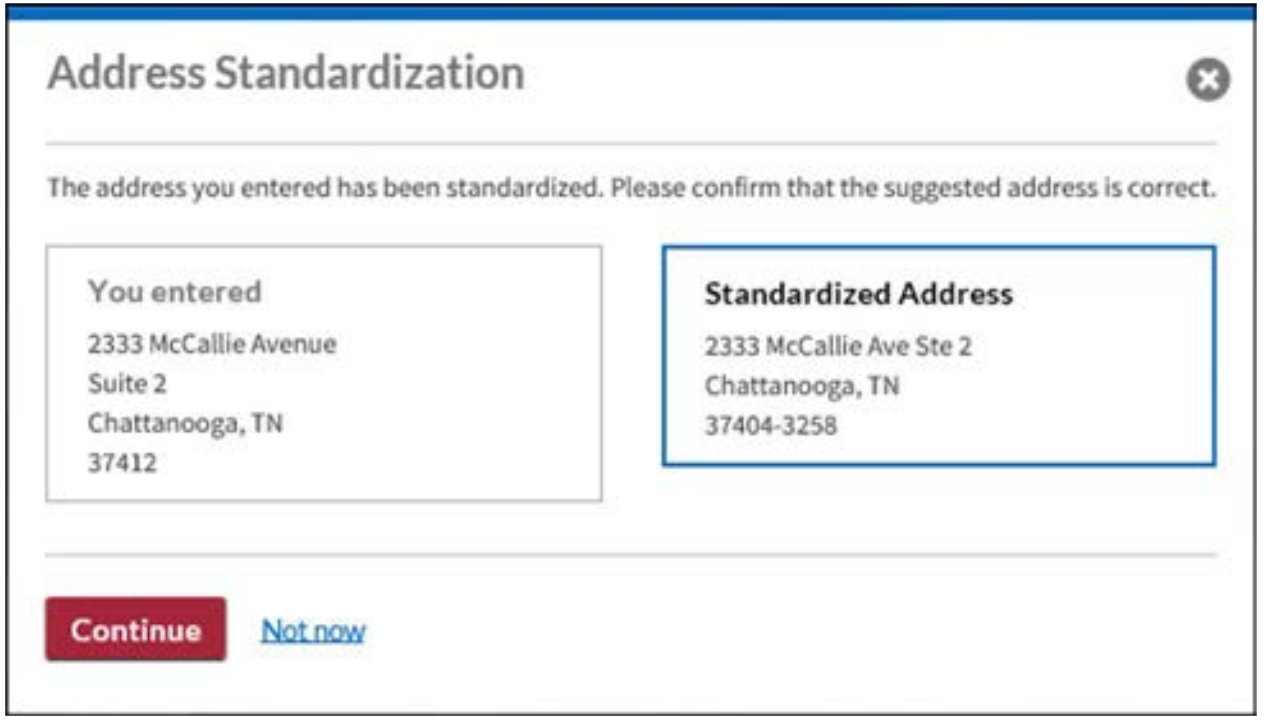
CAQH PROVIEW PRACTICE LOCATION

Confirm Affiliation - Address

- Review this each time you attest.
- Notice which affiliations display in the directory.
- Notice which affiliations do NOT display in the directory.
- If a provider's address is displayed in the directory, a patient should be able to call that number and make an appointment with that provider at that location.

Address Standardization

1. USPS Standard
2. Make sure there's an accurate location to help your patients find your practice.
3. Allows all your providers to have the same address information for the same location.



Consolidated Appropriations Act – Directory Suppression

Directory Suppression

- Consolidated Appropriations Act (CAA) requires that you attest to your CAQH information every 90 days
- Warning letter will be sent if you have not attested in over 90 days.
- If we do not receive attested information from CAQH the suppression process will be initiated.
- Your practice location will not be visible to members until you re-attest.

of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbst.com

April 8, 2024

RE: Urgent Reminder to Update Your Provider Directory Information

Dear Provider: Reference #: 1972920452

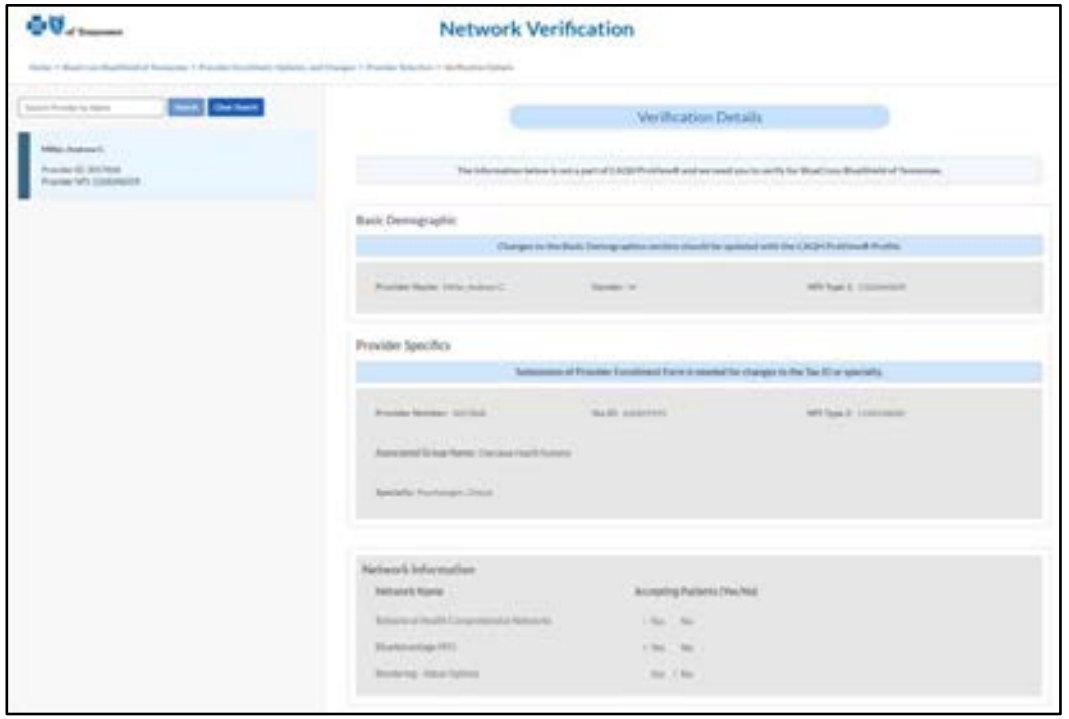
We're writing to remind you that you're required to verify and update your provider directory information at least every 90 days, as required under the Consolidated Appropriations Act, 2021. This requirement is included in the Provider Network section of our Commercial Provider Administration Manual.

As of today, we haven't received verification of your information in over 90 days, so please complete your verification for the providers listed on the following page(s). If an update and/or an attestation isn't received timely, we may suppress your information for the providers listed on the following page(s) from our provider directory (https://bcbst.sapphirecareselect.com/) until your information is validated.

Practitioners:
Review and attest to your information in CAQH ProView® **and** complete the Network Verification Form in Availity®. This allows you to update your information and attest that it is accurate for each practitioner and location. When you have a change, you'll also need to update your information at CAQH ProView and Availity.

Network Verification

1. Information not collected or collected differently than from what BlueCross requires.
2. Accepting Patient Status-critical to patients seeking care.
3. Billing Address
4. New services within your group.
5. Quick and easy way to see what BlueCross has and update what's missing.
6. An easy way to let us know when a provider has left your group.



Only Available through the BlueCross Payer Spaces in Availity

Enrollment Process

Getting Started

Our goal is to complete the enrollment process within 45 days.

Requirements and steps to begin the enrollment process:

- You must have an NPI registered through NPPES to begin.
- Register with the Council for Affordable Healthcare, Inc. (CAQH) and get an ID number.
- Give us access to your data and attest that it's correct no more than 90 days prior to giving us access.

Getting Started (cont.)

Our goal is to complete the enrollment process within 45 days.

Requirements and steps to begin the enrollment process:

- You must have an account with Availity®. To register, access Availity and go to the BlueCross BlueShield of Tennessee Payer Spaces.
- Complete the BlueCross online electronic funds transfer (EFT) and electronic remittance advice (ERA) forms.

To alter an existing contract, please contact your Provider Network Manager before submitting an application.

Intake Audit

Our teams confirm that we've received all your information and will contact you for additional documentation if needed.

- We may send a letter asking for more information to complete the review of your application.*
- You may receive a discontinuance letter if we aren't able to process your request.

* This communication requires a response. Failure to respond will cause your application to be delayed or discontinued.

Credentialing

We verify all information received from providers applying to be in our BlueCross networks.

- We may send a letter asking for additional credentialing criteria to complete your application.*
- We'll send a credentialing acceptance letter when we complete our review.
  - Please note: the date listed is the credentialing approval date, not your network participation date. You'll receive that during Provider Enrollment.
- If we're unable to credential a provider, we'll send a credentialing denial letter.

* This communication requires a response. Failure to respond will cause your application to be delayed or discontinued.

Contracting

At this step, we approve or deny requests for participation in various BlueCross networks and send out the appropriate contracts.

- We'll send a denial notice if the network applied for isn't available to the provider.

Note: Approved contracts, amendments and other related communications will be sent through DocuSign or emailed from us.

Enrollment Audit

Our teams review documentation to make sure all enrollment requirements are met, that providers are credentialed or pre-approved, and that contracts are completed.

Provider Enrollment

We add the approved networks to provider records and configured information in our systems to make sure claims will be paid correctly and that all information displays accurately in our directory.

- We'll send applicable acceptance letters with effective dates for all contracted networks.

eCommerce

Our teams will set up EFT, remittance advice and claims submission.

- We'll send a letter confirming the provider has been approved to transmit claims through our vendor.
- We'll also send a letter letting you know that electronic funds transfer (EFT) is set up, and payments will be made electronically.

Questions?

- Providers with questions should contact **Contracts_Reqs_GM@bcbst.com**.
- To check an application status any time, visit the BlueCross Payer Spaces in Availity:
  - Provider Enrollment > Updates and Changes > Provider Type/Request Type/Track a Request.

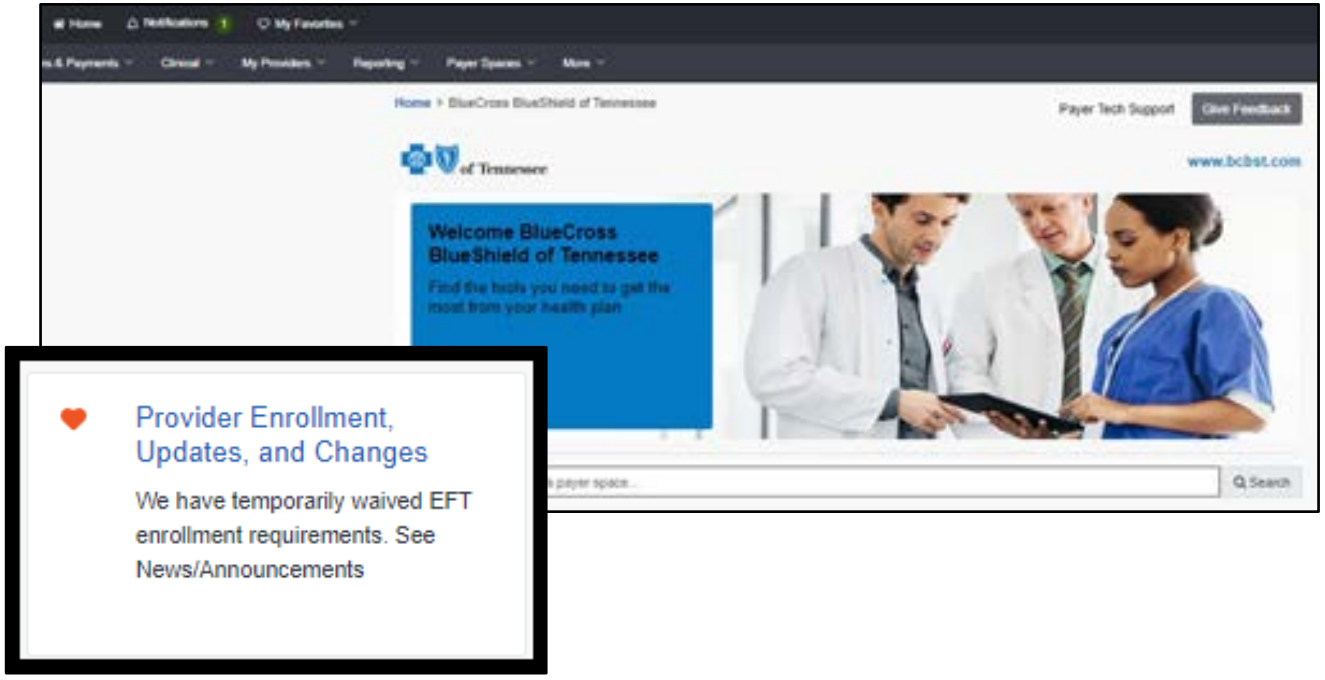
Provider Portal

- Navigating the Persona Page and accessibility
- Enrollment Applications Suite and Contact Preference
- Application Status Tracker
- Reference page

Digital Suite

Accessing the Digital Suite

Mark us as a favorite from our Payer Spaces for easy accessibility.



Source: Research Resource Credited Here

Persona Page

Messaging – Yellow Section

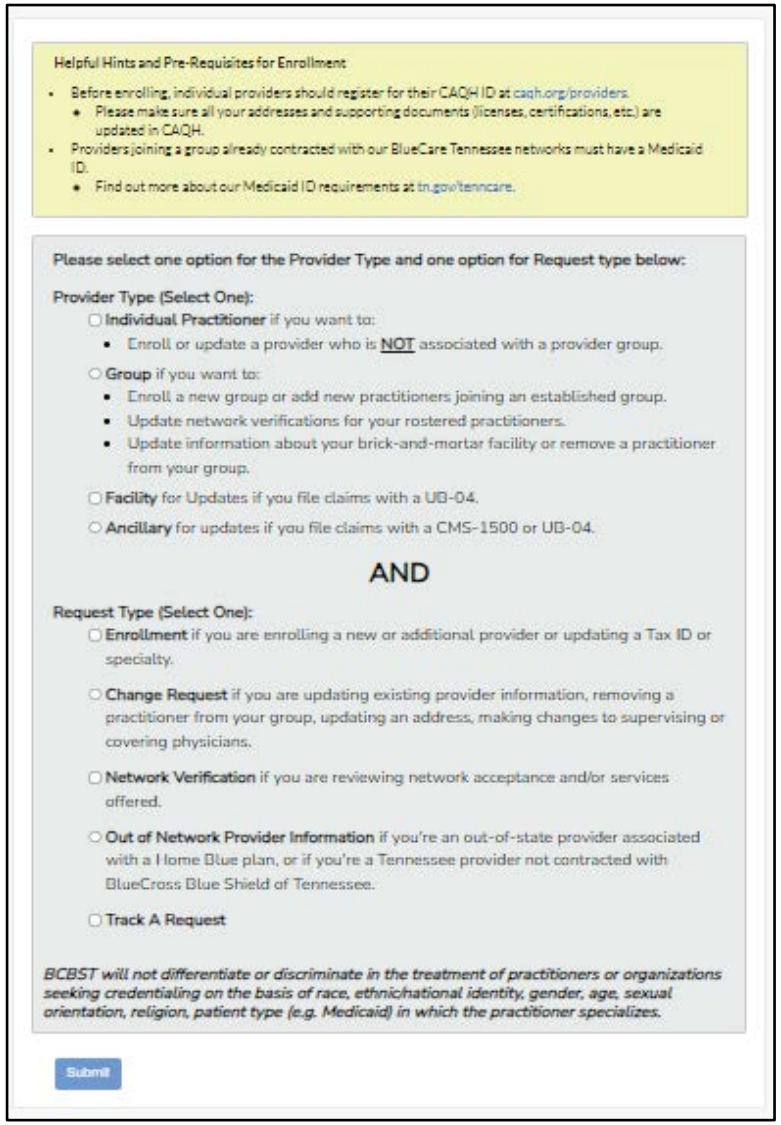
In this section you will find important messaging related to process changes, enhancements and general details to help guide the experience.

How to Navigate – Grey Section

The More Info section in grey will help guide your selection options when navigating the persona page. This self-directed section can help you direct your request to the appropriate application.

Persona Navigations

By utilizing a persona, each user can navigate through different scenarios from a single page, accessing our library of applications simply by presenting a few generalized questions.



Source: Research Resource Credited Here

Persona Page – Options

Individual Practitioner

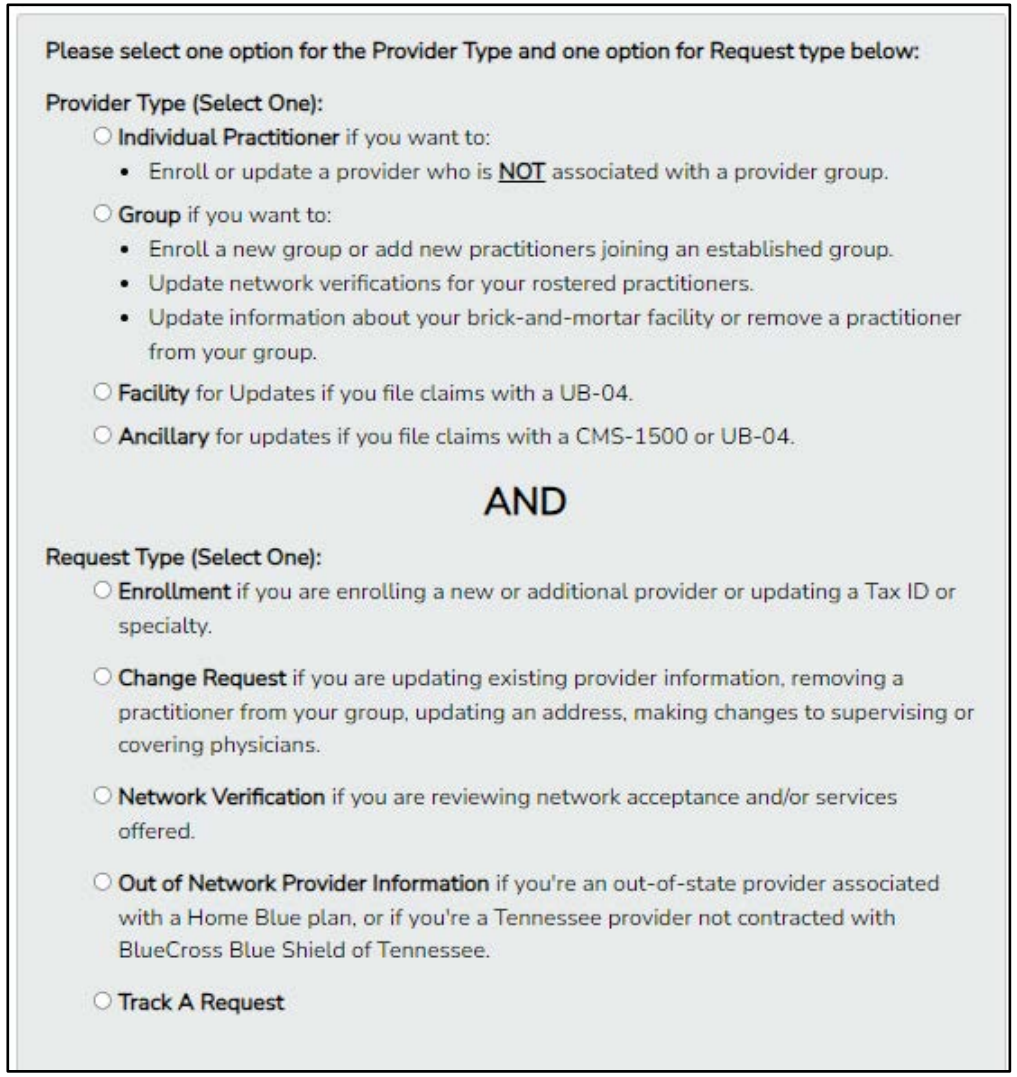
Enroll a new provider who will **not be associated with a provider group entity.** Update an existing provider with Type 1 NPI Specialty or Tax ID.

Group

Enroll a new group or add providers to an existing group. Up to 15 providers may be added on a single submission. Type 2 NPI is required for this selection. Individuals with a Type 2 NPI are accepted as well.

Ancillary and Facility

These options are available and can update network verifications, enroll for out of network, and request changes. Enrollment options are not available at this time.



Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ○ **Individual Practitioner** if you want to:
  - Enroll or update a provider who is NOT associated with a provider group.
- ○ **Group** if you want to:
  - Enroll a new group or add new practitioners joining an established group.
  - Update network verifications for your rostered practitioners.
  - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ○ **Facility** for Updates if you file claims with a UB-04.
- ○ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

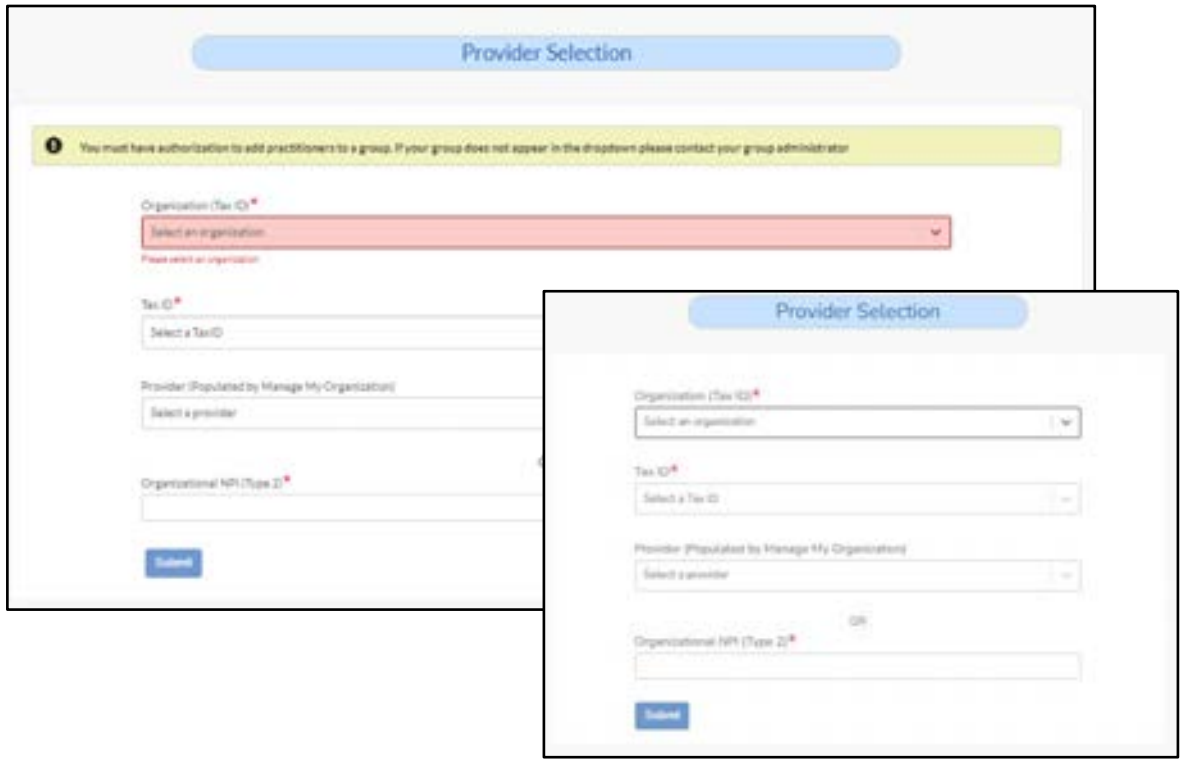
- ○ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ○ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ○ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ○ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ○ **Track A Request**

Source: Research Resource Credited Here

Accessing Providers

Accessing Your Organization

Improved navigation using the Tax ID(s) associated to the Organization in Availity.



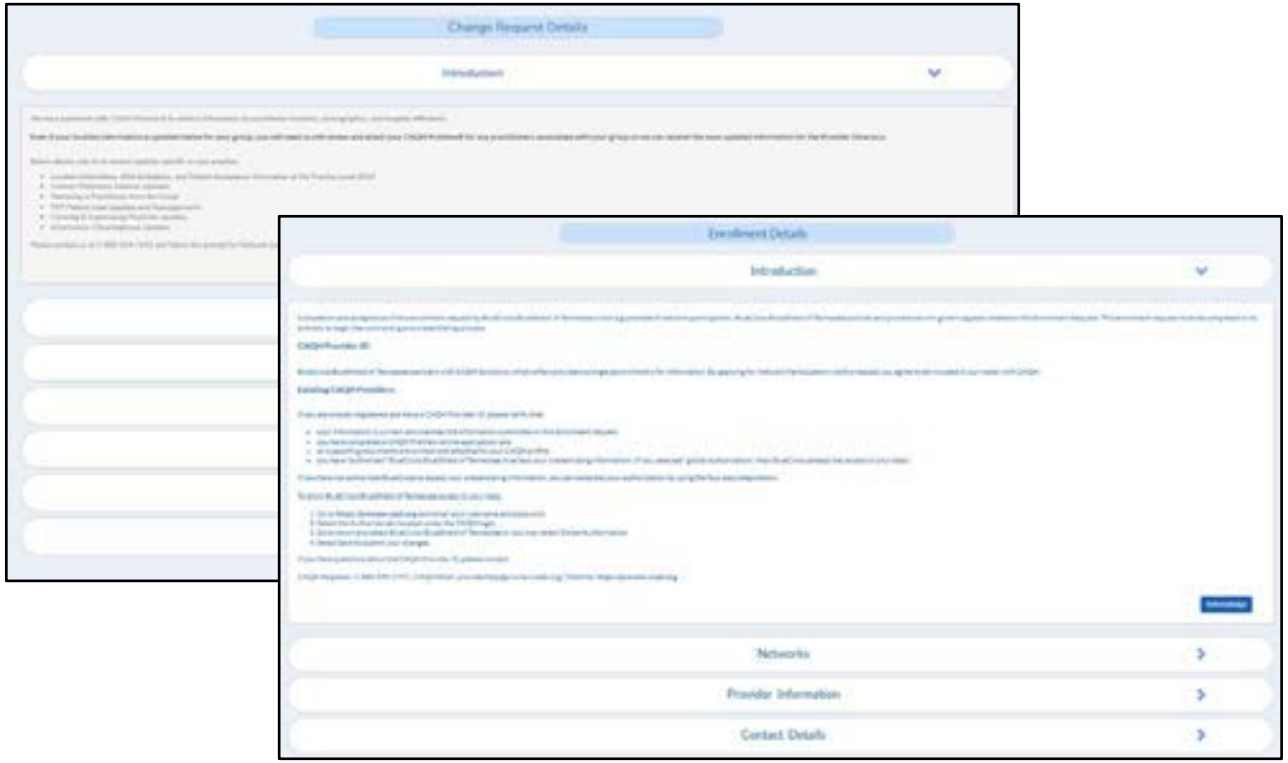
Source: Research Resource Credited Here

Digital Application – Options

Individual Practitioner - Existing

The following options are available:

- Update Provider Network Information
  - Provider Change Request
- Update Out-of-Network Provider
  - Out-of-Network Enrollment
- Add or Update Tax ID or Specialty
  - Individual Enrollment Request
- Update Network Verification
  - Network Verify Request
- Join a group
  - Group Enrollment Request

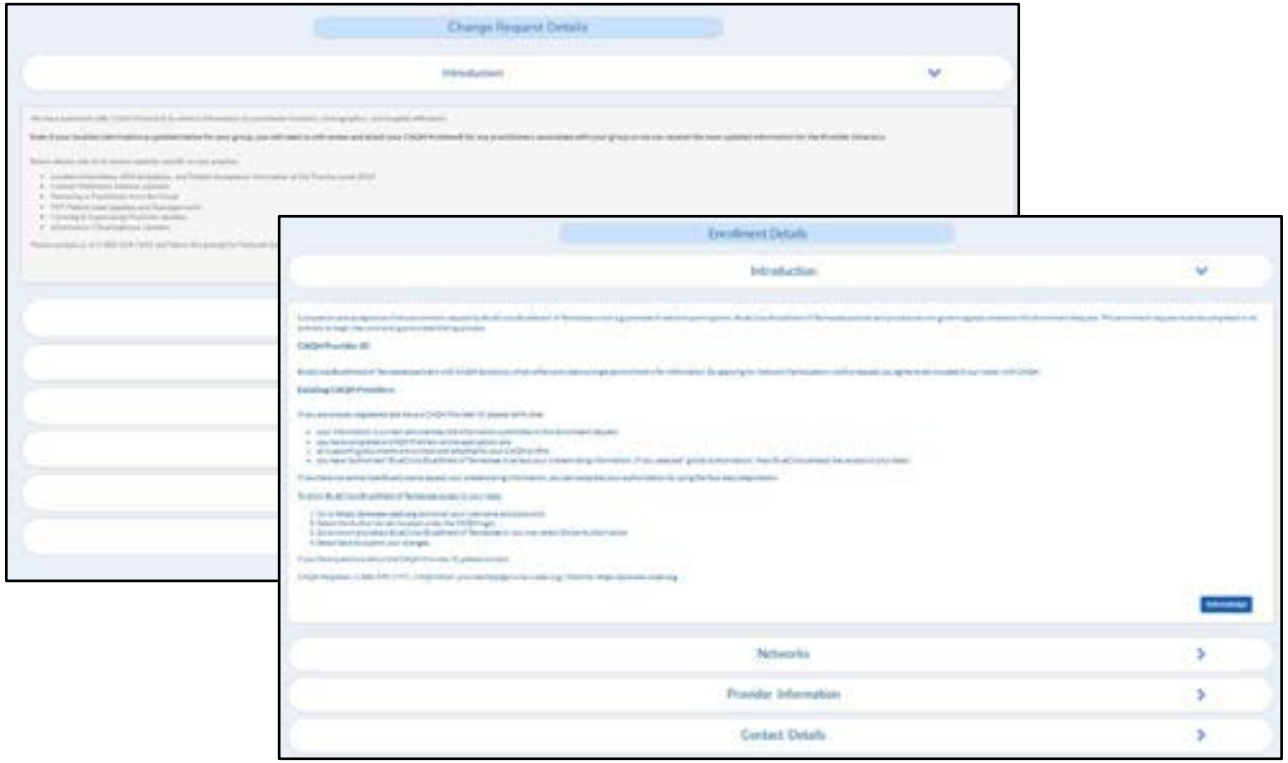


Digital Application – Options

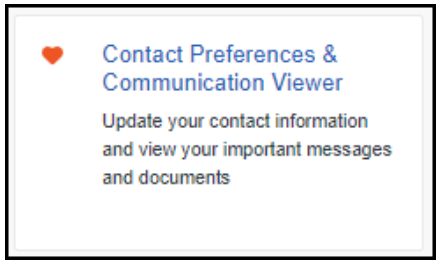
Group - Existing

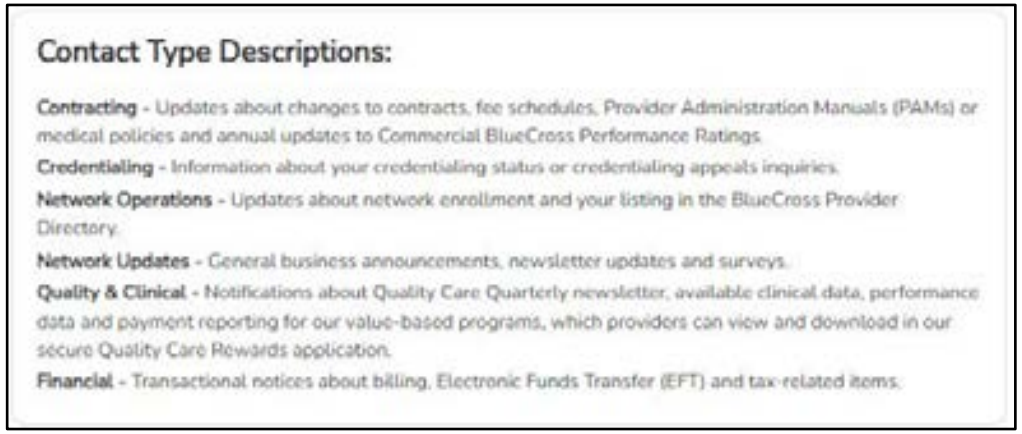
The following options are available:

- Add or Remove Networks
  - Contact Network Manager or Email: Contracts_Reqs_GM@bcbst.com
- Enroll Additional Providers
  - Group Enrollment
- Update Out-of-Network Enrollment
  - Out-of-Network Enrollment
- Add or Update Tax ID or Specialty
  - Contact Network Manager or Email: Contracts_Reqs_GM@bcbst.com
- Update Network Verification
  - Network Verify Request



Contact Preferences

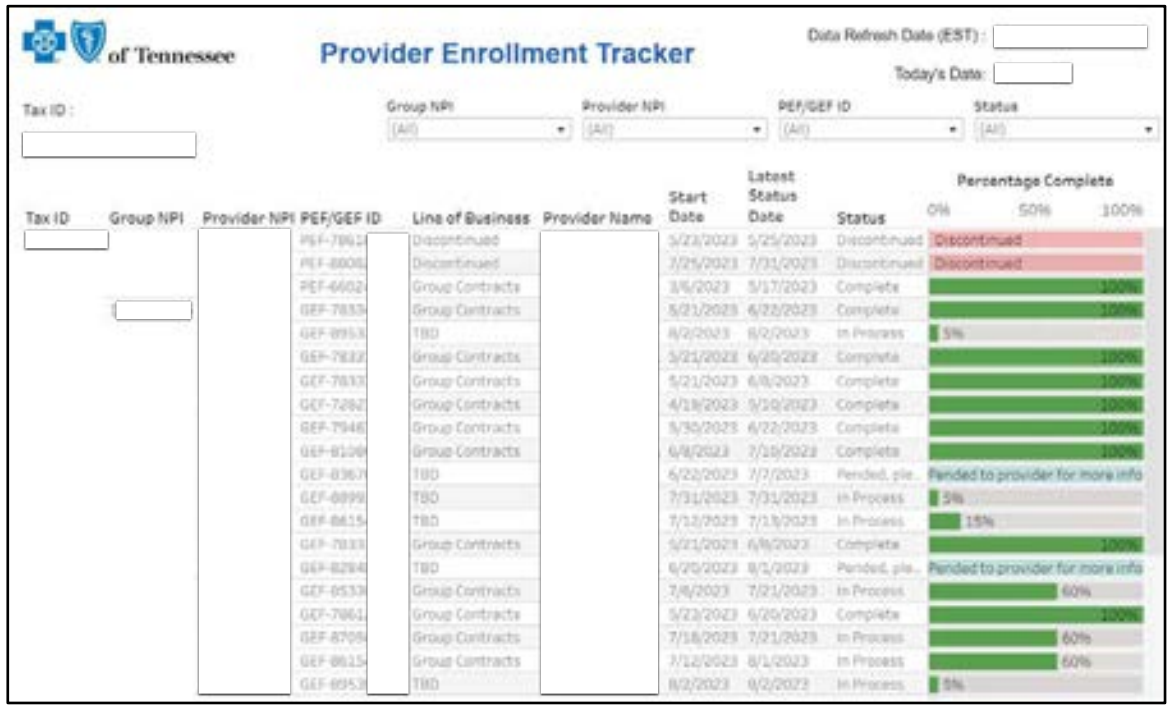




Source: Research Resource Credited Here

Enrollment Tracker

Self-Service Tracker – Track a Request



Source: Research Resource Credited Here

Why the New Enhancement

To better serve our customers, we are developing a self-service tracker for Group and Individual enrollment applications. This new capability lets you see the status and progress of any active enrollments submitted.

Real-time updates will be available directly from our Persona Page.

REFERENCES

Provider Network Operations

Provider Network Services

Questions or concerns regarding enrollment status, contracts, or credentialing

Phone: **1-800-924-7141** Credentialing and Contracting Option

Email: **Contracts_Regs_GM@bcbst.com**

Provider Operations Process Support

Submission of provider enrollment supporting documentation

Email: **ProviderSupport@bcbst.com**

REFERENCES

Provider Network Operations (cont.)

Provider Maintenance

Questions or concerns regarding provider changes, data verifications, or correspondence

Email: **PNS_GM@bcbst.com**

Provider Directory

If you see something incorrect in our online Directory, you can report it with one click by choosing **See something incorrect? Let us know.**

REFERENCES

Provider Network Operations (cont.)

Steps to enroll or make changes in our network

Here's where you'll start to enroll as a new provider or add a provider to your group contract.

1. Enter/update your information in **CAHQ ProView.**
2. Complete the BlueCross online EFT and ERA forms.
3. Register with **Availity** & complete your enrollment application or change form.

REFERENCES

Provider Network Operations (cont.)

Important Links

- Provider News and BlueAlerts
- Provider Quick Reference Guide
- Availity
- CAQH Proview
- Find My BlueCross Contact

GENERAL SESSION

Medicare Advantage

MEDICARE ADVANTAGE

Medical Management

Prior Authorization Updates

- PA requirements for 86 codes removed Jan. 1, 2024, for select durable medical equipment and surgical procedures.
  - Refer to our **Master Prior Authorization List Code Removals** document for full list of codes that were removed.
- Continuing to review code list for additional removals
  - Refer to our **Master Prior Authorization** List document for a full list of codes that currently require a PA.

Medical Management

Acute Inpatient Admission Authorization Requirement Changes Coming

- Initial requests for acute inpatient admission will continue to require PA.
- Concurrent review for approval of additional days beyond what the current initial approval provides (typically beyond six days) will be removed.
  - The additional days not covered under the established DRG payment will move to a post-claim payment review for medical necessity.
- Tentative implementation date is Q4 2024.

MEDICARE ADVANTAGE

Quality Improvement & Stars

Health Equity

› Health Equity Index (HEI)

- Designed by CMS to gauge efforts toward reducing health disparities for Medicare Advantage members facing specific social risk factors.
  - Low Income
  - Dual Eligible
  - Disabled
- Data from performance year 2024 and 2025 for a subset of Star Ratings measures will be used to provide a score for health plans that will replace the Reward Factor in 2027.

Quality Improvement & Stars

Social Determinants of Health (SDOH)

- Identification, resource allocation and health management of your patients experiencing:
  - Barriers to health care access and quality
  - Economic instability
  - Nutrition/food insecurity
  - Housing needs
  - Transportation needs

QUALITY+
PARTNERSHIPS

Quality Improvement & Stars

Quality Gaps

- Focused initiatives addressing barriers to preventive services and health care needs
- Quality gaps reports that provide awareness of social risk factor needs

QUALITY+
PARTNERSHIPS

MEDICARE ADVANTAGE

Pharmacy

Pharmacy Updates

- Smart PA on GLP-1 medications
- CMS excluded meds
- 100-day supplies for Tier 1 and Tier 2 medications
- Opportunities
- Trends
- Star Measure Changes for 2025
- Partnerships / Initiatives

Medication Adherence

Medication Adherence Tips

- New therapies
- Established maintenance medications
- Dose changes
- 100-day supply benefit
- Prescription directions
- Drug cost discussion
- Set expectations
- Medication adherence packaging
- Medication adherence opportunity report

Medication Adherence Measures

- Medication Adherence for Cholesterol (Statins)
- Medication Adherence for Hypertension (RASA)
- Medication Adherence for Diabetes (OAD)

MEDICARE ADVANTAGE

We’re Right Here

For more information, please contact:

Julie Mason, MSSW, LAPSW, CCM

Manager, MA Provider Engagement and Outreach

Julie_Mason@bcbst.com

Lauren Tunney, PharmD

Manager, Quality Pharmacy

Lauren_Tunney@bcbst.com

Thank You

Breakout Session

EPISODES OF CARE (EOC)

of Tennessee

ALL Blue 2024

Agenda

- Introduction to Risk Adjustment
- How Risk Adjustment Affects Your Episodes
- How Episode Risk Factors are Derived for THCII EOC
- How Episodes of Care Risk Factors Are Modeled For THCII EOC
- Examples of Risk Factors Impacting Episode Cost
- Risk Adjustment Tips
- Questions

Introduction to Risk Adjustment

- Quarterbacks are compared based on their performance with quality metrics and the average spend for their episodes.
- Risk adjustment is one of the tools that BlueCross uses to get a fair comparison in episode spend across all Quarterbacks.
  - Each payer runs its own risk adjustment model based on cost and there are variations in the population covered by each payer. Risk factors may vary across payers.

Introduction to Risk Adjustment

Risk scores are derived from Internally developed regression models at the episode of care level.

- A regression model is a tool that describes the relationship between one or more independent variables (ICD-10 codes) and a response, dependent, or target variable (risk as it relates to episode cost).

Introduction to Risk Adjustment

Risk models estimate the expected cost of a particular episode of care given:

- Member demographics (age and gender)
- Clinical information for the 12 months prior to the beginning date of the episode of care

How Risk Adjustment Affects Your Episode of Care Spend

How Risk Adjustment Affects Your Episode of Care Spend

- Risk adjustment is used to fairly compare episode spend across all QBs.
- Based on the number of identified factors in a valid episode, a member risk score is derived.
- A risk score less than 1.0 is considered less risky and will adjust the cost of your episode up; whereas a score greater than 1.0 is considered riskier than average and will adjust your episode cost down.

How Episode of Care Risk Factors Are Derived For THCII EOC

- The study period for all episodes of care models starts 12 months prior to the beginning date of a valid EOC and stops on the end date of the EOC.
- Clinical Classifications Software (CCS) groups developed at the Agency for Healthcare Research and Quality (AHRQ) is a tool used for clustering patient diagnoses and procedures (IDC-10-CM codes) into a manageable number of clinically meaningful categories.

How Episode of Care Risk Factors Are Derived For THCII EOC (cont.)

- A binary indicator of CCS presence or absence is assigned to each member by examining claims experience during the study period.
- Only factors with at least five occurrences in the modeling dataset were retained for further analysis as potential candidate variables in the models.
- Risk Factor weights are calculated by dividing the regression coefficient (estimate) by the mean episode of care allowed amount.

How Episode of Care Risk Factors Are Modeled For THCII EOC

A Risk Factor Score is calculated for each member’s episode of care by summing the respective risk weights present for that member’s episode of care.

The actual episode of care cost is then adjusted by dividing the original actual episode of care amount by the risk factor.

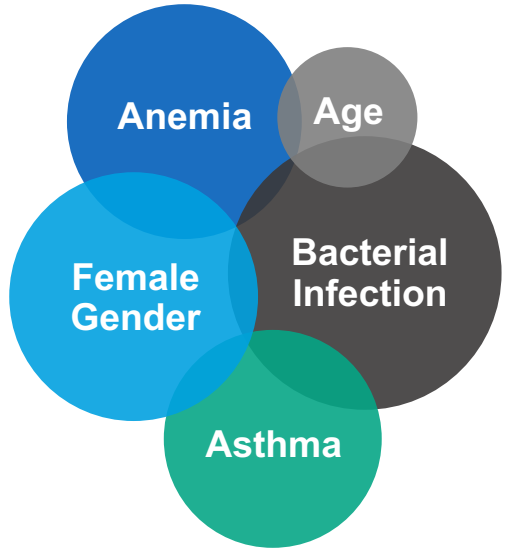
- Example: A member has the following demographic and clinical attributes (with respective weights) for a TJR episode of care.
  - 36 years of age (0.072)
  - Female (0.743)
  - Chronic rheumatic disease of heart valves (0.109)
  - Bypass of three coronary arteries (0.221)
  - Congenital hip deformity (0.126)

This EOC has an expected total cost 1.271 times that of the average TJR episode of care.

A	B	C	D	E
Member ID	**Episode of Care**	**Actual Episode of Care Cost**	**Risk Factor**	**Adjusted Count Amount**
12345	TJR	$17,498.23	1.271	$13,767.29
54321	TJR	$15,321.12	0.98	$15,633.80
49123	TJR	$18,167.97	1.02	$17,811.73

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Perinatal Risk Factors



This member's unadjusted episode cost = $5,775

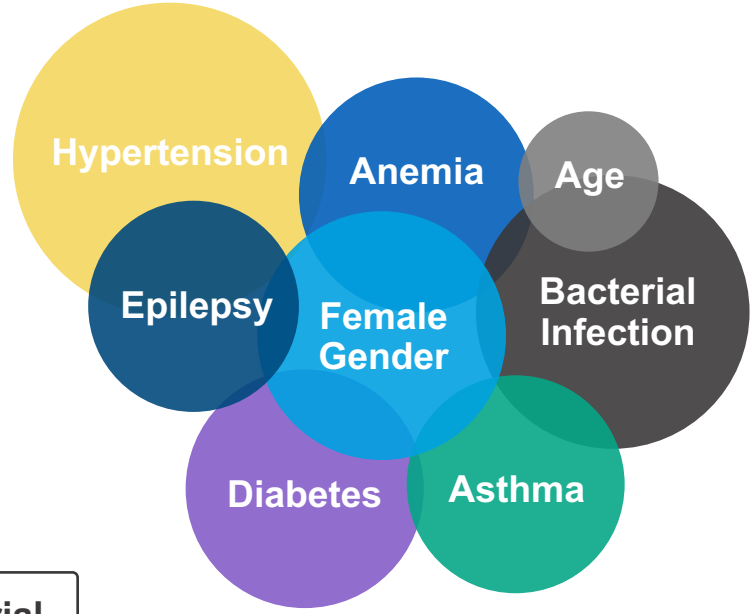
The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Age 21 0.042	+	Female Gender 0.706	+	Anemia 0.038	+	Asthma 0.055	+	Bacterial Infection 0.042	=	Episode Risk Score 0.883

The member's risk adjusted episode cost is $5,775/0.883 = $6,540

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Perinatal Risk Factors



This member's unadjusted episode cost = $5,775

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

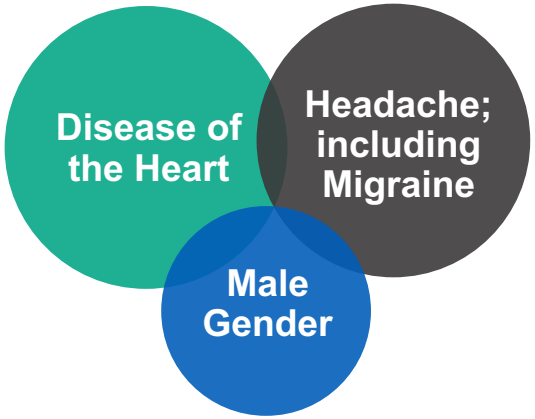
Age 21 0.042	+	Female Gender 0.706	+	Anemia 0.038	+	Asthma 0.055	+	Bacterial Infection 0.042	+		
		Hypertension 0.079	+	Epilepsy 0.099	+	Diabetes 0.082	=	Episode Risk Score 1.143			

The member's risk adjusted episode cost is $5,775/1.143 = $5,052*

*Cost difference of $1,488

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Back and Neck Pain Risk Factors



This member's unadjusted episode cost = $1,113

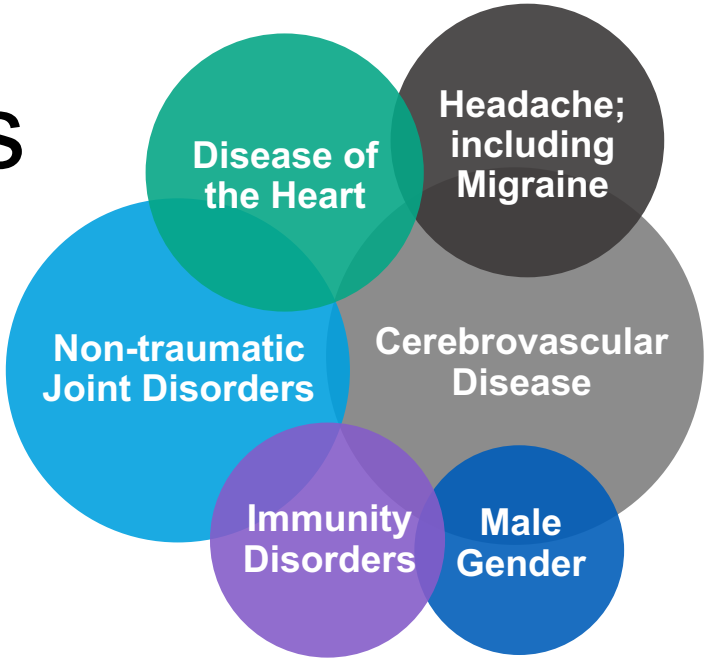
The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Male Gender 0.476	+	Disease of the Heart 0.100	+	Headache; including migraine 0.145	=	Episode Risk Score 0.721

The member's risk adjusted episode cost is $1,113/0.721 = $1,544

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Back and Neck Pain Risk Factors



This member's unadjusted episode cost = $1,113

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Male Gender 0.476 + **Disease of the Heart** 0.100 + **Headache; including migraine** 0.145 +

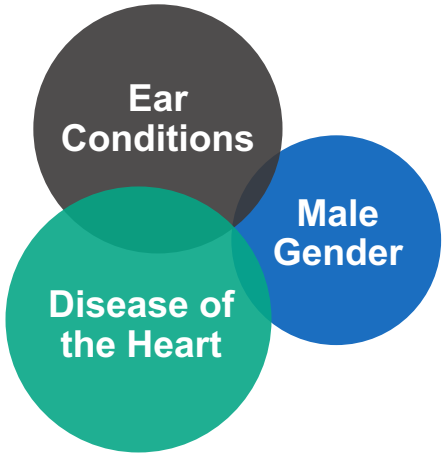
Non-traumatic Joint Disorders 0.140 + **Immunity Disorders** 0.134 + **Cerebrovascular Disease** 0.067 = **Episode Risk Score** 1.062

The member's risk adjusted episode cost is $1,113/1.062 = $1,048*

*Cost difference of $496

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Respiratory Infection Risk Factors



This member's unadjusted episode cost = $84

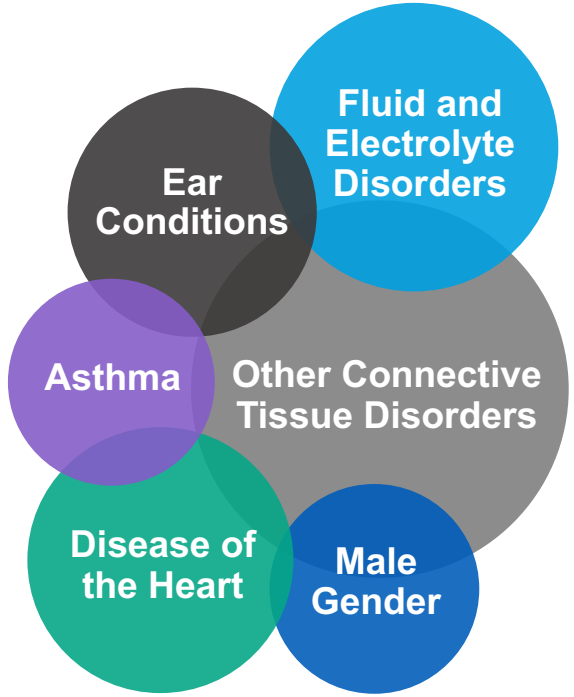
The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Male Gender 0.799	+	Disease of the Heart 0.112	+	Ear Conditions 0.025	=	Episode Risk Score 0.936

The member's risk adjusted episode cost is $84/0.936 = $90

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Respiratory Infection Risk Factors



This member's unadjusted episode cost = $84

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

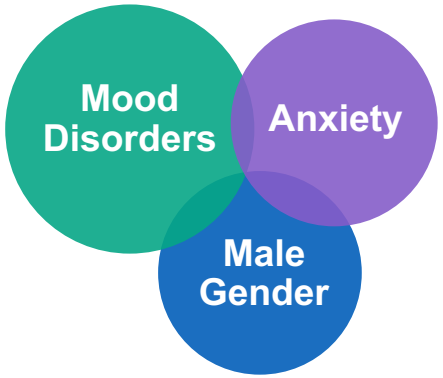
Male Gender 0.799 + **Disease of the Heart** 0.112 + **Ear Conditions** 0.025 + **Asthma** 0.130 + **Fluid and Electrolyte Disorders** 0.154 + **Other Connective Tissue Disorders** 0.031 = **Episode Risk Score** 1.251

The member's risk adjusted episode cost is $84/1.251 = $67*

*Cost difference of $23

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

ADHD Risk Factors



This member's unadjusted episode cost = $249

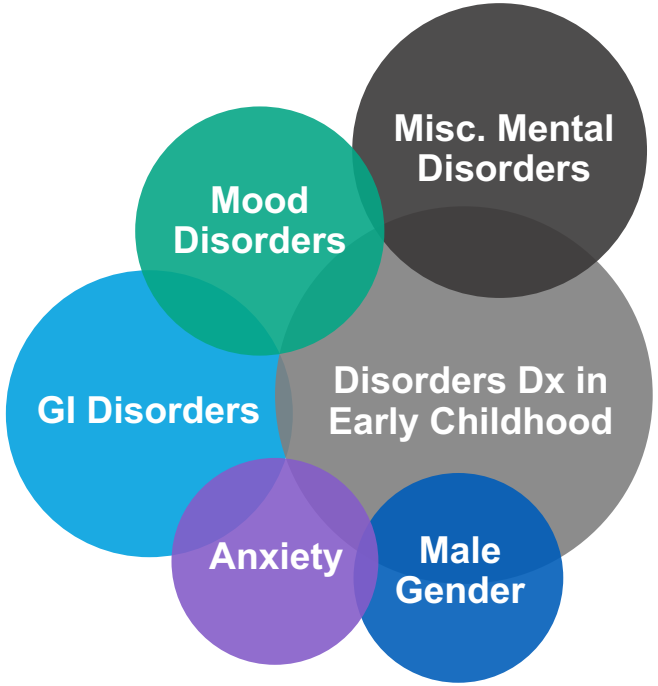
The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Male Gender 0.950	+	Anxiety 0.094	+	Mood Disorders 0.075	=	Episode Risk Score 1.119

The member's risk adjusted episode cost is $249/1.119 = $223

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

ADHD Risk Factors



This member's unadjusted episode cost = $249

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Male Gender 0.950 + **Anxiety** 0.094 + **Mood Disorders** 0.075 +

Disorders Dx in Early Childhood 0.088 + **GI Disorders** 0.041 + **Misc. Mental Disorders** 0.133 = **Episode Risk Score** 1.381

The member's risk adjusted episode cost is $249/1.381 = $180*

*Cost difference of $43

Risk Adjustment Tips

1. Be as accurate as possible with every patient encounter. You are telling us a story using diagnostic and procedure codes. If you don't document it, we only get half the story. This could be the difference between a risk share OR a gain share payment.

2. Utilize THCII documents for risk adjustment. Knowing what risk factors impact your episodes will help ensure risk accuracy. You can find more information on our website here: **508C** 2024 Episodes of Care Risk Adjustment.

3. Review your quarterly reports. Taking the time to review your reports each quarter will ensure they are accurate and reflect the intensity of each patient encounter.

4. Reach out with questions anytime. We want you to succeed in the Episodes of Care program. For more information, please email Darlene_Smith@bcbst.com.

5. Notice inconsistencies? No worries. If you notice a patient's risk score is inaccurate, you have until June 30th of that year to file a corrected claims form to adjust the risk score to accurately reflect that patient's risk intensity before final reports are populated.

Questions?

Breakout Session

BEHAVIORAL HEALTH

Blue Cross Blue Shield of Tennessee

ALL Blue 2024

General Reminders

CHOW – Change of Ownership or Control

BlueCross defines a change of ownership or control as one or more of the following:

- The direct or indirect sale or other disposition of all or a majority of the assets of a provider
- Any transaction resulting in a change in the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests, or shares of the provider's voting stock (or membership interests or other equity)

CHOW – Change of Ownership or Control (cont.)

BlueCross defines a change of ownership or control as one or more of the following (cont.):

- The lease of all or part of a provider's facility or practice location
- The removal, addition or substitution of a partner in a partnership
- Transfer of title and property of a sole proprietorship to another party
- Any other transaction that results in a change to an entity-type provider's Tax Identification Number (TIN)/Employer Identification Number (EIN) or National Provider Identifier (NPI)

CHOW – Change of Ownership or Control (cont.)

What you should do if you're considering a CHOW

- Providers planning a CHOW should complete a Facility, Ancillary Provider and Professional Group Change of Ownership Notification form and submit it to BlueCross **at least 60 calendar days** from the anticipated effective date of the change of ownership.
- If more than one group/facility/provider is being sold or purchased, a Change of Ownership Notification form and all required documentation (listed below) should be submitted for each Tax ID/EIN and NPI combination.

CHOW – Change of Ownership or Control (cont.)

How does BlueCross determine the effective date?

- If we receive the CHOW notification form at least 60 calendar days prior to the effective date of the change of ownership/control and a Consent to Assignment has been executed, the buyer's network effective dates will be the CHOW effective date. If we receive the CHOW notification form after the change of ownership has occurred, the buyer will be asked to complete the credentialing application to participate in our BlueCross networks. The buyer will receive a new contract and the network effective dates will be determined by BlueCross.

CHOW – Change of Ownership or Control (cont.)

How should you submit claims before & after the CHOW?

- If a Consent to Assignment is executed:
  - Claims for dates of service prior to the CHOW effective date should be submitted using the existing provider's (seller's) NPI and Tax ID. Once the CHOW becomes effective, the buyer is the only party that legally owns the provider agreement. Therefore, any claims for dates of service on or after the CHOW effective date must be submitted using the new owner's NPI and Tax ID.
- If a Consent to Assignment is not executed:
  - Claims for dates of service prior to the CHOW effective date should be submitted using the existing provider's (seller's) NPI and Tax ID. Claims for dates of service on or after the CHOW effective date should be submitted with the new owner's NPI and Tax ID. **There could be a gap in participation.**

For answers to your Frequently Asked Questions regarding CHOWs, please visit:
bcbst.com/providers/forms/Change_Ownership_FAQ.pdf

BlueCare Tennessee

BlueCare/ABA

As a reminder, changes were made to ABA codes effective Jan. 1, 2023.

We are no longer using the H codes for services.

Current codes are CPT® codes that align with our Commercial line of business are as follows:

BlueCare/ABA

CPT / HCPCS Code[1]	Modifier	Brief Description — see coding resources for full description	Certified / Licensed Master's Level and Above Applied Behavior Analyst ("ABA")[2]
97151	—	Behavior identification assessment, administered by a physician or other qualified health care professional, per 15 minutes	**$21.25**
97152	—	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with patient, per 15 minutes	**$12.75**
0362T	—	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient	**$21.25**
97153	—	Adaptive behavior treatments by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, per 15 minutes	**$12.75**

BlueCare/ABA

CPT / HCPCS Code[1]	Modifier	Brief Description — see coding resources for full description	Certified / Licensed Master's Level and Above Applied Behavior Analyst ("ABA")[2]
97153	HO	Adaptive behavior treatments by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, per 15 minutes	**$21.25**
0373T	—	Adaptive behavior treatment with protocol modification, each 15 minutes of technician's time face-to-face with patient	**$21.25**
97155	—	Adaptive behavior treatments with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with on patient, per 15 minutes	**$21.25**
97154	—	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, per 15 minutes	**$6.38**

BlueCare/ABA

CPT / HCPCS Code[1]	Modifier	Brief Description — see coding resources for full description	Certified / Licensed Master's Level and Above Applied Behavior Analyst ("ABA")[2]
97158	—	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, per 15 minutes	**$14.88**
97156	—	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), per 15 minutes	**$14.88**
97157	—	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, per 15 minutes	**$14.88**

BlueCare/TennCare*Select*

As a reminder, we updated BlueCare and TennCare*Select* fee schedules/codes effective

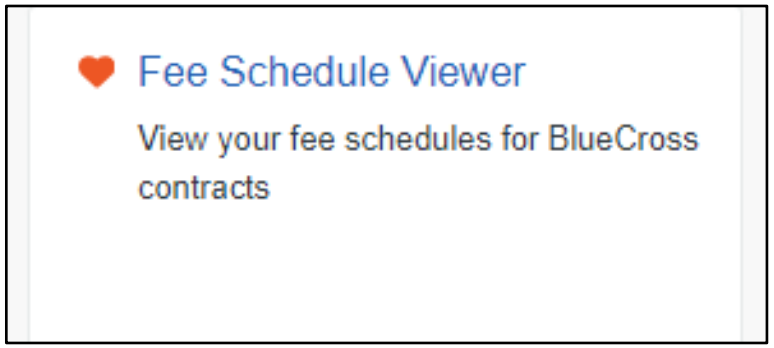
April 1, 2023.

Please ensure you refer to the Availity fee schedule viewer when assessing eligibility for reimbursement.

FEE SCHEDULE VIEWER

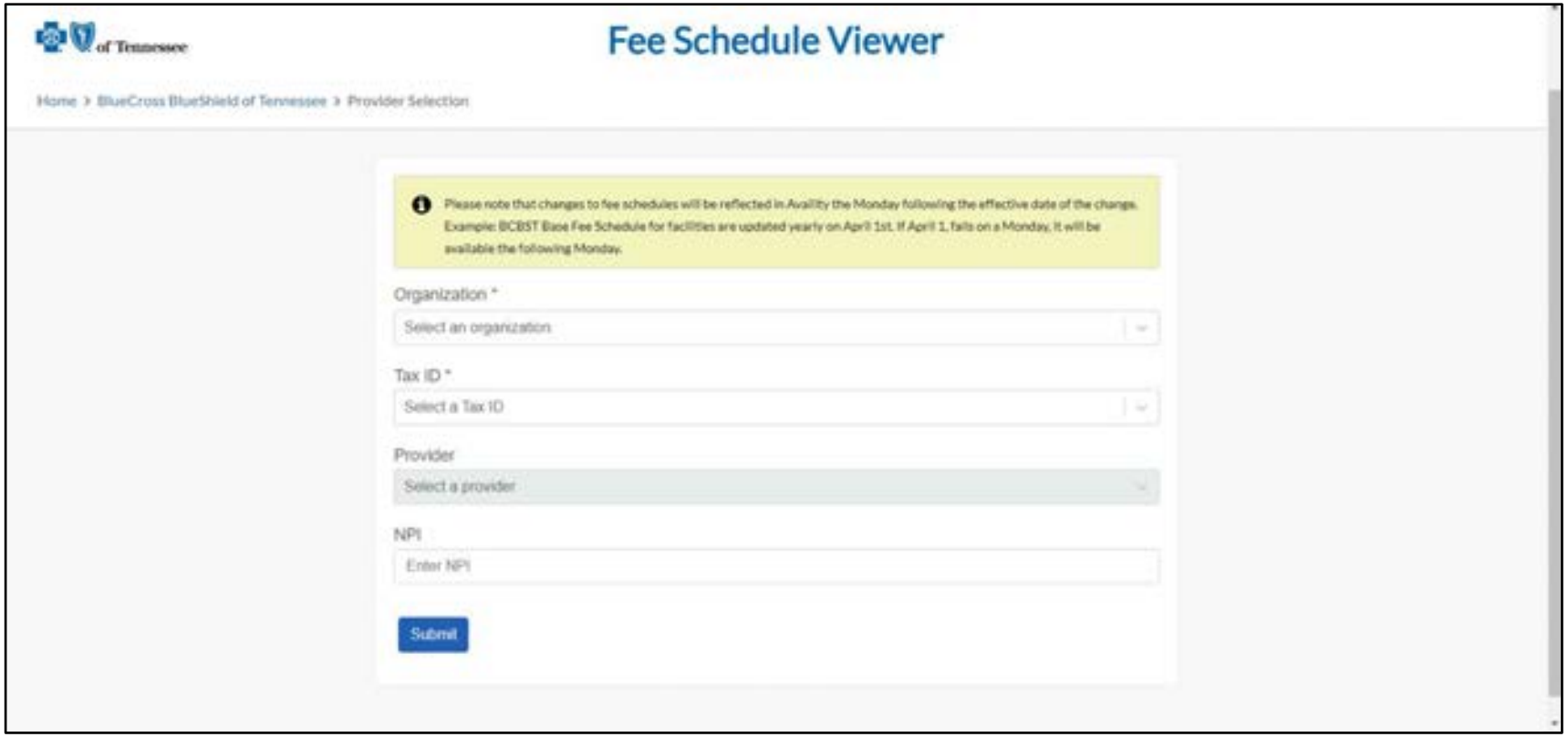
BlueCare/TennCare*Select*

- Fee Schedule Viewer User Role = Provider Enrollment & Contracting
- The Fee Schedule Viewer Application tile is housed on Availity® Payer Spaces
- Access BlueCare/TennCare Select and Commercial Fee Schedules



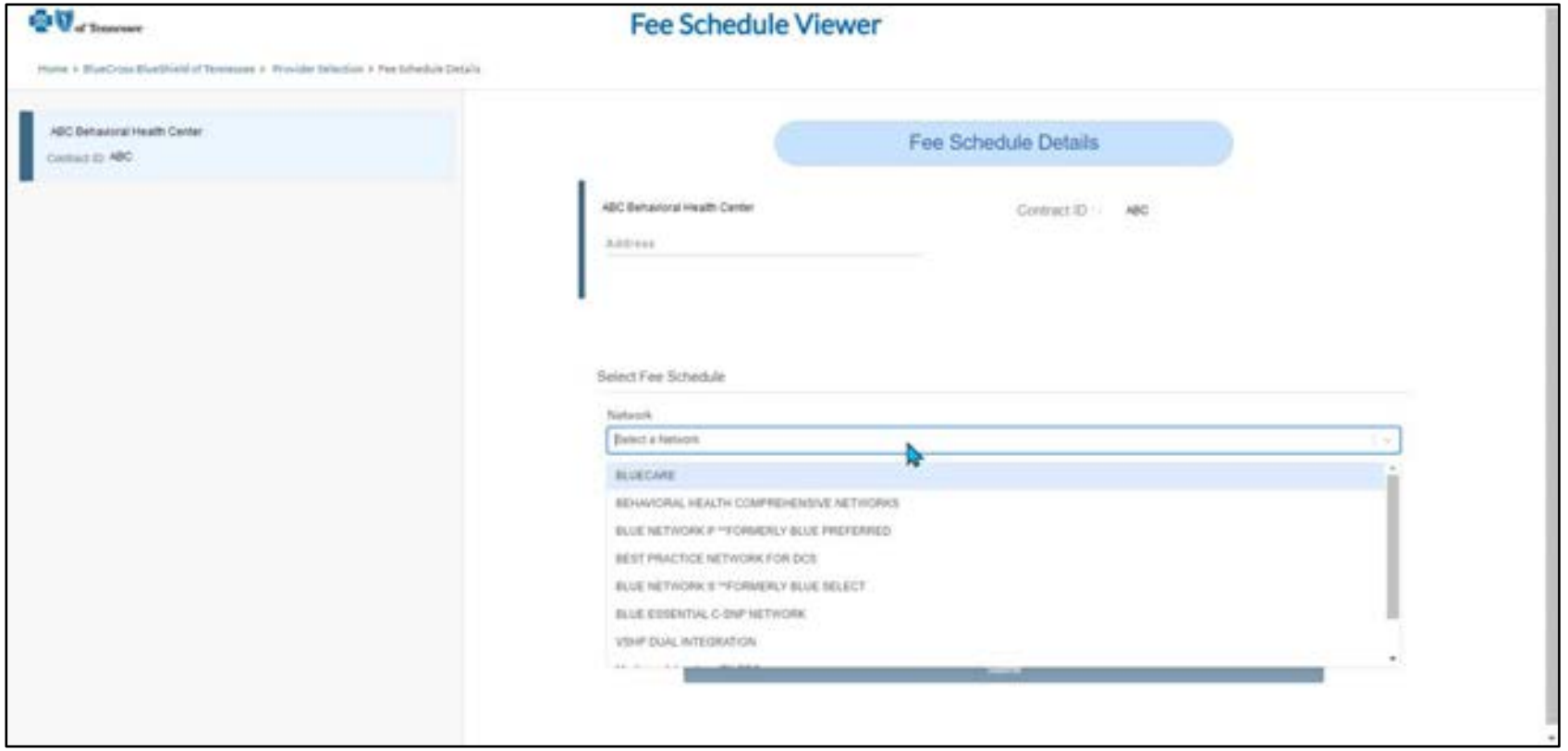
FEE SCHEDULE VIEWER

BlueCare/TennCare*Select*



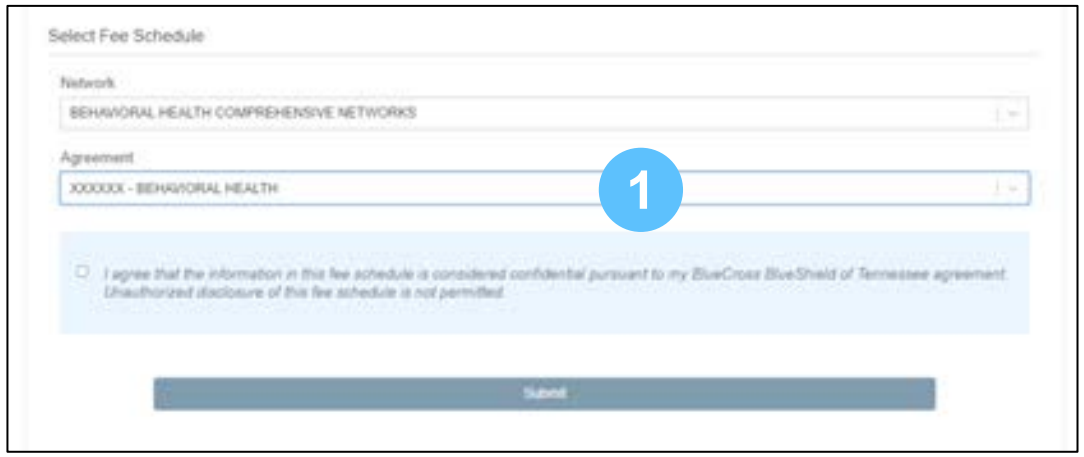
FEE SCHEDULE VIEWER

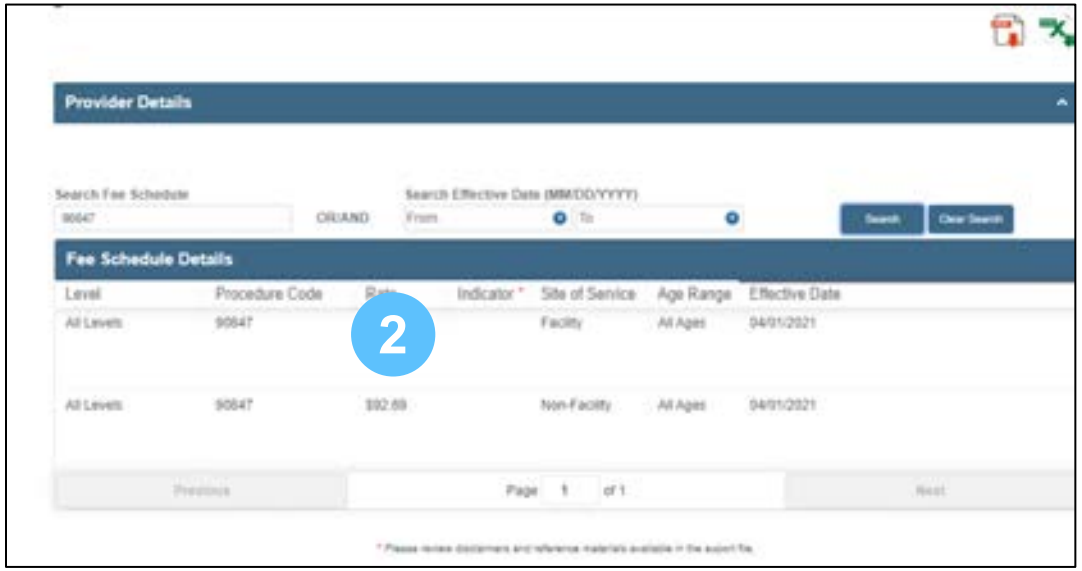
BlueCare/TennCare*Select*

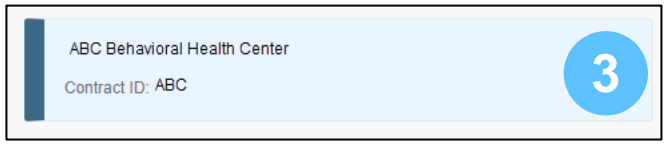


FEE SCHEDULE VIEWER

BlueCare/TennCare*Select*







Click Contract ID Tile to clear search to view another network fee schedule

BlueCare Modifiers

Medicaid Modifiers

To receive appropriate reimbursement, BlueCare Behavioral Health Providers should bill the correct modifier code in accordance with their licensure levels.

Please remember that all services billed should be rendered by the licensed, credentialed and contracted BlueCross provider listed on the claim. We do not allow incident billing unless you're contracted with us as a community Behavioral Health center or Behavioral Health facility.

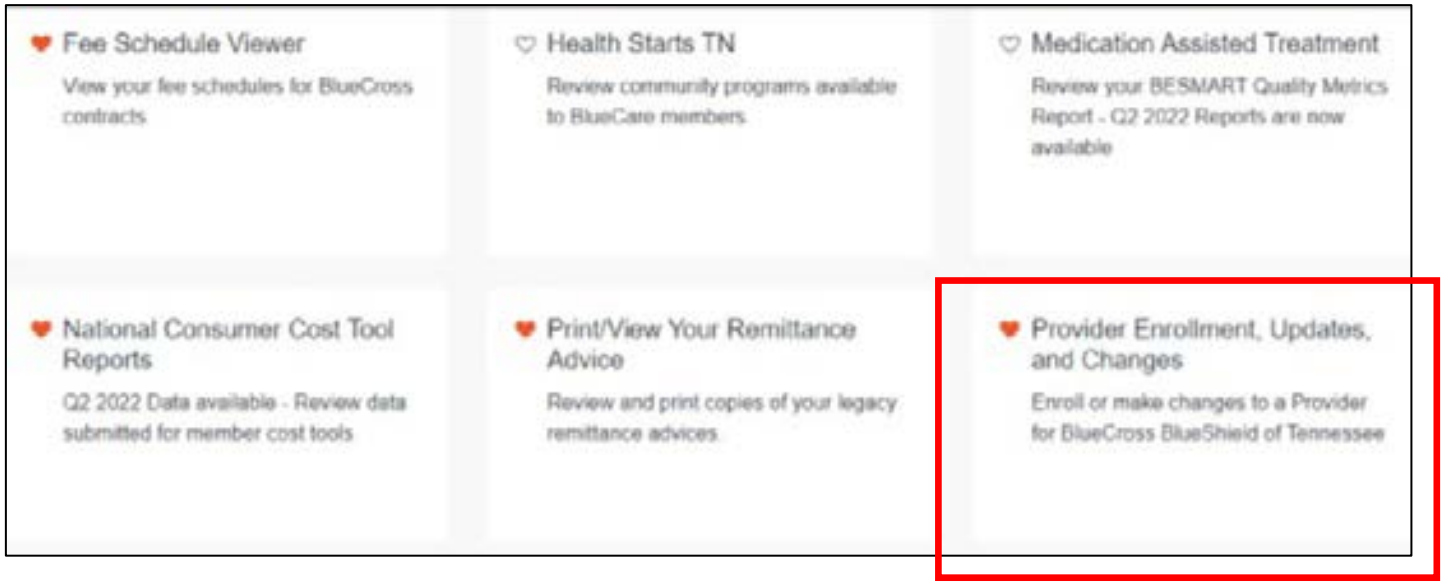
Licensure Level	Appropriate Modifier
MD	None
Doctoral	HP
NP	SA
Masters	HO

Notification of Upcoming Changes

Blue Alert – Monthly newsletter

We notify all providers of upcoming changes via Availity communication.
If you are not receiving communications from us, please confirm that your email address is correct in Availity.

Notification of Upcoming Changes



Click on the **Provider Enrollment, Updates and Changes** application to begin the Provider Enrollment Form, Change Request or Network Verification.

BESMART

BESMART ENROLLMENT PROCESS

Enrollment of a New Provider

1. Each provider enrollment must be submitted on a group enrollment form via Availity.
2. All providers must be participating in Medicaid to be eligible for the Commercial BESMART networks.
3. Providers, except those who prescribe addiction medicine and psychiatrists, must complete all additional educational requirements to be eligible to receive our enhanced bundled reimbursement for BESMART services.
4. We've replaced our PDF attestations with Smartsheets. All prescribers ***MUST*** complete a Smartsheet to be enrolled with BlueCross as a BESMART provider.
5. Please provide us with an email address for each new prescriber to your practice so we can send them a Smartsheet to complete.
6. Once we receive Smartsheets for your newly enrolled prescribers, we'll check their eligibility to receive our enhanced bundled reimbursement for BESMART services.

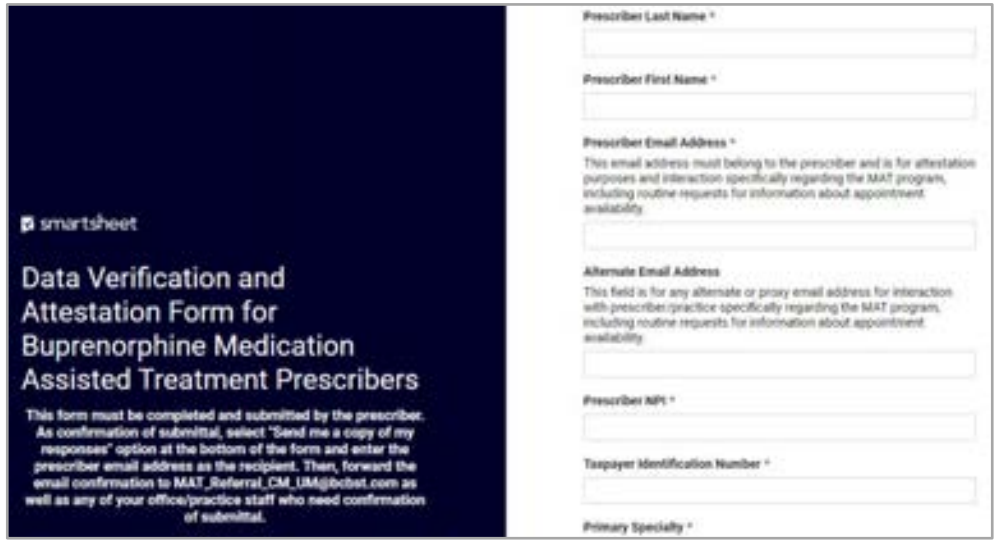
BESMART ENROLLMENT PROCESS

Requesting a MAT Smartsheet

MAT SmartSheet Requests

To request a MAT Smartsheet, please email us at:
MAT_Referral_CM_UM@bcbst.com

Attestation Form:



BESMART REMINDERS

TennCare Buprenorphine Coverage.

For BESMART providers, there's no Prior Authorization requirement for up to a maximum daily dose (MDD) of 16mg of preferred products buprenorphine/naloxone tablets and films.

For Non-BESMART providers, there's no Prior Authorization requirement for an initial five-day supply of buprenorphine/naloxone tablets up to 18 MDD if there are no paid claims on the last 180 days.

BESMART REMINDERS

TennCare Buprenorphine Coverage.

The buprenorphine changes that occurred on May 15, 2023, only apply to buprenorphine/naloxone film and tablets, and for providers within the BESMART Network.

For all other TennCare providers, the changes only apply to buprenorphine/naloxone tablets.

All non-preferred agents, including single buprenorphine-containing products, remain subject to prior authorization requirements.

Commercial and Medicare Advantage

NEW RATE STRUCTURE

Increasing BH Reimbursement

1. Our BH professional providers began receiving new Commercial contracts in August 2023. For BH providers who signed these documents in 2023, their contracts included a two-year phased increase.

2. These contracts are based off a percentage of the 2021 base fees outlined by CMS.

3. This structure is based on CMS values and aligns with the industry standard.

4. We're replacing the existing contracts regardless of whether the fixed terms have expired.

5. We're continuing our efforts to make sure all our professional providers have new contracts. If you haven't received your new contract, please check your email for a DocuSign document and contract from your Network Manager.

COMMERCIAL RATES

LCSWs/LPCs

CPT	Category	Rate
90791	Medicine – BH	161.58
90834	Medicine – BH	92.36
90836	Medicine – BH	80.56
90837	Medicine – BH	136.40

Category	Percentage of CMS 2021 base fees
Medicine – BH	93%
Medicine – Other	93%
E&M Office Visits	96%

COMMERCIAL RATES

Psychiatrists, Psychologists & BH NP

CPT	Category	Rate
90791	Medicine – BH	168.53
90834	Medicine – BH	96.33
90836	Medicine – BH	84.02
90837	Medicine – BH	142.27

Category	Percentage of CMS 2021 base fees
Medicine – BH	97%
Medicine – Other	97%
E&M Office Visits	100%

Behavioral Health Network Managers

Jennifer Ramsden
Middle Region
(423) 535-3807
Jennifer_Ramsden@bcbst.com

Tara Maffett
East Region/Chattanooga
(423) 309-8495
Tara_Maffett@bcsbt.com

Justine Carter
West Region
(865) 312-4254
Justine_Carter@bcbst.com

Lee Green
Middle Region
(615) 483-7886
Lee_Green@bcbst.com

Jonathan Fricks
East Region/Knoxville
(865) 228-9164
Jonathan _Fricks@bcbst.com

Kay Newcomb
East Region/TriCities
(615) 924-9588
Kay_Newcomb@bcbst.com

Thank You

Breakout Session

ANCILLARY

of Tennessee

ALL Blue 2024

ANCILLARY BREAKOUT SESSION

Agenda 2024

Presenters

- Shawanna Mason, Ancillary Network Manager II
- Starla Scruggs, Ancillary Network Manager II

ANCILLARY BREAKOUT SESSION

Agenda 2024

- Home Health Agency and Private Duty Nursing (PDN)
- T1000 Billing Guidelines
- Electronic Visit Verification (EVV)
- Hospice Billing and Reimbursement
  - Billing for Inpatient and Outpatient Hospice
  - Medicaid Provider Indicator Number

ANCILLARY BREAKOUT SESSION

Agenda 2024

- Durable Medical Equipment/Orthotics and Prosthetics Billing Guidelines
  - Place of Service 99 vs. Place of Service 12
  - Date Spans
  - HCPCS A4224 (Supplies)
- Complex Rehabilitation Technology (CRT)
  - BlueCare CRT Form
  - Commercial CRT Form

ANCILLARY BREAKOUT SESSION

Agenda 2024

- Breast Pump Billing Reminders
  - HCPCS K1005 (breast milk storage bags)
- BlueCard Georgia Service Areas
  - Catoosa, Dade and Walker counties
- Invoices
  - BlueCare
  - Commercial

Home Health and Private Duty Nursing (PDN)

- T1000 is for Private Duty/Independent Nursing service(s), licensed up to 15 minutes
- T1000 should only be billed to BlueCare. This is a Medicaid code only.
- T1000 is billable with revenue code 0589 only.
- T1000 is not reimbursable under Commercial plans.

Home Health and Private Duty Nursing (PDN)

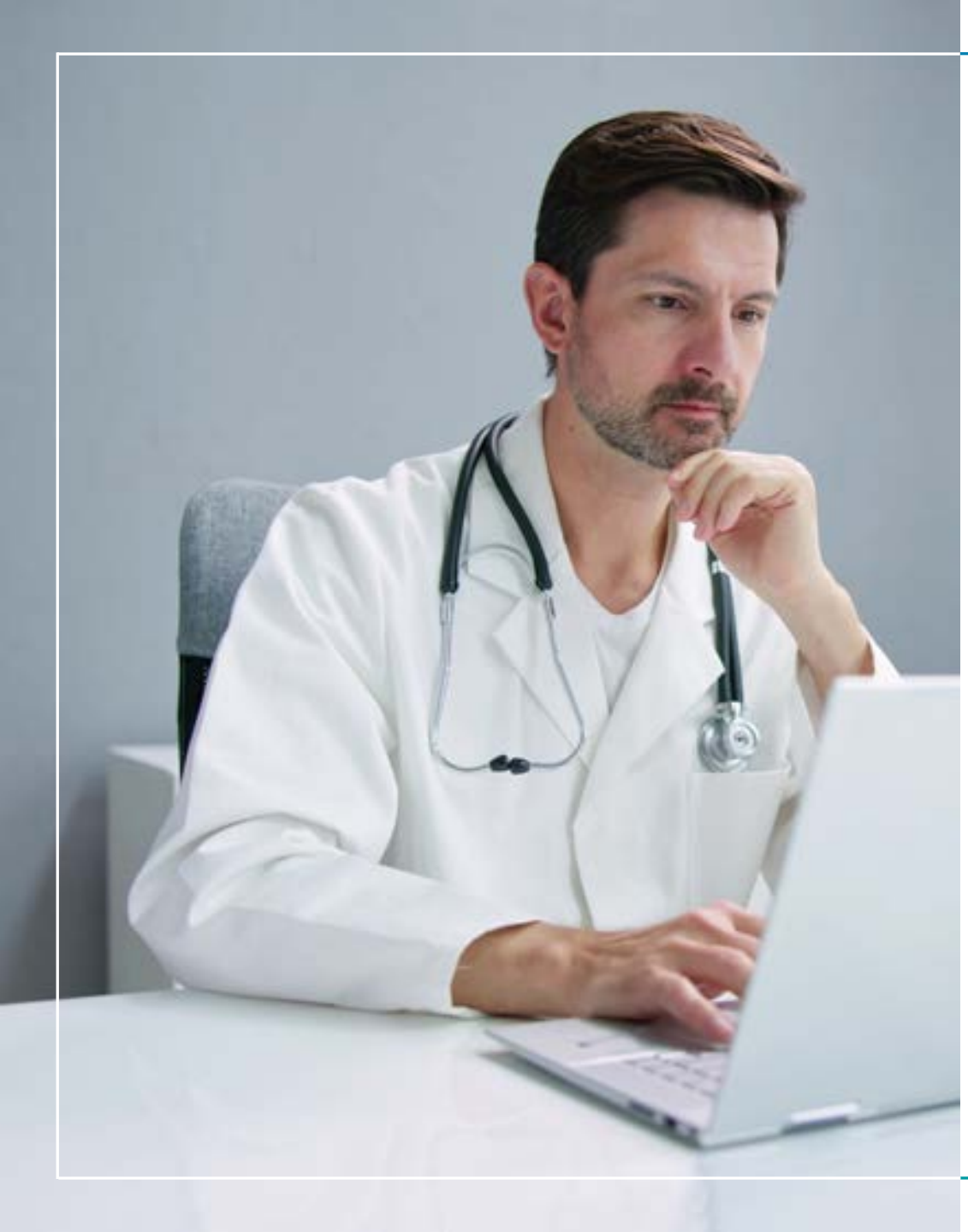
- T1000 is not reimbursable with revenue code 0552 or 0572.
- Commercial PDN is billable with revenue code 0552 and 0572.
- Commercial claims billed with PDN revenue codes and T1000 will deny.

BlueCare Home Health and PDN Billing Guidelines

Type of Service	Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Visits	Physical Therapy	0421	Not required	1 unit per visit
	Occupational Therapy	0431	Not required	1 unit per visit
	Speech Therapy	0441	Not required	1 unit per visit
	Medical Social Services	0561	Not required	1 unit per visit
Home Health Intermittent Visits	Skilled Nursing Visit (RN)	0551	G0299	1 unit / 15 minute
	Skilled Nursing Visit (LPN)	0551	G0300	1 unit / 15 minute
	Home Health Aid Visit	0571	G0156	1 unit / 15 minute
Home Health Extended Visits	Skilled Nursing Hour (RN)	0552	S9123	1 unit / hour
	Skilled Nursing Hour (LPN)	0552	S9124	1 unit / hour
	Home Health Aid Hour	0572	S9122	1 unit / hour
Private Duty	Private Duty Nursing	0589	T1000	1 unit / 15 minute

Commercial Home Health and PDN Billing Guidelines

Type of Service	Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Visits	Home Health Agency Physical Therapy	0421	Not required	1 unit per visit
	Home Health Agency Occupational Therapy	0431	Not required	1 unit per visit
	Home Health Agency Speech Therapy	0441	Not required	1 unit per visit
	Home Health Agency Skilled Nursing (RN or LPN)	0551	Not required	1 unit per visit
	Home Health Agency Medical Social Services	0561	Not required	1 unit per visit
	Home Health Agency Home Health Aide	0571	Not required	1 unit per visit
Private Duty Nursing	Private Duty Nursing (RN or LPN)	0552	Not required	1 unit per hour
	Private Duty Nursing (Home Health Aide)	0572	Not required	1 unit per hour



Home Health Claims Denials Related to Electronic Visit Verification (EVV)

Home Health Claims Denials Re: EVV

Effective July 1, 2023, we began denying claims for home health services if an agency isn’t using an EVV system. As a reminder, all home health agencies treating members enrolled in a Medicaid plan must use an EVV system to track that member visits occurred as scheduled.

Home Health Claims Denials Re: EVV

At minimum, EVV systems should track:

- Type of service performed
- Individual receiving services
- Date of service
- Location of service
- Individual providing the service
- Time the service begins and ends

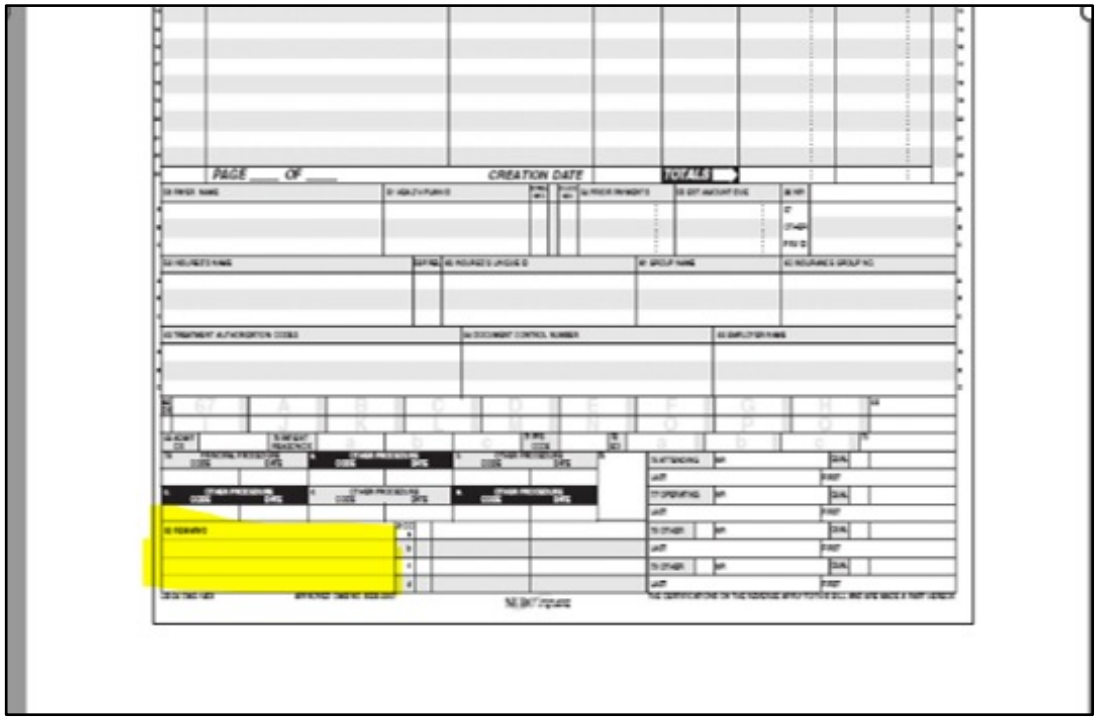
Home Health Claims Denials Re: EVV

If you have questions, please contact your Provider Network Manager. We also recently developed a web page with specific information for home health agencies.

To review these online resources, which include details about EVV, please visit **bluecare.bcbst.com/providers/tools-resources** and choose Resources for Home Health Providers.

BlueCare Hospice Billing Guidelines

- Revenue Code 0658 should be used for Inpatient Room and Board for nursing home residents.
- Inpatient Hospice claims require the Hospice Indicator in Blk#80 of the facility CMS-1450 form.
- The Hospice Indicator is the seven-digit Medicaid Number assigned to the facility.
- The Medicaid Number begins with “Q,” “744” or “044.”



BlueCare and Commercial Billing Guidelines

Durable Medical Equipment, Orthotics and Prosthetics Correct Billing

- Date Spans
- Place of Service 99 vs. POS 12
- Supply Code A4224

BlueCare and Commercial Billing Guidelines

Durable Medical Equipment, Orthotics and Prosthetics Correct Billing

Block 24b – Place of Service (POS)

- The POS should represent where the item is being used, not where it’s dispensed.
- For all lines of business, DME providers must use “99” as the POS code when submitting a claim for an item purchased by and delivered to a member at a retail store/place of business.

BlueCare and Commercial Billing Guidelines

Durable Medical Equipment, Orthotics and Prosthetics Correct Billing

Block 24a – From and To Date(s) of Service

- Enter the month, day and year for each procedure, service or supply.
- The following items require the use of span dates (i.e., a span of time between the “from and to” dates of service. Failure to use span dates will result in incorrect payment for:
  - Enteral feeding supply kits
  - Continuous passive motion device
  - Enteral formulae
  - Food thickener
  - External insulin pump supplies

BlueCare and Commercial Billing Guidelines

Durable Medical Equipment, Orthotics and Prosthetics Correct Billing

Example

- Code A4224 also includes all cannulas, needles, dressings and infusion supplies (excluding insulin reservoir A4225).
- Supplies for external insulin infusion (pump, syringe-type cartridge, sterile each) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784).
- Billing for more than one unit of service per week is incorrect use of the code and will be denied.

Source: cgsmedicare.com

Complex Rehabilitation Technology (CRT) Durable Medical Equipment (DME)

For CRT, all codes/line items to be billed must be provided to preview for billable codes and provide coverage determinations of service.

For DME to be reviewed as CRT, please complete the CRT DME authorization form with the required information.

Forms can be found at **provider.bcbst.com/tools-resources/documents-forms**.

Complex Rehabilitation Technology (CRT) Durable Medical Equipment (DME)

Prior authorization isn't required for repairs of this technology or equipment unless:

- The repairs are covered under a manufacturer's warranty
- The cost of the repairs exceeds the cost to replace the CRT or manual wheelchair: OR
- The CRT or manual wheelchair needing repair is subject to replacement because their age exceeds, or is within one year of the expiration of, the recommended lifespan of the CRT or manual wheelchair.

BlueCare Tennessee

Complex Rehabilitation Technology Durable Medical Equipment (DME) Authorization Request

Please type/print legibly and fax the completed form to: BlueCare Tennessee Utilization Management at **1-800-292-5311 OR** Submit online authorization requests via Availity® anytime day or night.*

Member Name: _____ Date of Birth: _____

Member ID Number: _____ Diagnosis with Diagnosis Codes: _____

Ordering Physician: _____ Provider # and/or NPI #: _____

Physician Address: _____

Physician Phone Number: _____ Fax Number: _____

DME Supplier: _____

DME Supplier Address: _____

DME Supplier # and/or NPI #: _____

DME Supplier Phone Number: _____ Fax Number: _____

Start Date Duration: _____

Requester's Name: _____

Phone: _____ Fax Number: _____

Special Note Regarding Needed Information:

For Complex Rehabilitation Technology, please complete the table on page 2 (if needed).

We need the code/line items to be billed and other required information noted below to review billable codes and provide coverage determinations for complex rehabilitation technology. The reimbursement of billable codes/line items will be based on established/published reimbursement in the BlueCare Tennessee Provider Administration Manual and/or contracted fee schedules.

*Contact the eBusiness Marketing team for all your Availity registration and training needs by calling **423-535-5710** option 2 or emailing eBusiness_marketing@bcbst.com.

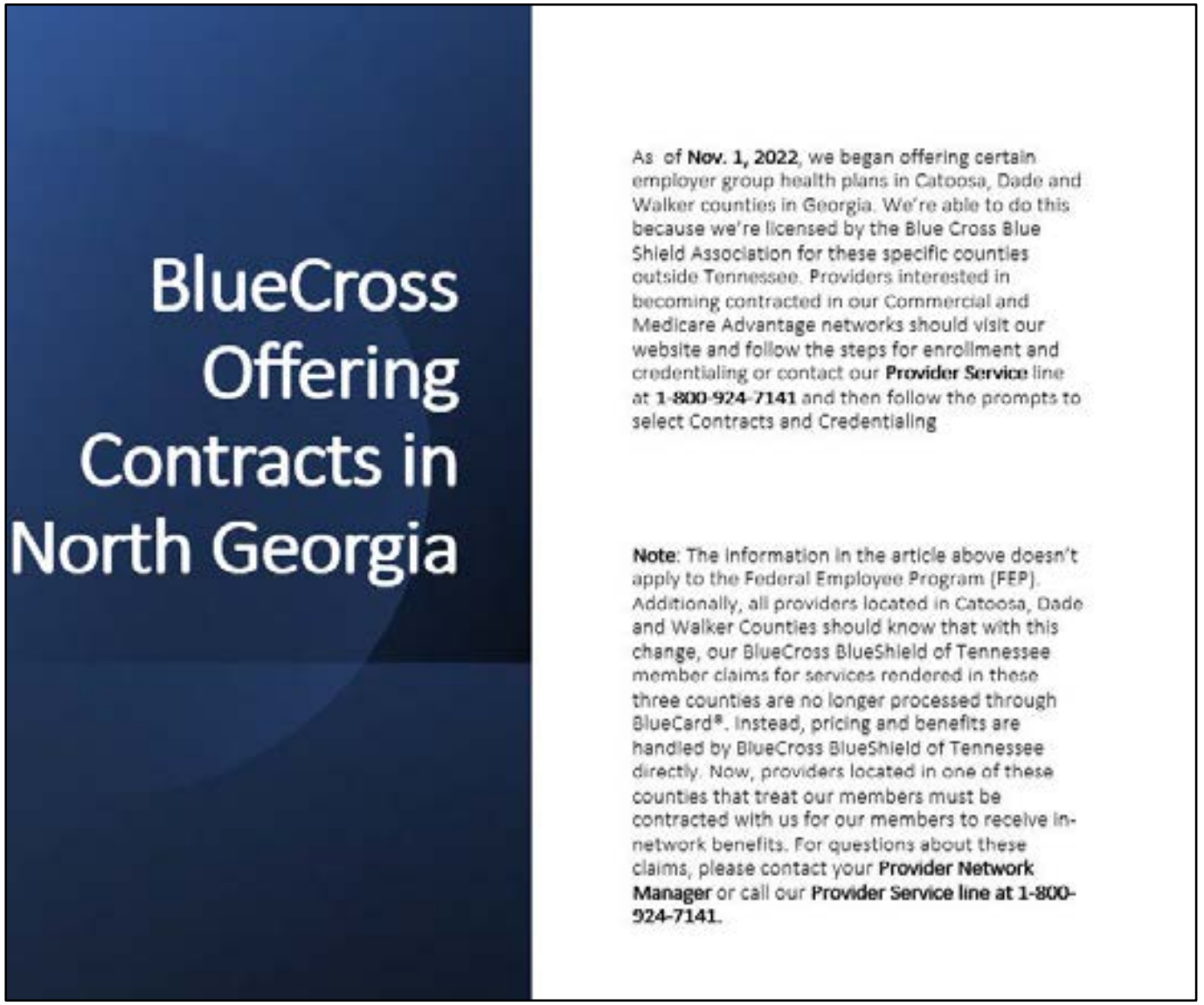
Equipment Codes Requested

Code	Description	Manufacturer	Product Name	Product Number	Units

Clinical Information

Please attach records of all pertinent and order of necessity information and allow up to 15 days for a determination.

22PED19517000 (1/23)


BlueCross Offering Contracts in North Georgia
As of Nov. 1, 2022, we began offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our website and follow the steps for enrollment and credentialing or contact our Provider Service line at 1-800-924-7141 and then follow the prompts to select Contracts and Credentialing
Note: The information in the article above doesn't apply to the Federal Employee Program (FEP). Additionally, all providers located in Catoosa, Dade and Walker Counties should know that with this change, our BlueCross BlueShield of Tennessee member claims for services rendered in these three counties are no longer processed through BlueCard®. Instead, pricing and benefits are handled by BlueCross BlueShield of Tennessee directly. Now, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. For questions about these claims, please contact your Provider Network Manager or call our Provider Service line at 1-800-924-7141.

BlueCare Breast Pump Supplies

E0602 Manual Breast Pump

E0603 Electric Breast Pump

› Accessories:

- A4281 Tubing for breast pump, replacement
- A4282 Adapter for breast pump, replacement
- A4283 Cap for breast pump bottle, replacement
- A4284 Breast shield and splash protector for use with breast pump, replacement
- A4285 Polycarbonate bottle for use with breast pump, replacement
- A4286 Locking ring for breast pump, replacement
- A4287 Effective Jan. 1, 2024, replaced K1005

Please note: Effective Oct. 1, 2023, for BlueCare, codes A4281-A4286 can be covered for replacement if an invoice is submitted because these codes do not have rates.

Commercial Breast Pump Supplies

A breast pump comes with adequate supplies for one pregnancy. We have a manual review process in place to pay for additional supplies if a member needs additional supplies due to multiple pregnancies, loss or unforeseen circumstances.

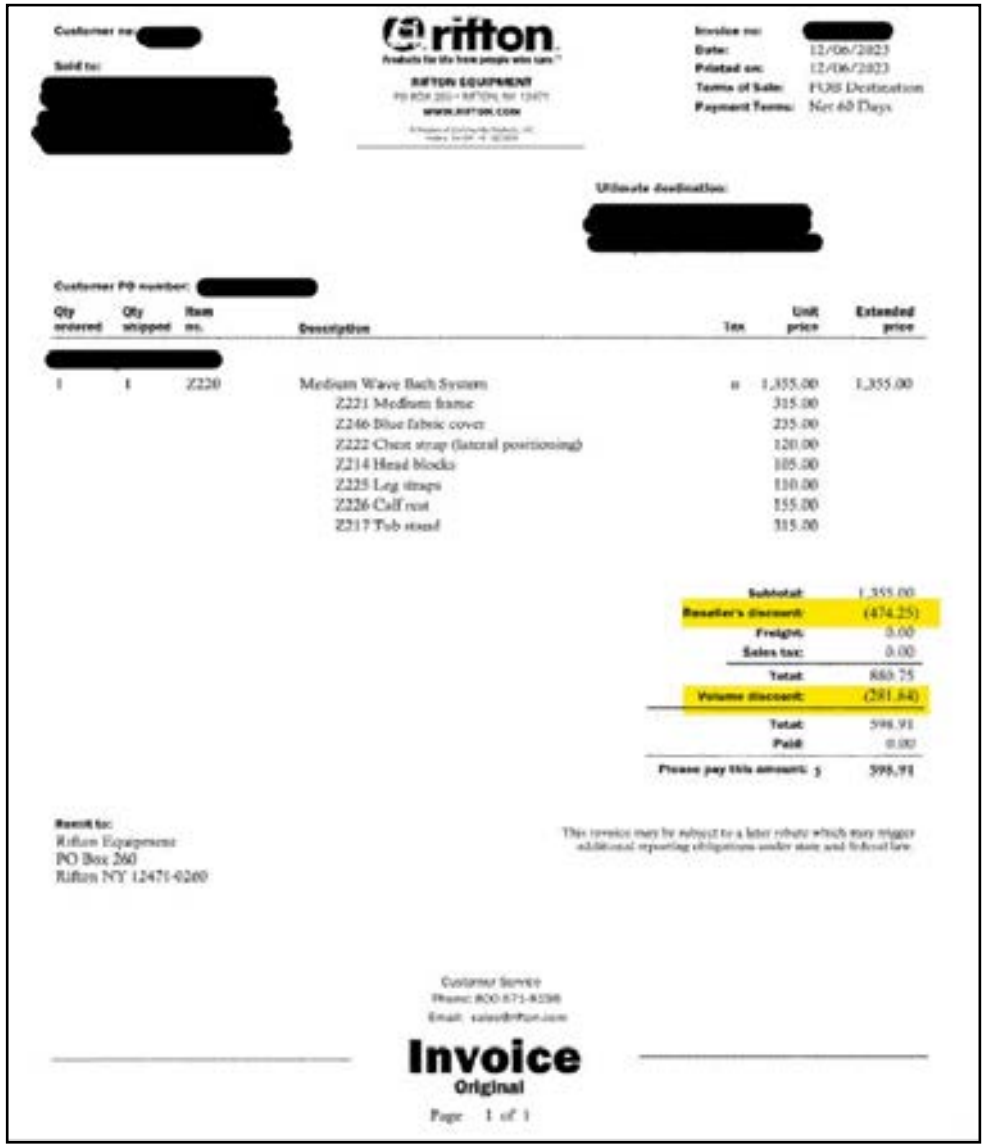
This configuration is in place for in-network DME providers. Additionally, for our commercial lines of business, the electric breast pumps are now covered (as of Jan. 1, 2023). Please note as isa one-time set up and additional supplies are members' responsibility.

Commercial Breast Pump Supplies

We will only pay for the initial breast pump and the supplies that come with it. BlueCross does not reimburse for additional supplies as they are affordable enough for members to get over the counter.

The only time that we'll pay for additional supplies is when the member has multiple pregnancies or when the new guideline for BlueCare apply.

Invoices
BlueCare/Commercial



Customer no: [redacted]

Sold to: [redacted]

rifton
Products for life from people who care.™
RIFTON EQUIPMENT
PO BOX 260 • RIFTON, NY 12471
WWW.RIFTON.COM

Invoice no: [redacted]
Date: 12/06/2023
Printed on: 12/06/2023
Terms of Sale: FOB Destination
Payment Terms: Net 60 Days

Ultimate destination: [redacted]

Customer PO number: [redacted]

Qty ordered	Qty shipped	Item no.	Description	Tax	Unit price	Extended price
[redacted]						
1	1	Z220	Medium Wave Bath System	n	1,355.00	1,355.00
			Z221 Medium frame		315.00	
			Z246 Blue fabric cover		235.00	
			Z222 Chest strap (lateral positioning)		120.00	
			Z214 Head blocks		105.00	
			Z225 Leg straps		110.00	
			Z226 Calf rest		155.00	
			Z217 Tub stand		315.00	

Subtotal:	1,355.00
Reseller's discount:	(474.25)
Freight:	0.00
Sales tax:	0.00
Total:	880.75
Volume discount:	(281.84)
Total:	598.91
Paid:	0.00
Please pay this amount: $	598.91

Remit to:
Rifton Equipment
PO Box 260
Rifton NY 12471-0260

This invoice may be subject to a later rebate which may trigger additional reporting obligations under state and federal law

Customer Service
Phone: 800-571-8398
Email: sales@rifton.com

Invoice
Original

Page 1 of 1

Invoices

1. The Provider Administration Manual (PAM) states: Information must be visibly published by the manufacturer (e.g., product catalogs, product price listings and manufacturer order forms).
2. If the manufacturer does not publicly publish prices, we MUST have the acquisition invoice with discounts in order to price.
3. BlueCross does not accept “quotes” as invoices.
4. The dates on the invoice must be current for verification.
5. Please use the appropriate modifiers and correct units at all times.
6. Reminder that BlueCross follows CMS, NCCI and the PAM for guidelines.

30-Day vs. 90-Day Supplies

BlueCare/Commercial

- Regular submission of claims for supplies that exceed the usual use may prompt a request for medical records to support the need for additional supplies.
  - Additional supplies must be requested by a member or caregiver before being dispensed. Supplies shouldn't automatically be dispensed on a predetermined and regular basis.
  - Claim submission for reimbursement consideration should be done on a monthly basis.

Medicare Advantage

- The only line of business that allows for a 90-day supply

Thank You

Breakout Session

COMMERCIAL QUALITY

of Tennessee

ALL Blue 2024

Health Equity

HEALTH EQUITY

Health Equity Goal: Improving Access to Care for Everyone

Our Health Equity Report looks at how race and other social factors affect our members' health care and health outcomes. You can find the report at **provider.bcbst.com**. The report focuses on:

- Maternal health
- Cancer
- Chronic condition management
- Child and adolescent well care
- Behavioral health
- Social drivers of health

Health Equity and Preventive Screenings

We help promote access to preventive health care by educating members on:

- Benefits and preventive screenings
- How to find a primary care provider
- Planning for appointments
- Managing their health and health plan benefits
- Healthy living

Quality Interactions

2024 Quality Interactions: Cultural Competency

QUALITY INTERACTIONS

Cultural Competency

- Commercial network providers now have access to three cultural competency education courses through Quality Interactions at no cost to them.
- Courses are interactive, engaging and fully mobile-friendly, so you can learn on the go.
- Because they’re accredited, you’ll be eligible for one hour of CME, CEU or CCM credits and a Cultural Competency designation in our online provider directory upon completion.

Cultural Competency (cont.)

Courses offered include:

- **ResCUE Model for Cross-Cultural Clinical Care:** This course applies the action-based ResCUE Model™ to address common cross-cultural issues and facilitate effective negotiation of care management plans. You'll learn how to communicate effectively and build rapport without making assumptions, communicate in cross-cultural interactions, and ask questions and develop management strategies that help you understand and engage patient perspectives.

Cultural Competency (cont.)

Courses offered include:

- **Improving Adherence in Diverse Populations:** This course provides a research-based overview of adherence behaviors and cross-cultural barriers, followed by actionable strategies that include an adherence screening and counseling tool, the ESFT Model™, which you'll apply to interactive case scenarios.
- **Recognizing and Responding to Implicit Bias in Maternal Health:** This course shares an overview of the research surrounding implicit bias, how it impacts maternal health outcomes, and how providers can offer stigma-free care. You'll acquire and practice applying a person-centered approach for addressing implicit bias and building trust in your patient interactions.

QUALITY INTERACTIONS

Cultural Competency

You can access the Quality Interactions training at: learn.qualityinteractions.com/bcbstn/bcbstnproviders.

To submit course completion for a Cultural Competency designation, or for more information, please contact Leigh Sanders, RN, Clinical Consultant, at Leigh_Sanders@bcbst.com.

Vaccinations

Childhood Immunization Status (CIS)

Goal of the Measure

Patients should complete the entire series of all immunizations below before turning 2:

- Four DTaP (diphtheria, tetanus and pertussis)
- Three IPV (polio)
- One MMR (measles, mumps and rubella)
- Three HiB (haemophilus influenza type B)
- Three Hep B (hepatitis B)
- One Hep A (hepatitis A)
- One VZV (varicella)
- Four PCV (pneumococcal conjugate)
- Two or three RV (rotavirus)
- Two Flu (influenza)

You can find an immunization schedule and information about the different vaccines at **cdc.gov/vaccines**.

Helpful Tips

- All doses of all vaccines must be completed for the gap to close.
- If a child turns 2 and hasn't had all doses, the gap for CIS will remain open and can't be closed.
- Flu vaccines and rotavirus vaccines are the ones most frequently missed.
- Exclusions
  - Children in hospice
  - Children who had a contraindication for a specific vaccine
    - In this case, the exclusion must have occurred by the child's second birthday.

It's important to list in the record if the rotavirus vaccine is the two- or three-dose vaccine. Upon record review, if it only says "rotavirus" and doesn't specify two or three doses, we're required to assume it's the three-dose vaccine. So, if only two doses are documented, the record won't be compliant.

Immunizations for Adolescents (IMA, IMA-E)

Goal of the Measure

- Patients should complete the entire series of all immunizations below before turning 13:
  - One meningococcal given between 11 and 13 years old
  - One Tdap (tetanus, diphtheria toxoids and acellular pertussis) given between 10 and 13 years old
  - Completed HPV series between 9 and 13 years old

You can find an immunization schedule and information about the different vaccines at **cdc.gov/vaccines**.

Helpful Tips

- All doses of all vaccines must be completed for the gap to close.
- If an adolescent turns 13 and hasn't had all doses, the gap for IMA will remain open and can't be closed. Schedule the well visit **before** the 13th birthday to close the gap.
- Exclusions:
  - Adolescents in hospice
  - Adolescents who had a contraindication for a specific vaccine. In this case, the exclusion must have occurred by the child's 13th birthday.

Did you know?

HPV is the most missed vaccine.

Adult Immunization Status (AIS)

Goal of the Measure

- Patients 19 years and older should be up to date on recommended routine vaccines for:
  - Influenza (flu)
  - Tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap)
  - Herpes zoster
  - Pneumococcal (not listed on the QCPI scorecard for 2024)

You can find an immunization schedule and information about the different vaccines at **cdc.gov/vaccines**.

Helpful Tips

Flu shot:

- Applies to patients 19 years and older
- Annual vaccine
- Must be administered on or between July 1 of the year prior and June 30 of the measurement year
- Scores in 2024 are based on data from July 1, 2022, through June 30, 2023

Helpful Tips (cont.)

Tdap/Td vaccine:

- Applies to patients 19 years and older
- Patients should get at least one vaccine by the end of the measurement year or within the nine years prior (given every 10 years)
- Patients can also meet the measure if they have a documented history of at least one of the following contraindications:
  - Anaphylaxis due to diphtheria, tetanus or pertussis vaccines
  - Encephalitis due to diphtheria, tetanus or pertussis vaccines

Helpful Tips (cont.)

Herpes Zoster Vaccine

- Applies to patients 50 years and older
- Patients should get the vaccine on or after their 50th birthday and either before or during the measurement period
- Patients can receive either:
  - One dose of the herpes zoster live vaccine **or**
  - Two doses of the herpes zoster recombinant vaccine at least 28 days apart

Helpful Tips (cont.)

Pneumococcal Vaccine

- Applies to patients 66 years and older
- Patients should get the 23-valent pneumococcal polysaccharide vaccine (PPSV23)

Resources

Quality Improvement Internal Resources

- Provider:
  - 2024 Quality Care Measures & Comprehensive Program Information Guide
  - QCPI Quality Measure Quick Guides
  - Quality Care Newsletter
  - Provider Videos/Continuing Education
  - QCR Portal Vaccination Status Reports

Resources (cont.)

Quality Improvement Internal Resources (cont.)

- Patient:
  - Vaccination Brochures: Childhood, Adolescent and Adult (New for 2024)
  - Vaccine Hesitancy Brochures: Childhood, Adolescent and Adult (New for 2024)
  - Childhood and Adolescent Vaccine Schedule Magnets
  - Vaccine Kit Give-Aways: Child, Adolescent and Adult (New for 2024)

Resources (cont.)

Quality Improvement brochures to address childhood, adolescent and adult vaccinations and hesitancy:

Resources (cont.)

Additional vaccine resources:

Behavioral Health

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

ADD-E

Follow-Up Care for Children Prescribed ADHD Medication

Goal of the Measure:

- All eligible population, 6 to 12 years old, who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits after the ADHD medication was dispensed
- Measurement Period – March 1 to the last day of February of the following year
- Newly prescribed is defined as no claims for an ADHD medication for 120 days before the dispense date

How to Close the Gap:

- First follow-up visit must be within 30 days of the medication dispense date with a provider that has prescribing authority. This visit can be a telehealth or telephone visit, as well as an office visit.
- Follow-up visits two and three must occur with any provider within nine months after the continuation phase for children who stayed on the medication at least 210 days.
- Of the second and third visits, only one can be a virtual assessment/check-in visit.

Exclusions:

- Hospice or hospice services
- Death
- Narcolepsy diagnosis

Antidepressant Medication Management (AMM)

ADD-E

Antidepressant Medication Management

Goal of the Measure:

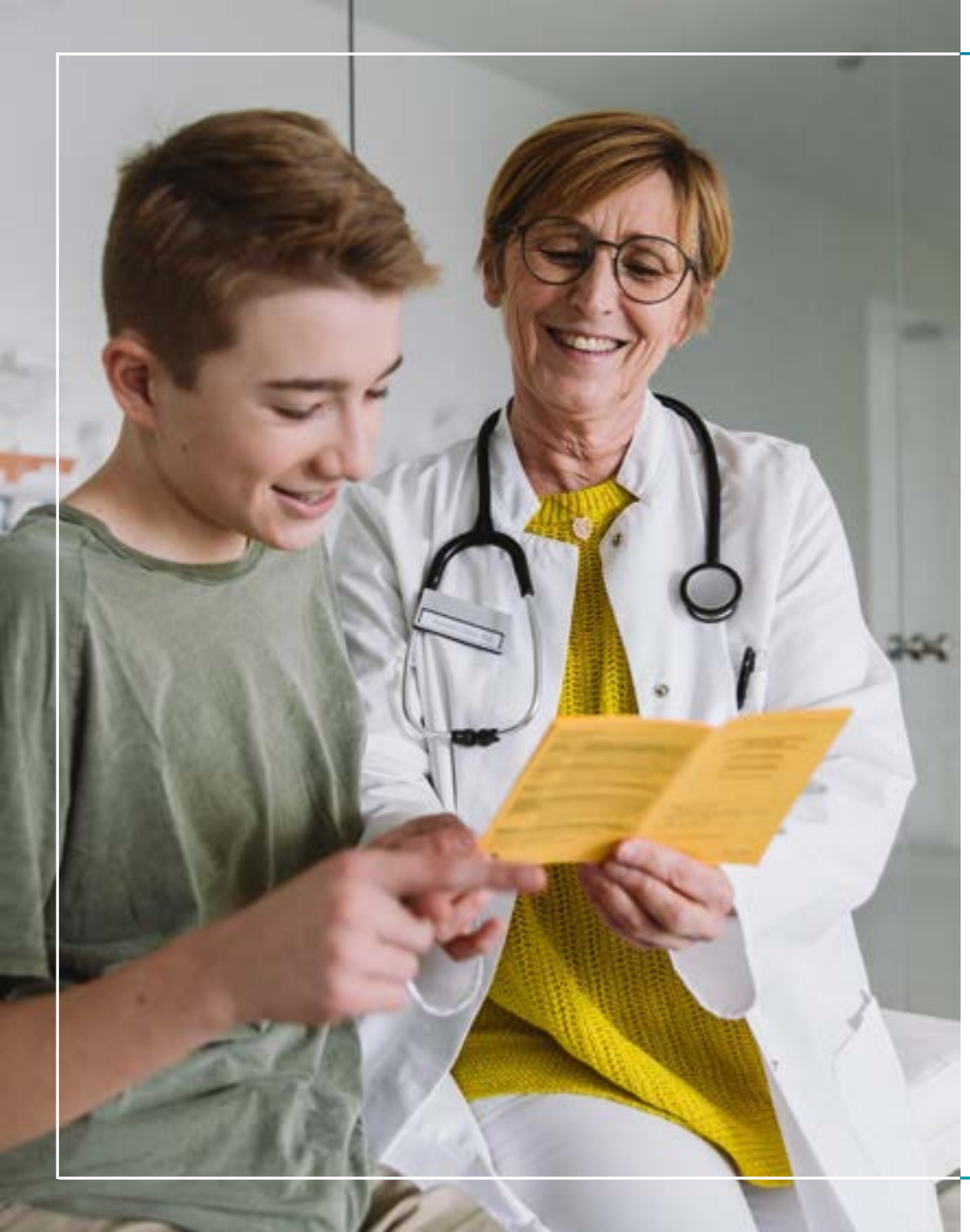
- Adults, ages 18 and older, who are treated with antidepressant medication with a diagnosis of major depression and remain on the medication
- Initiation phase – Must remain on the medication 84 days
- Continuation phase – Must remain on the medication at least 180 days

How to Close the Gap:

- The Ratings measure is Continuation, and the member must remain on the medication for 180 days to close the gap.

Exclusions:

- Hospice or hospice services
- Death



Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)

ADD-E

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Goal of the Measure:

- Children, 1 to 17 years, on antipsychotics received both glucose and cholesterol tests every year
- Glucose – can be blood glucose or Hemoglobin A1C
- Cholesterol – can be LDL only or lipid panel
- Measurement Period – Jan. 1 to Dec. 31

How to Close the Gap:

- Glucose and cholesterol tests both must be done yearly to close the gap

Exclusions:

- Hospice or hospice services
- Death

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

APP

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Goal of the Measure:

- Children, 1 to 17 years, who had a new prescription for antipsychotics have documentation of psychosocial care as a first-line treatment
- Measurement Period – Jan. 1 to Dec. 1

How to Close the Gap:

- Psychosocial care or residential behavioral health treatment within 90 days before the prescription fill date or within 30 days after the prescription fill date

Exclusions:

- Medication as first line care is appropriate for patients with: schizophrenia, bipolar disorder, schizoaffective disorder, autism, or other psychotic or developmental disorders. They must have this diagnosis on two claims with different dates of service.
- Hospice or hospice service
- Death

Screening Measures Overview

Screening and Screening Follow-Up Measures Overview

Unhealthy Alcohol Use Screening and Follow Up (ASF-E)

- Patients, age 18 and older, should be screened for unhealthy alcohol use during the measurement year using a standard screening instrument, such as AUDIT. If positive, patients should get appropriate follow-up care within 60 days of the positive screening.
- Exclusions – Hospice or hospice services, death, alcohol use disorder treatment in the year before the measurement year, and cancer

Screening and Screening Follow-Up Measures Overview (cont.)

- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
  - Patients, age 12 and older, who had an outpatient visit for major depression or dysthymia should have a PHQ-9 score present in their record on the same date as the visit.
  - Exclusions – Bipolar disorder, personality disorder, psychotic disorder or pervasive development disorder anytime in the patient's history up to the end of the measurement year; hospice or hospice services; death

Screening and Screening Follow-Up Measures Overview (cont.)

- Depression Remission or Response for Adolescents and Adults (DRR-E)
  - Patients, age 12 and older, who have a diagnosis of depression and an elevated PHQ-9 score should show evidence of a response (score reduced by 50% or more) or remission (score <5) within four to eight months after the PHQ-9 score
  - Exclusions – Bipolar disorder, personality disorder, psychotic disorder or pervasive development disorder anytime in the patient's history up to the end of the measurement year; hospice or hospice services; death

Screening and Screening Follow-Up Measures Overview (cont.)

- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
  - Patients, age 12 and older, should be screened yearly for depression using a standardized age-appropriate instrument, such as PHQ-2, PHQ-9, EPDS or others. Follow-up care after a positive screening should occur within 30 days of the positive screening and include, but not be limited to, telephone visits, telehealth visits, a depression case management encounter, antidepressant medication dispensed, and therapy.
  - Exclusions – Bipolar disorder, depression diagnosis prior to the measurement year, hospice or hospice services, and death

Pregnancy-Related Screening Measures

Postpartum Depression Screening and Follow-Up (PDS-E)

- Patients, who delivered a live birth, should be screened for clinical depression during the postpartum period of seven to 84 days following the birth. The PHQ-2, PHQ-9, and CUDOS are examples of available screening tools, and the tool used should be age-appropriate. If positive, patients should get follow-up care within 30 days of the positive screening. Follow-up care includes, but isn't limited to, a telephone or telehealth follow-up visit, a depression case management encounter, a behavioral health visit or therapy, or a dispensed antidepressant medication.
- Exclusions – Hospice or hospice services and death

Pregnancy-Related Screening Measures (cont.)

Prenatal Depression Screening and Follow-Up (PND-E)

- Pregnant patients should be screened for depression using a standardized tool, such as the PHQ-2, PHQ-9 or others. Follow-up care for a positive screening should occur within 30 days. Follow-up care includes, but is not limited to, a telephone or telehealth follow-up visit, a depression case management encounter, or a dispensed antidepressant medication
- Exclusions – Birth before 37 weeks gestational age, hospice or hospice services, and death

Resources

Quality Improvement Resources

- Provider:
  - 2024 Quality Care Measures & Comprehensive Program Information Guide
  - QCPI Quality Measure Quick Guides
  - Quality Care Quarterly Newsletter
  - 2024 Pilot Provider Survey to assess the bidirectional flow of information from medical health care to behavioral health care
  - Behavioral health-specific HEDIS training
- Patient:
  - Behavioral health brochures and educational information
  - Integrated behavioral health staff on care management teams for a holistic approach to care

Provider Resources

RESOURCES

Keeping You Up to Date

We Value Your Participation in Our Quality Program

We know you're already providing high-quality care to your patients, and we want to ensure your practice gets the recognition it deserves. You're helping our members get important preventive screenings, providing effective, timely treatment, and improving medication adherence so they can be as healthy as possible. This quality care is central to our mission of delivering peace of mind through better health to the members we serve.

RESOURCES

Quality Resources for You and Your Patients

Provider Resources

To keep you informed of changes and best practices, the Commercial Quality Improvement team provides monthly, quarterly and annual publications. We offer a range of services and events, as well as on-site visits, to support your success in closing HEDIS measures for your patients. Our team can also share educational materials for you and your patients, as well as assist with health screenings and events.

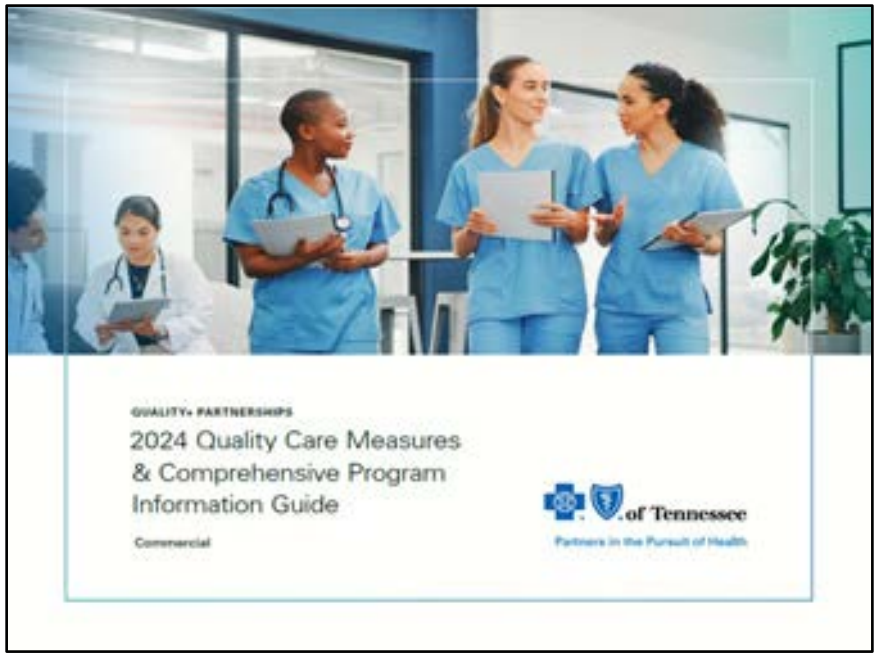
Educating Our Members

We believe quality care involves the promotion of care management for health and wellness measures as they relate to members' chronic conditions, age, gender and behavioral health.

Our goal is to empower our members to focus on preventive care and chronic condition management so they can make informed decisions and have an active voice in their health.

RESOURCES

Your Guide for Quality Care Measures



2024 Quality Care Measures & Comprehensive Program Information Guide

› This guide is printed annually and includes:

- New HEDIS specifications for the year
- Measure descriptions, what service is needed and what to report
- Measure-specific inclusion and exclusion criteria
- Sample diagnoses, CPT® and HCPCS codes related to gap closure
- Helpful tips and best practices

RESOURCES

Provider Tool Kits

Within the 2024 Quality Care Measures & Comprehensive Program Information Guide, you'll also find tool kits on these topics:

- Quality Measures Quick Reference
- Adolescents Immunizations Tool Kit
  - Additional resources, including a parent's reminder letter and tips for vaccination success and safety
- Support Guide for the Kidney Health Evaluation Measure (KED)
  - Helpful information for understanding the measure, including codes and best practices

RESOURCES

Provider Tool Kits (cont.)

- Guide to Statin Measures (SPC and SPD)
  - Helpful information for understanding these measures, including sample codes, exclusions and a statin medication list
- Antibiotic Stewardship Tool Kit and Pocket Guide
  - Details on the Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) and Upper Respiratory Infection (URI) measures, including CDC updates, exclusions and patient resources

RESOURCES

Provider Tool Kits (cont.)

Within the 2024 Quality Care Measures & Comprehensive Program Information Guide, you'll also find tool kits on these topics:

- Low Back Pain Pocket Guide and Low Back Pain Coding Guide
  - Includes a coding tool and exclusion pocket guide
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
  - Contains sample questions and helpful tips
- Cultural Competency in Health Care
  - Culture shapes how people experience their health care. Learn more about what it means to deliver culturally competent care and related resources.

RESOURCES

Provider Tool Kits (cont.)

- Commercial Telehealth Guide
  - Lists HEDIS specifications for closing gaps with telehealth, tips for coding and filing claims
- Guide to Advanced Illness and Frailty Exclusions
  - See how advanced illness and frailty impact HEDIS measures, including exclusion codes and tips

RESOURCES

Provider Newsletters

Monthly BlueAlert℠ Newsletter

- The BlueAlert newsletter gives you timely information on forms and process changes, coding tips, drug coverage and more. View the newsletter at **provider.bcbst.com**.

Quality Care Quarterly Newsletter

- The current edition of the Quality Care Quarterly is available at provider.bcbst.com, under **Quality Care Initiatives**. Previous editions are in the archived newsletters under **Provider News and Updates**. In it, you'll find a variety of informative articles, including best-practice highlights from your peers, helpful information on important HEDIS measures, tips on using the Quality Care Rewards (QCR) application in Availity, and upcoming events and training opportunities.

RESOURCES

On-Site Health Screenings – Wellness

Each year, we hold wellness events in communities across the state to help support your efforts to deliver quality care. Our goal is to make it easy for your patients to get the preventive care they need by bringing these events to their communities.

Our Quality teams often host screening events that can be held in your office, in our mobile unit or in the local community. We can customize these on-site events to meet your needs or preferences.

During these events, your patients are often able to close multiple gaps in care and get important educational material.

RESOURCES

On-Site Health Screenings (cont.)

Wellness Event Campaigns

We identify members who could benefit from these screenings and schedule a convenient time for them. Our on-site events can also include community outreach and member education.

Our team will be on site at your event to assist our vendor partners, answer questions and help educate your patients about the importance of preventive care and screening tests.

To schedule an event, email **GM_Commercial_Quality_Improvement@ bcbst.com.**

RESOURCES

On-Site Health Screenings (cont.)

We offer on-site health screening events at your location tailored to best fit the needs of your office. Services we can offer include:

- Breast cancer screenings
- Colorectal cancer screenings
- Diabetic retinal eye exams and other diabetic screenings
- Drive-through vaccine clinics

RESOURCES

Patient Educational Material: Health Planners, Brochures and Magnets

Educating patients on preventive care and chronic care management empowers them to:

- Remain in control of their health care
- Stay up to date on recommendations
- Make informed decisions
- Be as healthy as they can be

RESOURCES

Provider HEDIS Education for Quality Measures

We offer free customized virtual training on HEDIS quality measures. Learn best practice tips for closing gaps in care, keys to coding, yearly specification changes and more.

We cover as many measures as you'd like to know about.

Contact your Quality Improvement Clinical Consultants to schedule a time that's convenient for you and your staff.

Your Commercial Quality Improvement Clinical Consultant Team

Your Commercial Quality Team

Shannon Dunn, MHA, BSBA, LPN, CPHQ, PAHM, CHC
Manager, Quality Improvement
Shannon_Dunn@BCBST.com

Lisa Eaves, RN, BS, CPHQ, PAHM
Clinical Consultant, Quality Improvement
Lisa_Eaves@BCBST.com

Teri Conn, RN, BSN
Clinical Consultant, Quality Improvement
Teri_Conn@BCBST.com

Tamara Lindsey, LMSW, MBA
Clinical Consultant, Quality Improvement
Tamara_Lindsey@BCBST.com

Leigh Sanders, RN, CCM, CPHQ, PAHM
Clinical Consultant, Quality Improvement
Leigh_Sanders@BCBST.com

Jennifer Rollins, RN, MSN, CCM, CPHQ, PAHM
Clinical Consultant, Quality Improvement
Jennifer_Rollins@BCBST.com

To get credit for attending today, please email your name, group/provider and Tax ID to **ABW_QA_feedback@bcbst.com**

Thank You