



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



A photograph of a woman with curly hair smiling as a doctor examines a young child. The image is overlaid with a blue gradient and contains text.

GENERAL SESSION

BlueCare Tennessee

TennCare Kids

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.

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

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.

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.

TennCareSelect

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 Availability

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.

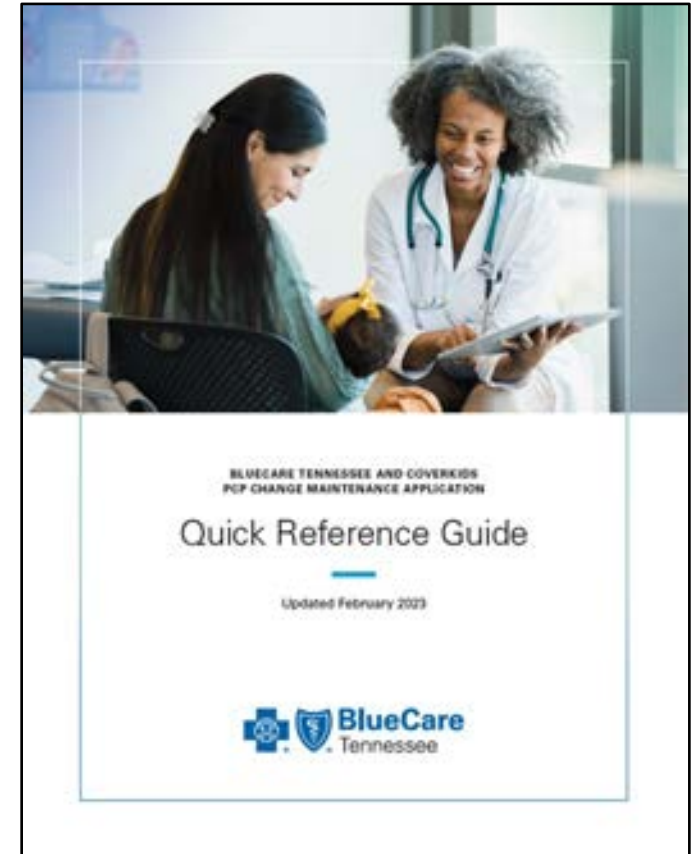
REVIEW OUR QRG

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.



The screenshot shows a member profile for Chris B. Hall. At the top, the name and address are listed: HALL, CHRIS B, 1 CAMERON HILL CIRCLE, CHATTANOOGA, TN 37402. Below this, a row of fields includes Member Status (Active Coverage), Date of Birth (Aug 6, 1969), Gender (Male), Current Plan Effective Date (Jan 1, 2019 - Dec 31, 2193), and Relationship to Subscriber (Self). A navigation bar contains buttons for 'Prior Authorization Requirements', 'Coverage Questions?', 'Patient Cost Estimator', 'General Exclusions', and 'Member Card', with the last button highlighted by a red box. The main content area displays Member ID (QM902218823), Group Number (100000), Group Name (CHRIS B HALL ENTERPRISES), and Plan Begin Date (Jan 1, 2024). It also shows the BlueCross BlueShield of Tennessee logo and Payer information (BCBS TENNESSEE). A section for 'Other or Additional Payer Information' includes a 'Secondary Payer' button and details for a secondary payer: Payer (NO OTHER INSURANCE), Group or Policy Number (NOTPROVIDED), and COB Date (Sep 23, 2023).

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.

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 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.

CROSSOVER CLAIMS

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.

CROSSOVER CLAIMS

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 *TennCareSelect*, and the claims will cross over from Medicare or the D-SNP to *TennCareSelect* 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 CLAIMS

Crossover Claim Prefixes

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

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

TennCareSelect QMB Only

QMB Only Benefits

TennCareSelect 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 BlueAlertSM.

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](https://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.

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

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

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

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

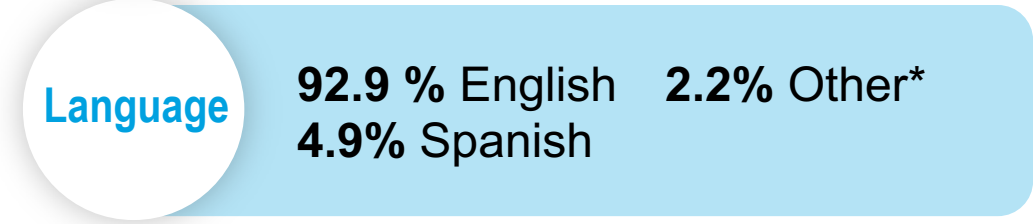
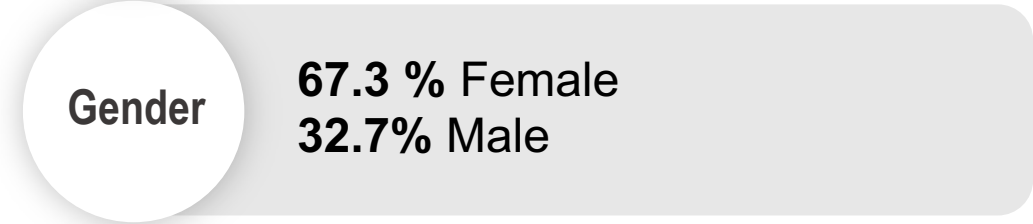
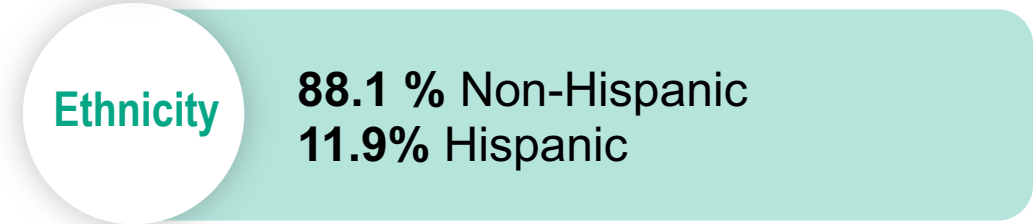
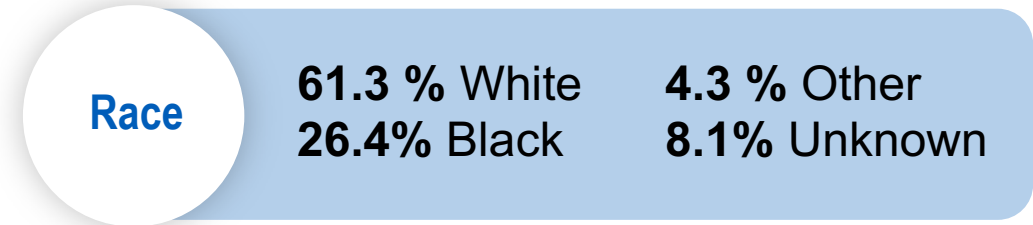
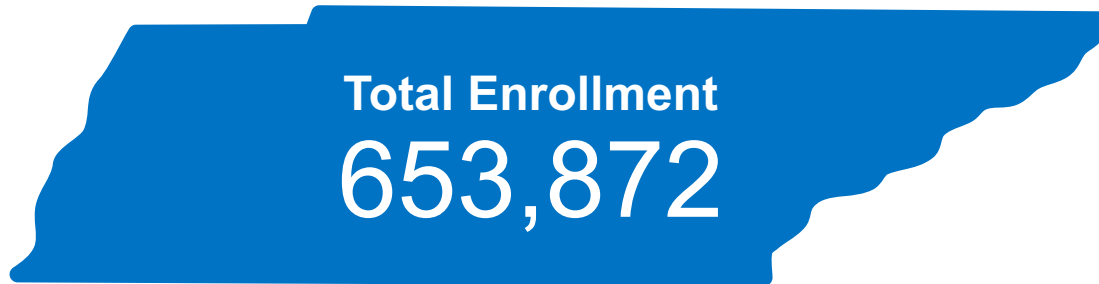
Priority Measures	BlueCare Interventions
Immunizations <ul style="list-style-type: none">› Childhood Immunization Status (CIS)› Immunizations for Adolescents (IMA)	<ul style="list-style-type: none">› Continue member outreach and provide education on vaccine hesitancy with immunizations› HPV Pilot
Well-Child <ul style="list-style-type: none">› 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)	<ul style="list-style-type: none">› Foster our strong community partnerships and focus on activities to support our providers.
Diabetes <ul style="list-style-type: none">› 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)	<ul style="list-style-type: none">› 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 <ul style="list-style-type: none">› Follow-Up After Hospitalization for Mental Illness (FUH)› Continuity and Coordination of Care	<ul style="list-style-type: none">› 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.

2024 Priorities

Priority Measures	Interventions
<p>Cardiovascular Conditions</p> <ul style="list-style-type: none"> › Controlling High Blood Pressure (CBP) 	<ul style="list-style-type: none"> › 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.
<p>Maternal Health</p> <ul style="list-style-type: none"> › Prenatal and Postpartum Care (PPC) 	<p>—</p>
<p>Long-Term Services & Supports</p> <ul style="list-style-type: none"> › 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) 	<ul style="list-style-type: none"> › Perform well in these measures. › We'll continue our ongoing activities to identify these members for timely follow-up and assessment completion.
<p>TennCare Outcome Metrics</p> <ul style="list-style-type: none"> › 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 	<ul style="list-style-type: none"> › 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

Member Demographics



* Top "Other" languages include: Arabic, Vietnamese, and Kurdish

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. HHCI 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

HOME HEALTH CRITICAL INCIDENTS

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 \(tn.gov\)](https://childabuse.referralandtracking.tn.gov/)

HOME HEALTH CRITICAL INCIDENTS

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

WHAT IS A DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)?

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 MEMBER BENEFITS

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

CHRIS B HALL
 Subscriber ID: **ABCD12345678**
 Medicare Contract # H3259-001

Group No. 129884

Copayments:
 Office Visit \$0
 Specialist Visit \$0
 ER Visit \$0
 Hospital Stay \$0

RXBIN 004336
 RXPCN MEDDADV
 RXGRP RX76AD
 Issuer 80840

MedicareRx
 Prescription Drug Coverage



BlueCare Plus Choice

CHRIS B HALL
 Subscriber ID: **ABCD12345678**
 Medicare Contract # H3259-002

Group No. 129884

Copayments:
 Office Visit \$0
 Specialist Visit \$0
 ER Visit \$0
 Hospital Stay \$0

RXBIN 004336
 RXPCN MEDDADV
 RXGRP RX76AD
 Issuer 80840

MedicareRx
 Prescription Drug Coverage



BlueCare Plus Select

CHRIS B HALL
 Subscriber ID: **ABCD12345678**
 Medicare Contract # H3259-003

Group No. 129884

Copayments:
 Office Visit \$0
 Specialist Visit \$0
 ER Visit \$0
 Hospital Stay \$0

RXBIN 004336
 RXPCN MEDDADV
 RXGRP RX76AD
 Issuer 80840

MedicareRx
 Prescription Drug Coverage



BlueCare Plus Tennessee
 An Independent Licensee of the BlueCross BlueShield Association

Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider.
 Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare.
 Prior authorization required for admissions and other selected medical services. Report all emergency admissions within one working day.

This card is for identification, not for proof of eligibility.

Medical/Dental Tennessee Providers
 Submit Claims to:
 BlueCare Plus Operations
 1 Cameron Hill Circle Ste 8002
 Chattanooga, TN 37402-0002

bluecareplus.bcbst.com
 Member Service: 1-800-332-5762
 Provider Line: 1-800-299-1407
 TTY/TDD: 711
 Prior Authorizations: 1-866-789-6314
 Pharmacists: 1-866-693-4620
 Clinical Vendor Prior Authorization:
 1-888-258-3864
 (Required for Advanced Radiological Imaging and Part B Meds)

CMD-83258
 249 (06/22)



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 (Required for Advanced Radiological Imaging and Part B Meds)

CMD-83258
 249 (06/22)

2024 MEMBER INCENTIVES

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

PATIENT ASSESSMENT & CARE PLANNING FORM (PACF) AND INTERDISCIPLINARY CARE TEAM (ICT)

BlueCare Plus Tennessee

Service	Codes	Coverage Notes	Amount
PACF	96160 96161	<ul style="list-style-type: none">› Submitted once per calendar year› Completed with the “Welcome to Medicare” Exam or AWW	\$155
ICT	99366- 99368	<ul style="list-style-type: none">› 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](https://www.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

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 (OAD)	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
Care for Older Adults (COA) - Medication Review*	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
Cervical 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-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

Measure Name

- Controlling High Blood Pressure (CBP)*
- Hemoglobin A1c Control For Patients With Diabetes (HBD) **9%*
- Medication Adherence for Cholesterol (Statins)
- Medication Adherence for Hypertension (RAS Antagonists)
- Medication Adherence for Non-insulin Diabetes Medications (OAD)
- Plan All-Cause Readmissions (PCR)
- Breast Cancer Screening (BCS)
- Care for Older Adults (COA) - Medication Review*
- Care for Older Adults (COA) - Pain Assessment*
- Colorectal Cancer Screening (COL)*
- Eye Exam For Patients With Diabetes (EED)*
- Follow-Up After Emergency Department Visit for People With Multiple-Risk Chronic Conditions (FMC)
- Osteoporosis Management in Women Who Had a Fracture (OMW)
- Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Statin Therapy
- Statin Use in Persons with Diabetes (SUPD)
- Transitions of Care (TRC)

Eligible Chronic Conditions

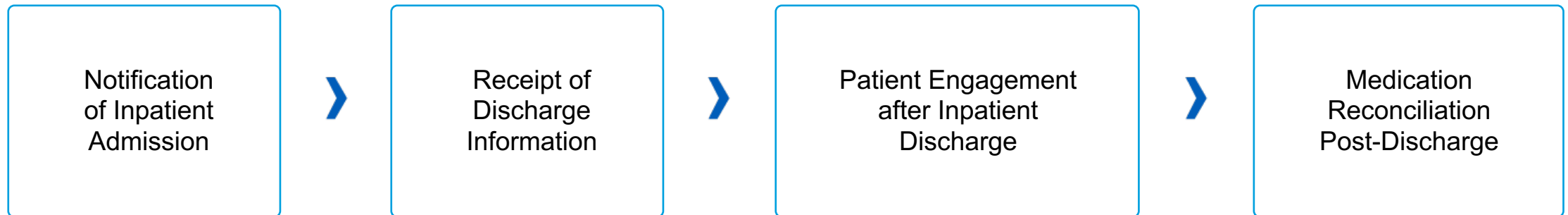
COPS and asthma	Alzheimer’s disease and related disorders
Chronic Kidney Disease	Depression
Heart Failure	Acute myocardial infarction
Atrial fibrillation	Stroke and transient ischemic attack
Follow up service office visit within 7 days after an ED visit (8 total days)	—

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

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:



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 (PEID)*	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

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



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association

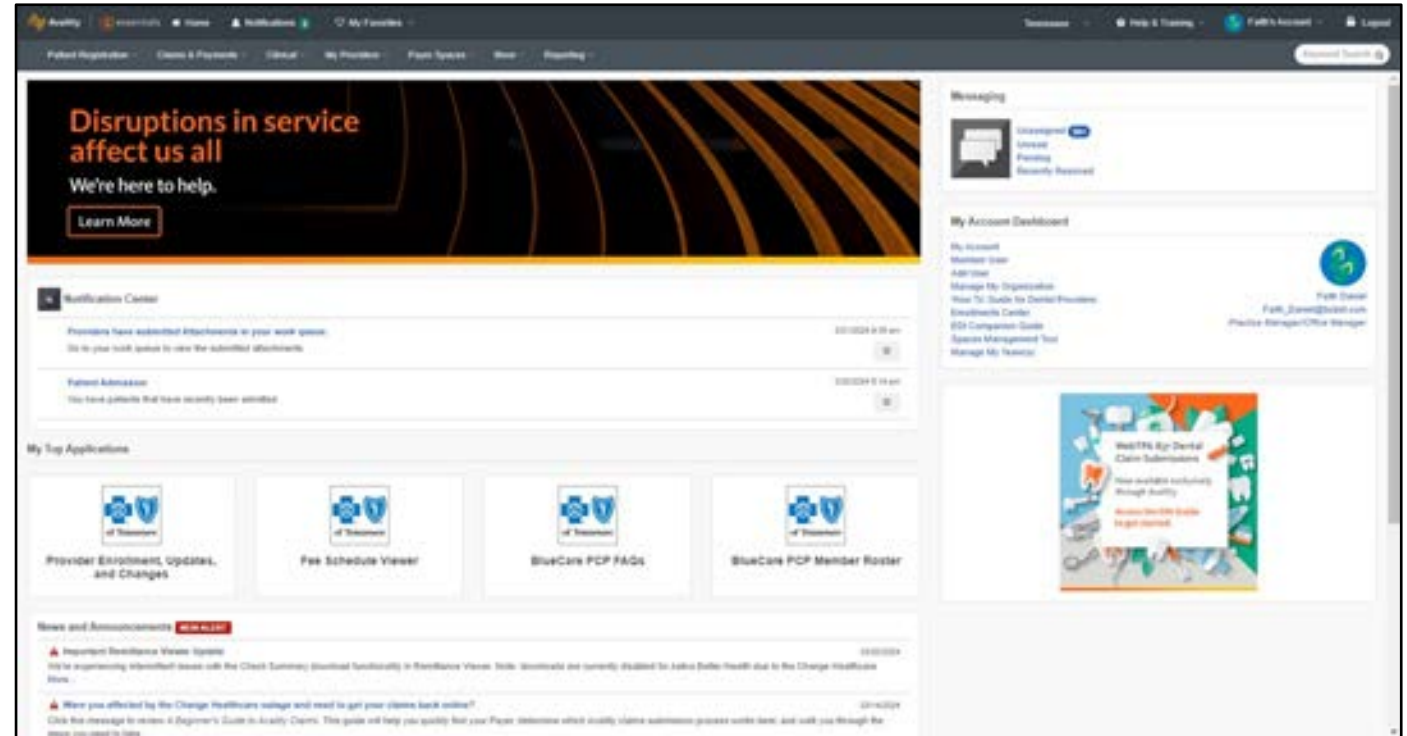
A smiling man with a beard, wearing a blue shirt, is sitting at a desk in an office. He is looking at a laptop. The desk has a desk lamp, a pen holder, and a smartphone. In the background, there is a bookshelf with books and a window with a view of a city. The entire image is overlaid with a blue gradient.

GENERAL SESSION

eBusiness

Home

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



Manage My Organization

My Account Dashboard

- My Account
- Maintain User
- Add User
- Manage My Organization**
- 'How To' Guide for Dental Providers
- Enrollments Center
- EDI Companion Guide
- Spaces Management Tool
- Manage My Team(s)

Manage My Organization

Note: You're viewing your organizations and associated providers. To administer your user accounts, go to [Manage My Team\(s\)](#)

Organizations

[Register an Organization](#)

Org N... Search...

Sorted by Newest to Oldest

Active 1 Pending Rejected 1

123 Test Clinic, LLC Customer ID 111111 Admins [Edit](#)

[View Roles](#) | [View Identifiers](#) | [Maintain Identifiers](#)

Tax ID(s)	NPI	Regions	Primary Taxonomy	Primary service Address
111111111	119479017	NY	Agencies - Day Training, Developmentally Disabled Services	229 The Test Lane New York, New York 10001

[Add Provider](#)
[Make Me Primary Admin](#)

[Add Payer Regions](#)

[Show all](#)

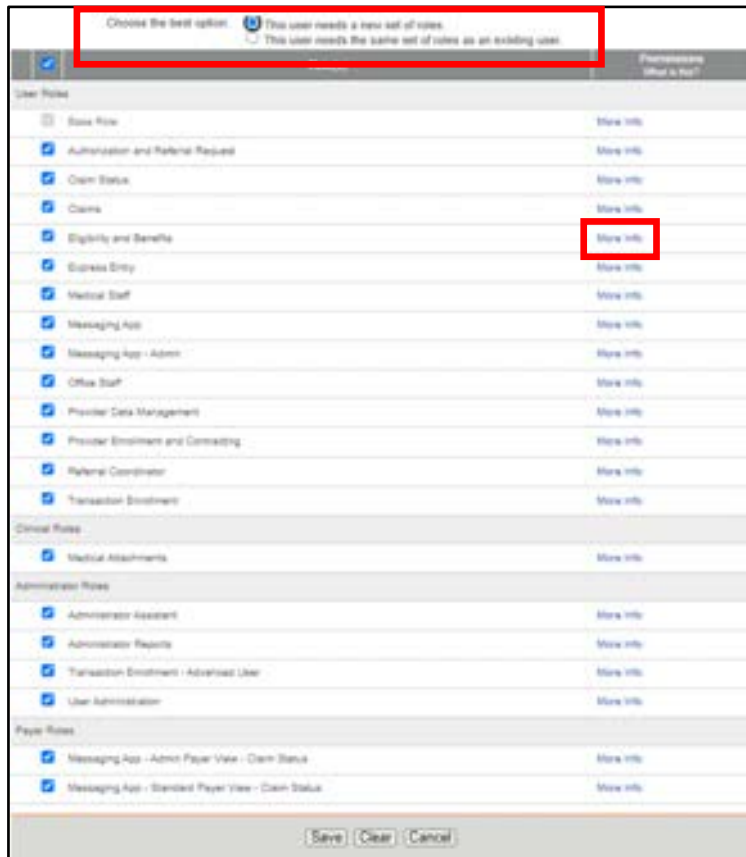
[Expand All](#)

Providers [Watch a video](#)

[Manage Providers](#)

- Add Provider(s)
- Bulk Delete Providers
- Export Providers

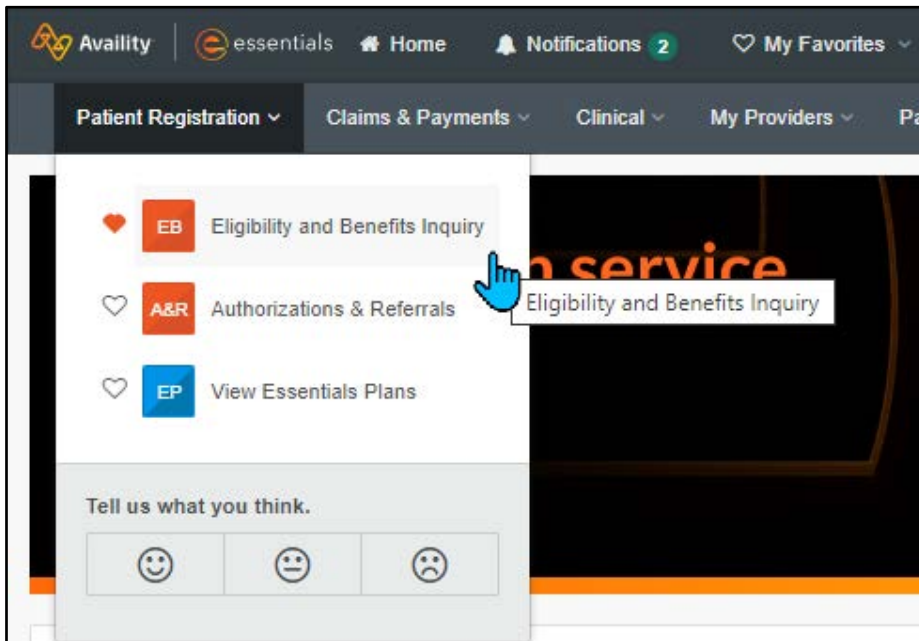
User Roles



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

Permissions	Players or Vendors That Support This Permissions
Eligibility and Benefits Inquiry	BCBS TENNESSEE
New Eligibility and Benefits Payer List	BCBS TENNESSEE, OTHER BLUE PLANS-TN
PCP Member Roster	BCBS TENNESSEE
RTCA	BCBS TENNESSEE

Patient Registration



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

Eligibility & Benefits

Need Help? Watch a video about Eligibility and Benefits [+ New Request](#)

Eligibility & Benefits

Fields marked with an asterisk * are required.

* Organization: BCBS eBusiness Marketing - Faith
* Payer: BCBS TENNESSEE

Provider Information

Select a provider or enter one of the following: Provider NPI or Provider Tax ID

Provider: ABC Medical Group

Provider NPI: 123456789

Service Information

* As of Date: 03/21/2024

* Benefit / Service Type: Health Benefit Plan Coverage - 30 X

Submit another patient

Submit

Patient Information

Member Search

Enter member information, then click on **Search**. If there are member search results...

Member Search Option(s):

- Member ID/Policy Number
- Member ID/Policy Number
- Member ID/Policy Number, Member Last Name, Date of Birth
- Member ID/Policy Number, Member Last Name, Member First Name
- Member ID/Policy Number, Member First Name, Date of Birth
- Member Last Name, Member First Name, Date of Birth


BlueCare Member Eligibility & Benefits

HALL, KRISTOPHER Edit Print Feedback

C/O BRANDY MATTHEWS
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402

Member Status Active Coverage	Date of Birth Aug 6, 1959	Gender Male	Current Plan Effective Date Jan 1, 2015 - Dec 31, 2199	Relationship to Subscriber Self
---	-------------------------------------	-----------------------	--	---

[Check Medicaid NPI](#) [Prior Authorization Requirements](#) [Coverage Questions?](#) [Patient Cost Estimator](#) [General Exclusions](#) [Member Card](#)

Member ID:	ZECMBCTEST00	 BCBS of Tennessee	
Group Number:	125000		
Group Name:	TENNCARE/BLUECARE		Payer: BCBS TENNESSEE
Plan Begin Date:	Jul 1, 2023		

Other or Additional Payer Information
No additional payer information provided.

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.

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

Check Medicaid Registration by NPI

Billing: 1234567890

Service Facility: [Empty]

Rendering: [Empty]

Ordering: 1234567800

Prescribing: [Empty]

Referring: [Empty]

Submit

This provider is on file with BlueCross as a TennCare-registered provider.

This provider is NOT on file with BlueCross as a TennCare-registered provider, please visit <https://www.bh.com/providersandproviderservices/registration.html> for more information.

Prior Authorization Requirements Coverage Questions?

Check Medicaid NPI

Prior Authorization Requirements

Coverage Questions?

Patient Cost Estimator

General Exclusions

Member Card

Prior Authorization Requirements

The screenshot shows a web page titled "Prior Authorization Requirements". At the top right, it displays transaction information: "Transaction: 003741-000-Auth-Auth-00000000000000000000", "Date: Mar 21, 2024, 3:08 PM", and "Customer ID: 010201". Below this, member information is listed: "Subscriber: KENNETH HILL", "Member ID: 00000000000000000000", "DOB: 1980-08-08", "Gender: Male", and "Plan/Coverage Start: Jan 01, 2014". The main content area is divided into sections: "CHIROPRACTIC SERVICES" with a note that effective 04/01/2023, chiropractic services do not require authorization; "CHOICES" with a note that all services must be on the member's approved Plan of Care; "DME" with a note that codes and supplies do not require prior authorization; and "OUTPATIENT REHAB / THERAPIES" with a note that prior auth is required for members under age 21. At the bottom right, there are "Close" and "Print" buttons.

Coverage Questions? “Fast Path”

The screenshot shows a pop-up window titled "Contact Payer". The text inside reads: "For more help, contact BlueCross using Fast Path by calling 1-833-FST-PATH (1-833-376-7284) and provide transaction ID 003741 during normal business hours." At the bottom right, there is a "Close" button.

- › Prior Authorization Requirements
- › Coverage Questions / Fast Path

Member Card

Check Medicaid NPI

Prior Authorization Requirements

Coverage Questions?

Patient Cost Estimator

General Exclusions

Member Card

Member Card

BlueCare Tennessee
Kristopher Hall
Member ID: ZECMBCTEST00
Group No. 125000
VER: S.1
Primary Care Provider (PCP): Collins, Kevin L.

BlueCare Tennessee
Effective Date: 04/11/2024
Member DOB: 08/06/1959
Benefit Level: G
Copayments:
PCP \$5
Specialist Visit \$5
ER Visit \$10
Hospital Stay \$5

BlueCare Tennessee
bluecare.bcbst.com
Member Service: 1-800-468-9698
Network Provider Outside Tennessee: 1-800-676-2583 (BLUE)
Provider Service: 1-800-468-9736
Prior Authorization: 1-888-423-0131
Advanced Radiological Imaging Auth: 1-888-693-3211
24/7 Nurseline: 1-800-262-2873

Providers: File all claims with local BCBS Plan.
Prior Authorization is required for certain services. Benefits will not be provided for unauthorized services or for non-emergency services provided by out-of-network providers.

BlueCare Tennessee Claims
Service Center 1 Cameron Hill
Circle Suite 0002
Chattanooga, TN 37402-0002

Members: Always show this card and tell your provider to check for prior authorization. Remember, you get your care from your primary care provider (PCP), listed on the front of this card, except in an emergency. Call your PCP within 24 hours of any emergency care. This card is for identification, not for proof of eligibility. 702 (09/21)

Additional Information

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

BlueCare Member Eligibility & Benefits

Health Benefit Plan Coverage - 30

Active Coverage

Insurance Type: Medicaid
Plan / Product: BLUECARE MIDDLE
Coverage Level: Individual

- FUNDING TYPE = MEDICAID
- NOTE - THIS MEMBER HAS A MEDICAID PLAN. VALIDATE THE NPI(S) INVOLVED IN THIS MEMBER'S CARE TO ENSURE NO DISRUPTION IN CLAIMS PROCESSING.

Information / Details	Individual	Family
Annual Deductible	\$0 / Service Year(s) -\$0 Year to Date	\$0 Remaining \$0 / Service Year(s) -\$0 Year to Date

Benefit Information **Expand**

- Audiology Exam - 71
- Chiropractic - 33
- Dental Care - 35
- Durable Medical Equipment - DM

> Coverage Level

- Funding Type = Medicaid
- Note – Validate the NPI(s) involved
 - Check Medicaid NPI button on previous slide

> Deductible

> Benefit Information

Commercial Member Eligibility & Benefits

HALL, CHRIS B
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402

Member Status: Active Coverage | Date of Birth: Aug 6, 1959 | Gender: Male | Current Plan Effective Date: Jan 1, 2019 - Dec 31, 2199 | Relationship to Subscriber: Self

[Prior Authorization Requirements](#) | [Coverage Questions?](#) | [Patient Cost Estimator](#) | [General Exclusions](#) | [Member Card](#)

Member ID: GM902218823 | Group Number: 100000 | Group Name: CHRIS B HALL ENTERPRISES | Plan Begin Date: Jan 1, 2024

Payer: BCBS TENNESSEE

Other or Additional Payer Information
Secondary Payer
Payer: NO OTHER INSURANCE
Group or Policy Number: NOTPROVIDED
COB Date: Apr 6, 2024

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

Health Reimbursement Account (HRA)

Plan Maximums and Deductibles

Health Benefit Plan Coverage - 30

Insurance Type: Preferred Provider Organization (PPO)
 Plan / Product: HRA (NETWORK P)
 Coverage Level: Employee and Children
 FUNDING TYPE: COMMERCIAL

Information / Details	Individual	Family
Annual Deductible	\$2,500 / Calendar Year(s) -\$301.58 Year to Date	\$2,100.42 Remaining \$1,000 / Calendar Year(s) -\$301.58 Year to Date
Out Of Pocket	\$1,000 / Calendar Year(s) -\$401.97 Year to Date	\$4,500.01 Remaining \$10,000 / Calendar Year(s) -\$401.97 Year to Date

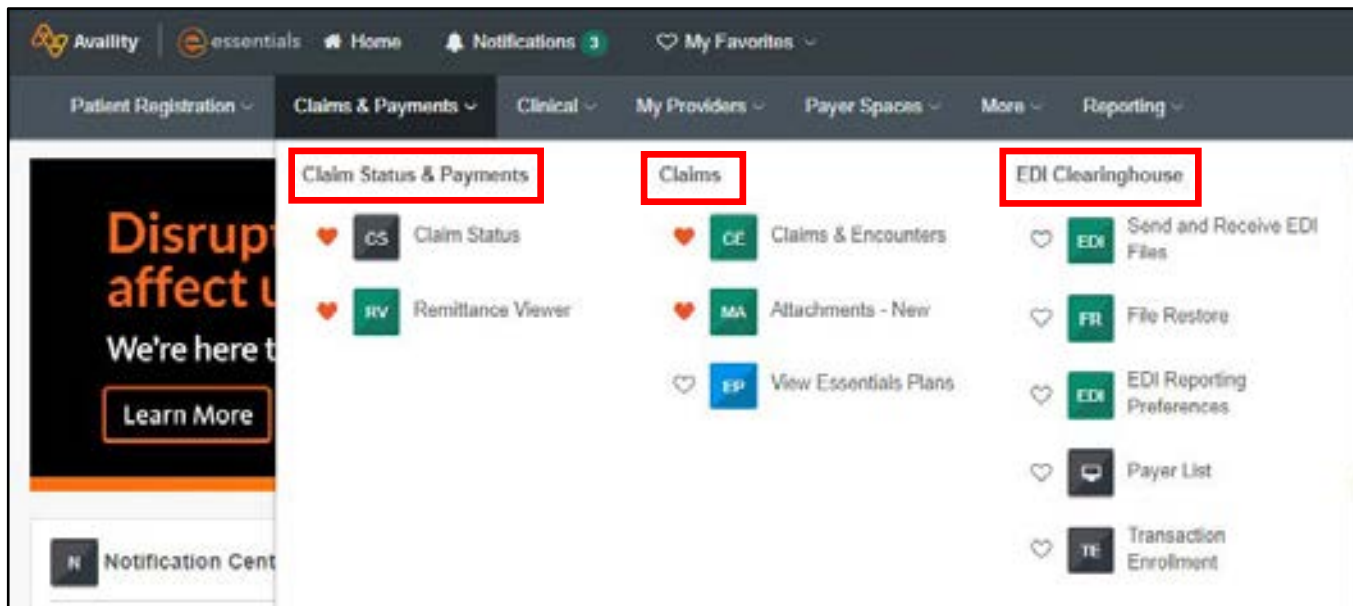
Benefit Descriptions

Plan / Product: HRA (NETWORK P) Coverage Level: Individual • HRA BALANCE	\$1,800 / Calendar Year(s)
Plan / Product: HRA (NETWORK P) Coverage Level: Individual • HRA BALANCE REMAINING	\$1,800.73 / Remaining
Plan / Product: HRA (NETWORK P) Coverage Level: Individual • HRA DEDUCTIBLE	\$200 / Calendar Year(s)

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

Plan / Product: HRA (NETWORK P) Coverage Level: Individual • HRA DEDUCTIBLE REMAINING	\$0 / Year(s)
Plan / Product: HRA (NETWORK P) Coverage Level: Family • HRA BALANCE	\$3,000 / Calendar Year(s)
Plan / Product: HRA (NETWORK P) Coverage Level: Family • HRA BALANCE REMAINING	\$3,400.73 / Remaining
Plan / Product: HRA (NETWORK P) Coverage Level: Family • HRA DEDUCTIBLE	\$500 / Calendar Year(s)
Plan / Product: HRA (NETWORK P) Coverage Level: Family • HRA DEDUCTIBLE REMAINING • HRA BALANCE • MEMBER • MEMBER PAYS FIRST • HRA REIMBURSES AT 80% OF THE FOLLOWING COST SHARES (WHERE APPLICABLE) • HRA REIMBURSABLE FOR COPY/NO • HRA REIMBURSABLE FOR CONSULTANCY/NO • HRA REIMBURSABLE FOR DEDUCTIBLE/YES	\$200 / Year(s)

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

The screenshot shows the Availity Multi-Payer Claim Status search interface. At the top, there is a navigation bar with links for Home, Search, and a feedback button. Below the navigation bar, the main heading is "Claim Status". The search form includes several fields: Organization (set to "eBusiness Marketing Claims - Fall"), Payer (set to "BCBS TENNESSEE"), Member, Service Dates, Check Number, Claim Number, and HIPAA Standard. There are also fields for Provider Tax ID (set to "4200200"), Select a Provider (set to "ABC State Group"), Provider NPI (set to "123456789"), Payer Assigned Provider ID, and Service Dates (set to "03/01/2024" to "03/08/2024"). A dropdown menu for Claim Status is open, showing options: All, Pending, Rejected, Denied, and Paid. The interface also includes a "Need help? Learn More" link and a "Claim Status Version 2.0" label.

Search By:

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

Claim Status

Claim Status Get Feedback

[Export to CSV](#) [Print this Page](#) [Return to Results](#) [New Search](#) [Edit Search](#)

[View EOB](#) [Message this Payer](#) [Dispute Claim](#)

Patient Information

Patient: Subscriber ID 98110001 **Patient Account Number:** Gender M

Claim Information

Status: DENIED **Line of Business:** SA01
Service Dates: 03/01/2024 - 03/01/2024 **Total Billed:** \$147.00
Received Date: 03/01/2024 **Total Paid:** \$0.00
Claim Number: **Total Patient Responsibility:** \$0.00

Payment Information

Check/EFT #: **Payment Date:** 03/07/2024
Provider ID: **Payee Provider ID:**

Line Level Information

Service Dates	Procedure Codes	Reason/Remark Code	Billed	Paid	Allowed	Not Covered	Deductible	Co-insurance	Co-Pay
03/01/2024 03/01/2024	99213	ZYC	\$147.00	\$0.00	\$0.00	\$147.00	\$0.00	\$0.00	\$0.00

- › 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.

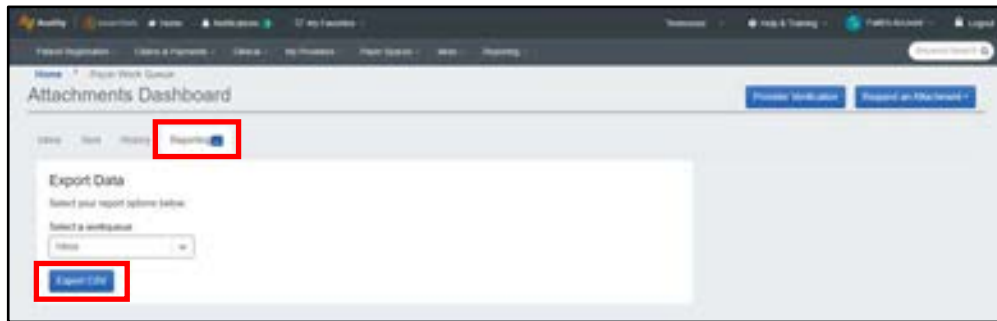
➤ Coming soon: Solicited Attachments for claims that have been previously processed.

Solicited Attachments

Request	Patient	Plan	Provider	Details
<p>Attachment due in 8 days</p> <p>REQUEST NUMBER PRODUCTCATEGORY TYPE STATUSDATE</p>	<p>PATIENT LAST, FIRST NAME DATE OF BIRTH SUBSCRIBER ID PATIENT ACCOUNT NUMBER</p>	<p>Health Plan Name</p>	<p>PROVIDER NAME PROVIDER IDENTIFIER PROVIDER IDENTIFIER</p>	<p>\$ CLAIM AMOUNT ④ SERVICE FROM DATE ④ SERVICE TO DATE ④ CLAIM NUMBER</p> <p>Solicit Attachment</p>
<p>Attachment due in 8 days</p> <p>REQUEST NUMBER PRODUCTCATEGORY TYPE STATUSDATE</p>	<p>PATIENT LAST, FIRST NAME DATE OF BIRTH SUBSCRIBER ID PATIENT ACCOUNT NUMBER</p>	<p>Health Plan Name</p>	<p>PROVIDER NAME PROVIDER IDENTIFIER PROVIDER IDENTIFIER</p>	<p>\$ CLAIM AMOUNT ④ SERVICE FROM DATE ④ SERVICE TO DATE ④ CLAIM NUMBER</p> <p>Solicit Attachment</p>
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<p>Attachment due in 14 days</p> <p>REQUEST NUMBER PRODUCTCATEGORY TYPE STATUSDATE</p>	<p>PATIENT LAST, FIRST NAME DATE OF BIRTH SUBSCRIBER ID PATIENT ACCOUNT NUMBER</p>	<p>Health Plan Name</p>	<p>PROVIDER NAME PROVIDER IDENTIFIER PROVIDER IDENTIFIER</p>	<p>\$ CLAIM AMOUNT ④ SERVICE FROM DATE ④ SERVICE TO DATE ④ CLAIM NUMBER</p> <p>Solicit Attachment</p>

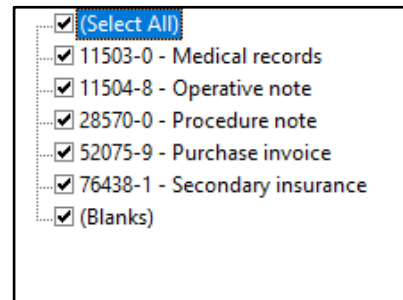
- Inbox is for incoming attachment requests.
 - Each row has a claim number listed and an attachment request assigned.
- Sent shows the submitted requests.
- History provides the history of submissions.
- Reporting allows filtering of data and will be shown on the next slide.

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



Applications **1** Resources News and Announcements Sort By A-Z

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

Advanced Specialty Drug Billing - TransactRx Authorization Submission/Review BlueCare Journey Reports Review reporting for the BlueCare

Applications Resources **2** News and Announcements Sort By A-Z

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Filter By Category Advanced Specialty Benefit Management TransactRX FAQ

Applications Resources News and Announcements **3**

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

Behavioral Health Providers - Please Renew Your Contracts

If you have not received your recent contract update email, please contact your Provider Network Manager. We want to make sure your information is correct, so members can find you and we can provide the best service to your practice.

- 1 Applications
- 2 Resources
- 3 News and Announcements

PAYER SPACES

Applications

Applications Resources News and Announcements Sort By A-Z

THESE LINKS MAY RE-DIRECT TO THIRD-PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD-PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

- Advanced Specialty Drug Billing - TransactRx**
Submit your claims for provider-administered specialty drugs via TransactRx.
- Authorization Submission/Review**
Submit and Review authorizations for BlueCross BlueShield of Tennessee
- BlueCare Journey Reports**
Review reporting for the BlueCare Journey program
- BlueCare PCP Maintenance**
Review and maintain your BlueCare & TennCare Select patient populations
- BlueCare PCP Member Roster**
Review your assigned members
- CHOICES & ECF Claim Submission**
Submit claims for CHOICES and ECF members.
- Contact Preferences & Communication Viewer**
Update your contact information and view your important messages and documents
- Fee Schedule Viewer**
View your fee schedules for BlueCross contracts
- Health Starts TN**
Initiative to test and improve the value returned from addressing social needs.
- Medication Assisted Treatment**
Review your BESMART Quality Metrics Report - Q1 2024 Reports are now available
- National Consumer Cost Tool Reports**
Q1 2024 Data available - Review data submitted for member cost tool
- Print/View Your Remittance Advice**
Review and print copies of your legacy remittance advices

- Provider Enrollment, Updates, and Changes**
We are waiving EFT requirements for provider enrollment. See News and Updates
- Quality Care Rewards (QCR Platform)**
Review gaps and track incentives for providing quality care.
- RC Claim Assist**
Provides data needed to correctly bill drugs administered under medical benefits
- Real Time Claims Adjudication**
Estimate liability and submit claims for BCBS Tennessee medical plans.
- THCII Reporting**
Episodes of Care Q1 2024 Reports will be available 02/15/2024
- THCII TN Health Link Enrollment**
Enroll BlueCare members eligible for THL to your organization.

Authorization Submission/Review

The screenshot shows the 'Submit Outpatient' form in the BlueCross of Tennessee system. The sidebar on the left contains various service categories, with 'Outpatient' selected. The main form area is titled 'Submit Outpatient' and includes a 'Select Patient Information' section. This section contains a table of patient details and a search field for the patient ID.

This is an Outpatient Notification/Authorization/Advance Determination for:	
Name:	CHAS HILL
Member ID:	902218023
Group ID:	100000
Birth Date:	06-06-1956
Age:	68
Address:	1 CAMERON HILL CIRCLE CHAT SWINGGA, TN 37402
Phone:	423833005
Digitel:	Yes

Requested Date of Service: 06/19/2024

To Select a Patient, Search by ID Number:

Patient ID: 902218023 0

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

PAYER SPACES

Initial Authorization Submission

If your request is regarding an urgent review, outside of normal business hours and you need an immediate response, please submit this request via phone at 1-800-924-7141. Otherwise, your request will be reviewed the next business day.

Patient Information
Patient ID: 902218823
Patient Name: Kirby Hall
To assist in member outreach, please provide the patient's phone number.
Patient Phone:

Requesting/Treating Provider
Provider ID:

Facility
(not required if same as requesting/treating provider)
Facility ID:

Service Information
Requested Date of Service:
Place of Service:
Type of Care:

Diagnosis Code(s)

ICD Code (No Decimals)	Description
<input type="text" value="1039"/>	<input type="text" value="Abnormal uterine and vaginal bleeding, unspecified"/>

Procedure Codes
Enter Only 5-digit procedure code, do not enter any modifiers

Procedure Code	Code	Description
<input type="text" value="58150"/>	<input type="text" value="58150"/>	<input type="text" value="Total abdominal hysterectomy with or without removal of tubes or"/>

Contact Information
Contact Name:
Provider Phone: Extension:
Facility Phone: Extension:
Contact Fax:
Submitting From: Facility Physician's Office

Attach Clinical Information
Only PDF, TIFF, and JPEG files. Each file will be limited to 5 MB. Only alphanumeric and underscores are allowed. Spaces are not allowed.
 (No file chosen)

PAYER SPACES

Milliman Care Guidelines (MCG)

Authorization Request Request Form 3 Document Clinical 3 Submit Request

mcg

Patient: 6709795 - Name: Hill, Kristy - DOB: 06/15/2009 - Gender: Female show more

Authorization: TEMP-0199958 - Type: Procedure Pre-authorization - Status: Authorization Has NOT Been Submitted show more

Diagnosis Codes: N93.91CD-10 Diagnosis: primary - Procedure Codes: S8150(OPT)(HCPCS) primary

Geographic Regions: All Clear

Procedure Code: S8150 (OPT)(HCPCS)
Requested Units: 1

Document Clinical

Submit Request Cancel Request Back

Authorization Request Request Form 3 Document Clinical 3 Submit Request

mcg

Patient: 6709795 - Name: Hill, Kristy - DOB: 06/15/2009 - Gender: Female show more

Authorization: TEMP-0199958 - Type: Procedure Pre-authorization - Status: Authorization Has NOT Been Submitted show more

Diagnosis Codes: N93.91CD-10 Diagnosis: primary - Procedure Codes: S8150(OPT)(HCPCS) primary

Geographic Regions: All Clear

Procedure Code: S8150 (OPT)(HCPCS)
Requested Units: 1

Guideline Title	Product	Code	Action
Gender Reassignment Surgery - Medical Policy	AC	S808T	add
Hysterectomy, Abdominal	ISC	S-650	add
No Guideline Applies			

- Click Document Clinical.
- Click Add Guideline.

PAYER SPACES

Milliman Care Guidelines (MCG)

- Select all clinical criteria.
- Click Save.

Geographic Regions: All Clear

Procedure Code: 58150 (CPT/HCPCS)
Requested Units: 1

5-650 - Hysterectomy, Abdominal - (ISC)

The procedure is/was needed for appropriate care of the patient because of ...

- Abnormal uterine bleeding and ...
 - Investigation (eg, hysteroscopy, imaging) has not identified specific etiology of abnormal uterine bleeding (eg, endometrial intraepithelial neoplasia, leiomyoma) ⓘ
 - Medical therapy (eg, intrauterine delivery system, systemic hormonal therapy, tranexamic acid) cannot be used because of ...
 - Uterine-sparing procedure (eg, endometrial ablation) cannot be used because of ...
- Cervical cancer or adenocarcinoma in situ ⓘ
- Cervical intraepithelial neoplasia (CIN), as indicated by ...
- Endometrial or other uterine cancer ⓘ
- Ovarian, fallopian tube, or primary peritoneal cancer ⓘ
- Endometrial intraepithelial neoplasia ⓘ
- Endometriosis and ...
- Adenomyosis and ...
- Malignant gestational trophoblastic disease and ...
- Gynecologic cancer prevention for patient with ...
- Leiomyoma ("fibroid") and ...
- Pelvic organ prolapse and ...
- Pelvic pain and ...
- Tubo-ovarian abscess and ...
- Vesicouterine fistula not amenable or refractory to repair ⓘ
- Severe bleeding (eg, postpartum or other hemorrhage) or uterine abnormality (eg, rupture) that cannot be controlled by conservative care ⓘ

Save Cancel

PAYER SPACES

Milliman Care Guidelines (MCG)

The screenshot shows the 'Authorization Request' form in the MCG system. At the top, there is a progress bar with three steps: 'Request Form' (completed), 'Document Clinical' (completed), and 'Submit Request' (current step, indicated by a red circle with the number 3). The patient information is: Patient: 6709795, Name: Hall, Krissy, DOB: 06/15/2009, Gender: Female. The authorization details are: Authorization: TEMP-01595958, Type: Procedure Pre-authorization, Status: Authorization Has NOT Been Submitted. The diagnosis code is N93.9(CD-10 Diagnosis) and the procedure code is 58150(CPT/HCPCS). The geographic region is set to 'All'. The procedure code 58150(CPT/HCPCS) is highlighted with a green checkmark, and the requested units are 1. A red box highlights the 'Submit Request' button. Below the form, there is a disclaimer: 'This system provides access to MCG evidence-based guidelines; however the determinations made using this system are directed by the health plan, based on a number of factors.'

The screenshot shows the 'Durable Medical Equipment (DME) Confirmation' page. The submission has been accepted and approved. The case number for the submission is 4000000. The confirmation message states: 'Your submission has been accepted and approved. Your case number for this submission is 4000000. An authorization is not a confirmation of coverage or benefits. Available benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered. Review & print for your records.' A yellow banner at the bottom says: 'Please click here to start a new authorization. Do not use the back button.' The 'Patient Information' section is visible at the bottom.

The screenshot shows the 'Durable Medical Equipment (DME) Confirmation' page. The submission has been accepted and is pending. The case number for the submission is 4000000. The confirmation message states: 'Your submission has been accepted and is pending. Someone will contact you with a decision. Your case number for this submission is 4000000. Please check later for case process status. Review & print for your records.' A yellow banner at the bottom says: 'Please click here to start a new authorization. Do not use the back button.' The 'Patient Information' section is visible at the bottom.

- Submit Request.
- Confirmation including Authorization number.

Auth Inquiry / Clinical Update Search

of Tennessee

Home

Authorization / Advance Determination Submission

Auth Inquiry/Clinical Update

BCEST

MSK

HTI

NIA - MAGELLAN

Genetic Testing Submission/Inquiry(Commercial Only)

Oncology/Radiology Submission/Inquiry(Commercial Only)

Authorizations

Find Authorizations by Provider, Member and Date Range

Provider* Select

Member* Member

From Date * - To Date * 12/25/2023 - 06/25/2024

Reset Search

Find Authorizations by Case/Confirmation number

Confirmation number Case ID

Reset Search

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

Auth Inquiry / Clinical Update Search

The screenshot displays the 'Authorizations' section of the BlueCross of Tennessee portal. It features two search filters: 'Find Authorizations by Provider, Member and Date Range' and 'Find Authorizations by Case/Confirmation number'. The 'Inpatient' section shows 'No inpatient authorizations found'. The 'Outpatient' section contains a table with one entry. Red boxes highlight the 'Case ID' column and the 'Status', 'Requesting Provider', and 'Servicing Provider' columns.

Patient Name	Patient ID	Case ID	From - To Date	Service Description	Status	Requesting Provider	Servicing Provider
CHRIS HALL	9027180	45000000	03/05/2024 - 03/30/2024	PRICE MOD REG Oxygen concentrator, single delivery port, capable of delivering 35% oxygen concentration at prescribed flow rate	Fully Approved	Harry Potter	Harry Potter

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

Auth Inquiry / Clinical Update Search

The screenshot displays the BlueCross of Tennessee Payer Spaces interface. The left sidebar contains navigation options: Home, Authorization / Advance Determination Submissions, Auth Inquiry/Clinical Update, BCBS, MDK, HTI, NA - MAGELLAN, Details, Testing Submissions/Inquiry(Commercial Only), and Denials/Exclusions Submissions/Inquiry(Commercial Only). The main content area is divided into several sections:

- Inpatient Stay Information:**
 - Patient Information:** Patient: CHRIS HALL, Member ID: 96219823
 - Authorization:** Authorization ID: 415000000, Authorization Status: Fully approved
 - Case Details:** Admitted: 01/09/2024, Expected Discharge: 01/15/2024, Requested LOS: 6, Approved LOS: 6
- Letter Details:** Letter Date Time: 2024-02-02 15:55, Issued By: Chris.Hall
- Facility and Provider:**
 - Facility:** Name: Harry Potter, ID: 1234567, Address: 1 Cameron Hill Circle, City: Chattanooga, State: TN, Zipcode: 37401
 - Provider:** Name: Harry Potter, ID: 1234567, Address: 1 Cameron Hill Circle, City: Chattanooga, State: TN, Zipcode: 37401

- › Letter Details
- › Authorization Status

PAYER SPACES

Clinical Update

Clinical Update Information

Please include all clinical information supportive of the request. LIST ALL PERTINENT INFORMATION SUCH AS: current medical status, activity, diet, medications with dosages, pain scale, physician orders, physician treatment plan, applicable office and/or inpatient progress notes, inpatient and/or outpatient treatment(s) including any special treatments such as alternative therapies or treatment, all pertinent lab values, and any other supportive information.

Contact Information

Name*

Phone*

Fax*

Service Information

Note Type*
Additional Information Only
DRG Update
Discharge Date

Only PDF, TIFF, and JPEG files that total < 5,000 KB are allowed. Only alphanumeric characters and underscores are allowed in file names. Spaces are not allowed.

No file chosen

› Update Existing Authorizations

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

PAYER SPACES

BlueCare PCP Maintenance

♥ BlueCare PCP Maintenance

Review and update BlueCare, TennCare Select, & BlueCare Plus patient populations

› BlueCare, TennCareSelect and BlueCare Plus patient populations

If the member has moved, please ask them to update their address with TennCareSM by calling TennCare Connect at 1-855-259-0701.
For urgent requests, please call Customer Service toll-free at 1-800-468-9736 for BlueCare, 1-800-276-1978 for TennCareSelect, or 1-800-924-7141 for CoverKids.

Please select the most appropriate option from the dropdown box below which will direct you to the desired path to update a member's PCP or review your PCP member roster.

I would like to

Select...

Change Member PCP

Review/Print My PCP Roster

Continue

Change Member PCP Details

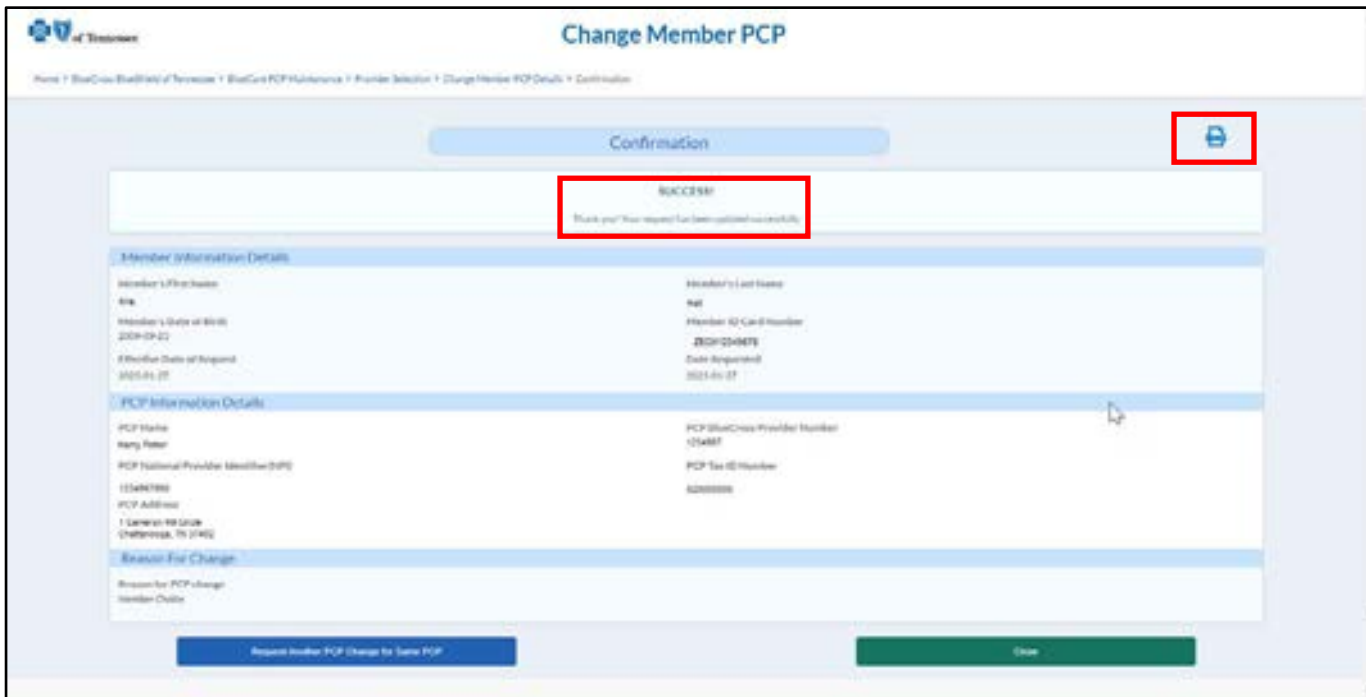
The screenshot shows a web form titled "Change Member PCP Details". It is divided into several sections:

- Member Information:** Contains three input fields: "Member ID (Card Number)" with the value "MB027510" (callout 1), "Effective Date of PCP Change" with a dropdown menu showing "06/01/2024" (callout 2), and "Requested Date" with a dropdown menu showing "06/01/2024" (callout 3). Below these are fields for "Member's First Name" (Dora), "Member's Last Name" (M), and "Date of Birth" (03/01/1971). A "Find Member" button is located to the right of the "Requested Date" field.
- New PCP Information:** A table with three columns: "PCP Name" (Mary Peller), "PCP Address" (1 Campus Hill, Chattanooga, TN 37401), "PCP Specialist Provider Number" (1234567), and "PCP National Provider Identifier (NPI)" (123456789).
- Reason For Change:** A section with a dropdown menu for "Member Choice" and a "Provide App Reason(s)" field.
- Authorization:** A section with a radio button for "By checking this box, I attest that I have:" and a list of checkboxes: "Read and understood the disclosure above", "Authorized to change members to this PCP (card above)", and "I understand patient records to which the member agrees to the PCP change as requested on this form". A "Save" button is at the bottom right (callout 5).

- 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](mailto:Fax_pcp@bcbst.com)

Payer Spaces

Review/Print My PCP Roster

♥ BlueCare PCP Maintenance

Review and update BlueCare, TennCare Select, & BlueCare Plus patient populations

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

If the member has moved, please ask them to update their address with TennCare by calling TennCare Connect at 1-855-259-0701. For urgent requests, please call Customer Service toll-free at 1-800-468-9736 for BlueCare, 1-800-276-1978 for TennCareSelect, 1-800-924-7141 for CoverKids, or 1-800-299-1407 BlueCare Plus.

Please select the most appropriate option from the dropdown box below which will direct you to the desired path to update a member's PCP or review your PCP member roster.

I would like to

Select...

Change Member PCP

Continue

Review/Print My PCP Roster

Payer Spaces

BlueCare PCP Roster

The screenshot shows the BlueCross BlueShield Tennessee website's PCP Member Roster Search page. The header includes the logo and contact information: "Blue Cross Blue Shield Tennessee, 1 Cannon Hill Circle, Chattanooga, TN 37403, www.bcbst.com". The main section is titled "PCP Member Roster Search" and contains a search form with the following fields and options:

- Provider:** A dropdown menu with "1234567" selected. To the right, it says "Sort by: Provider ID / Provider Name".
- Line of Business:** A list of checkboxes with the following options: BlueCare (checked), TennCareSelect (checked), SNTS (checked), BlueCarePlus (checked), and Crosswalk (checked).
- Real Time Roster:** A checkbox for "Current Members" (checked).
- Report Type (Updated Weekly):** Radio buttons for "Previously Assigned Members", "Members Transferred from Provider", and "Disenrolled Members".

A blue "Search" button is located at the bottom right of the search form. Below the form, there is a disclaimer: "Disclaimer: The Real Time Roster pulls current data. Please note the reports are updated weekly and may not reflect the most recent changes." This is followed by a note: "Note: Eligibility changes are constantly occurring with new members being added, members changing their PCP, members having coverage changes and members dropping from the plan." Further down, there is contact information for questions regarding PCP assignment and technical support. At the bottom, there is a footer: "BlueCare Tennessee and BlueCare, Independent Licensees of BlueCross BlueShield Association. BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association. BlueCare Plus Tennessee is an HMO SNP plan with a Medicaid contract and a contract with the Tennessee Medicaid program. Enrollment in BlueCare Plus Tennessee depends on contract renewal."

PAYER SPACES

Print / View Your Remittance Advice

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

BlueCross of Tennessee

Remittance Advice

[New Search](#) Main Menu

Remittance advices are available on a rolling 18 month basis.

Show 10 entries Search

Payee #	Payee Name	Tax ID #	Remit Date	Line of Business	Check Number	Paid Amount	Remit #	NPI #	Acción
1234567	ABC Medical Group	620000000	02/10/23	B223	N/A	\$1,236.00	12345678901234	1234567890	
1234567	ABC Medical Group	620000000	02/09/23	MV01	N/A	\$435.00	12345678901234	1234567890	
1234567	ABC Medical Group	620000000	02/03/23	B223	N/A	\$3,236.00	12345678901234	1234567890	

PAYER SPACES

Provider Enrollment, Updates and Changes

Provider Enrollment, Updates, and Changes

We are waiving EFT requirements for provider enrollment. See News and Updates

Helpful info and Pre-Requirements for Enrollment

- Before enrolling, individual providers should register for their CAQH (Out-of-network providers).
- Please make sure all your addresses and supporting documents (licenses, certifications, etc) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
- Find out more about our Medicaid ID requirements at [myperformance](#).

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 networked 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 US-04.
- Ancillary** for updates if you file claims with a CHS-2500 or US-04.

AND

Request Type (Select One):

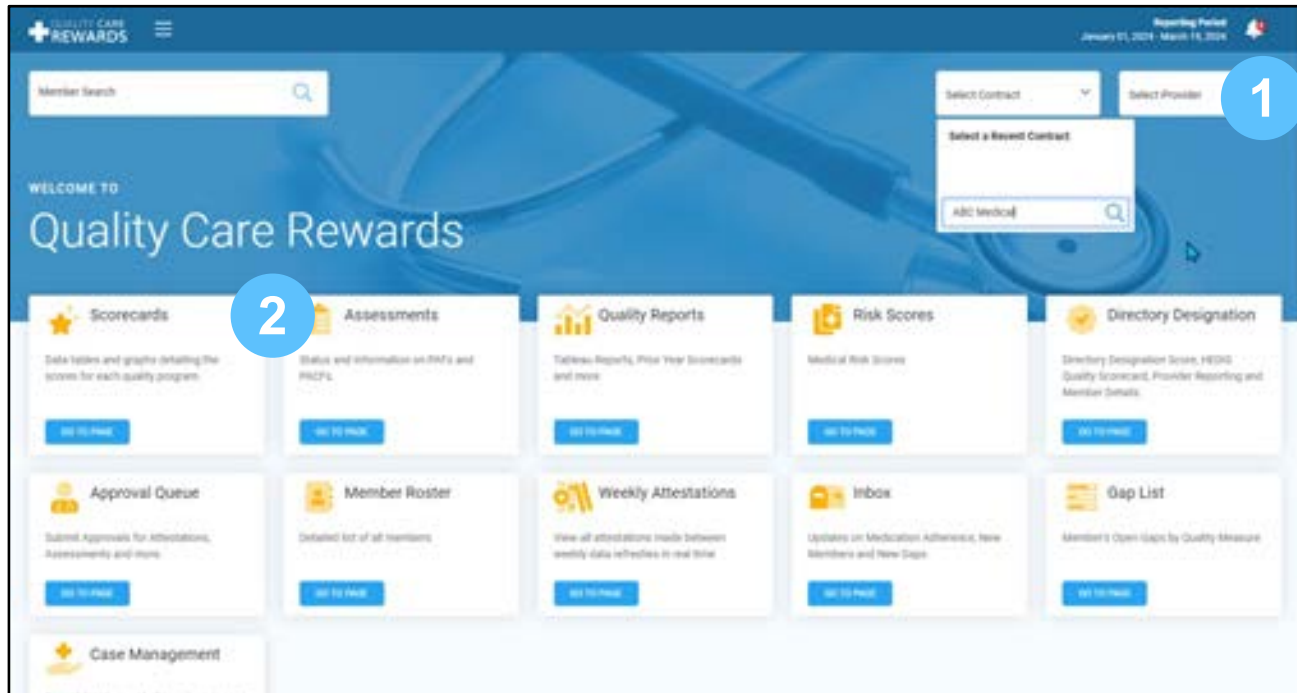
- Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- Network Verification** 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**.

BCBST will not differentiate or discriminate in the treatment of practitioners or organizations seeking credentialing on the basis of race, ethnic/racial identity, gender, age, sexual orientation, religion, patient type (e.g. Medicaid) in which the practitioner specializes.

- › 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.

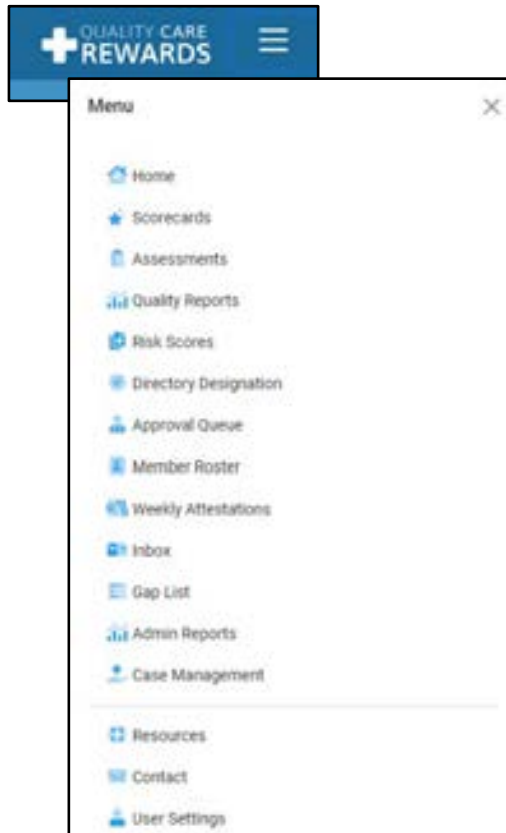
PAYER SPACES

Quality Care Rewards (QCR)



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

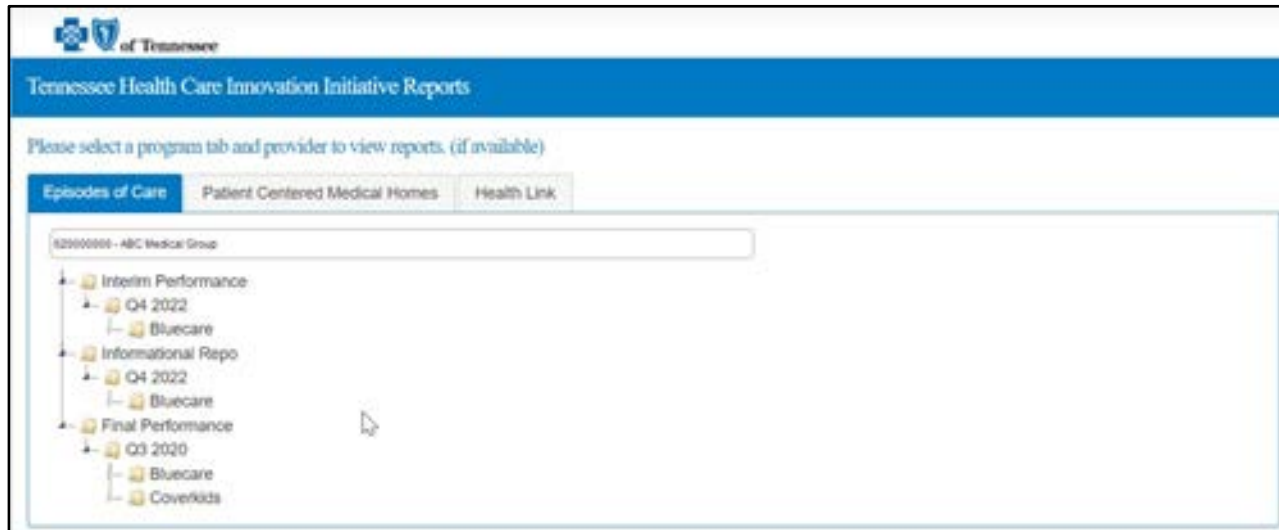
QCR Navigation



- › 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 \(tn.gov\)](https://www.tn.gov/episodes-of-care)
- Sign up for newsletters: [State of Tennessee \(formstack.com\)](https://www.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

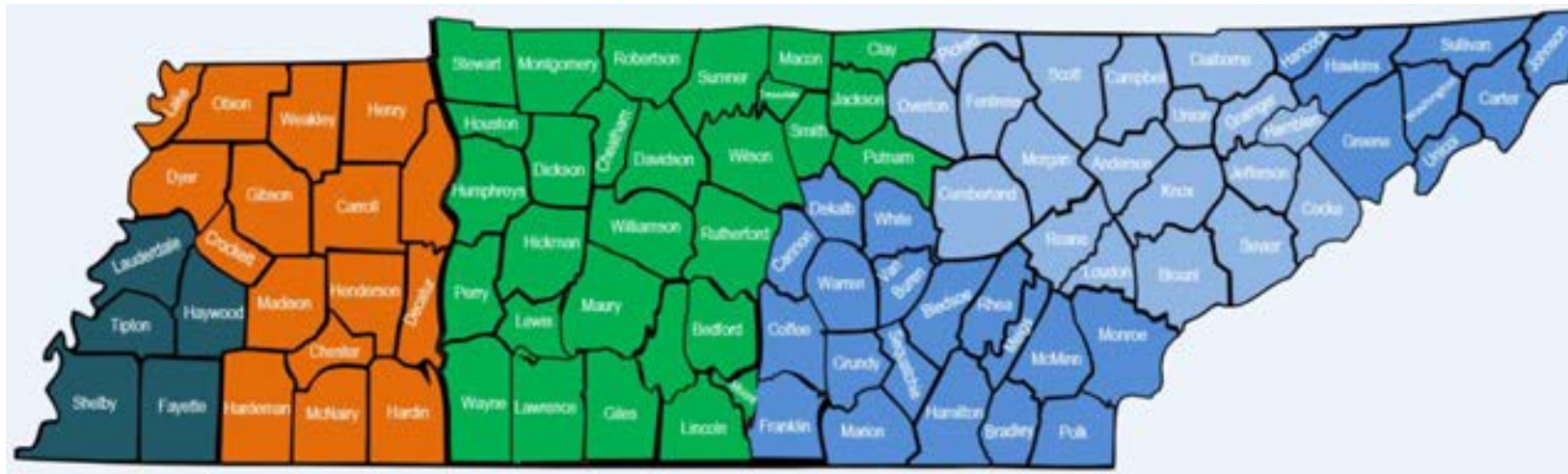
Faye_Mangold@bcbst.com

Faith Daniel

East Tennessee
Chattanooga, Knoxville, Tri-Cities

(423) 535-6796

Faith_Daniel@bcbst.com



Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association



GENERAL SESSION

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

CAQH PROVIEW HOSPITAL AFFILIATION

Hospital Affiliation

HOSPITAL AFFILIATIONS Import

* Required fields are indicated with a red asterisk. All other fields are optional.

If there are hospitals where you have current or pending admitting privileges, current or pending arrangements, or a different non-admitting affiliation, enter them below.

Admitting Privileges
Add if you can admit patients on an unrestricted, limited, or temporary basis. This also includes hospitals where you have pending admitting privileges.

Enter an admitting privilege Add

Admitting Arrangements
Add if you have an admitting arrangement where another provider or hospitalist group admits for you. This also includes hospitals where you have pending admitting arrangements.

Enter an admitting arrangement Add

Admitting Privilege Record Back to List

* Required fields are indicated with a red asterisk. All other fields are optional.

Please enter the details of your Admitting Privilege Record. An admitting privilege means that you can admit patients on an unrestricted, limited or temporary basis.

* **State** TN **Country** United States

* **Hospital Name**
--Select--
Acension Saint Thomas Behavioral Health Hospital
Acension Saint Thomas DeKalo
Acension Saint Thomas Hickman
Acension Saint Thomas Highlands
Acension Saint Thomas Hospital

Start Date

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.

Admitting Privilege Record [Back to List](#)

* Required fields are indicated with a red asterisk. All other fields are optional.

Please enter the details of your Admitting Privilege Record. An admitting privilege means that you can admit patients on an unrestricted, limited or temporary basis.

* State: TN Country: United States

* Hospital Name: Other Other Hospital Name: Erlanger Med Center

* Street 1: 123 East Third Street Street 2: White Hall Building

* City: Chattanooga

* Zip Code: 37412

* Phone Number: 425-555-1234 Fax Number:

Best Practice

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

Admitting Privilege Record [Back to List](#)

* Required fields are indicated with a red asterisk. All other fields are optional.

Please enter the details of your Admitting Privilege Record. An admitting privilege means that you can admit patients on an unrestricted, limited or temporary basis.

* State: Country:

* Hospital Name:

975 East Third Street
Chattanooga, TN 37403-2147
Phone: 423-778-7000
Fax: 423-778-7196

* Is this your primary hospital?
 Yes
 No

* Admitting Privilege Status
 Active
 Inactive
 Pending

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

The screenshot shows the 'PRACTICE LOCATION' form in the CAQH Proview system. The form is divided into several sections, with red boxes highlighting the following areas:

- Physical Address:** Includes fields for Street Address, City, State, and Zip.
- Appointment Phone:** Includes fields for Appointment Phone Number and Appointment Hours.
- Business Identifiers:** Includes fields for Tax ID and NPI.
- Organization (Type 2) NPI:** Includes fields for Organization Name and NPI.
- Practice Affiliation:** Includes a table with columns for Name, Address, and Affiliation.

CAQH PROVIEW PRACTICE LOCATION

Confirm Affiliation - Address

Confirm Affiliation

To ensure that directories show accurate information about you, please confirm or update your answer to the affiliation question below.

* Required fields are indicated with a red asterisks. All other fields are optional.

* Please describe your affiliation with this location

I cover or fill-in for colleagues within the same medical group on an as needed basis

I don't know

Cancel Confirm

* Required fields are indicated with a red asterisks. All other fields are optional.

* Please describe your affiliation with this location

I cover or fill-in for colleagues within the same medical group on an as needed basis

Select

This location should appear in a directory because...

I see patients by appointment at least one day per week on a regular basis

This location should not appear in a directory because...

I see patients by appointment at least one day per month, but less than one day per week on a regular basis

I see patients at this location, but not by appointment

I cover or fill-in for colleagues within the same medical group on an as needed basis

I read tests, perform imaging, or provide other services as my primary function at this

- › 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.

CAQH PROVIEW PRACTICE 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.

Address Standardization ✕

The address you entered has been standardized. Please confirm that the suggested address is correct.

You entered 2333 McCallie Avenue Suite 2 Chattanooga, TN 37412	Standardized Address 2333 McCallie Ave Ste 2 Chattanooga, TN 37404-3258
---	---

[Continue](#) [Not now](#)

Consolidated Appropriations Act – Directory Suppression

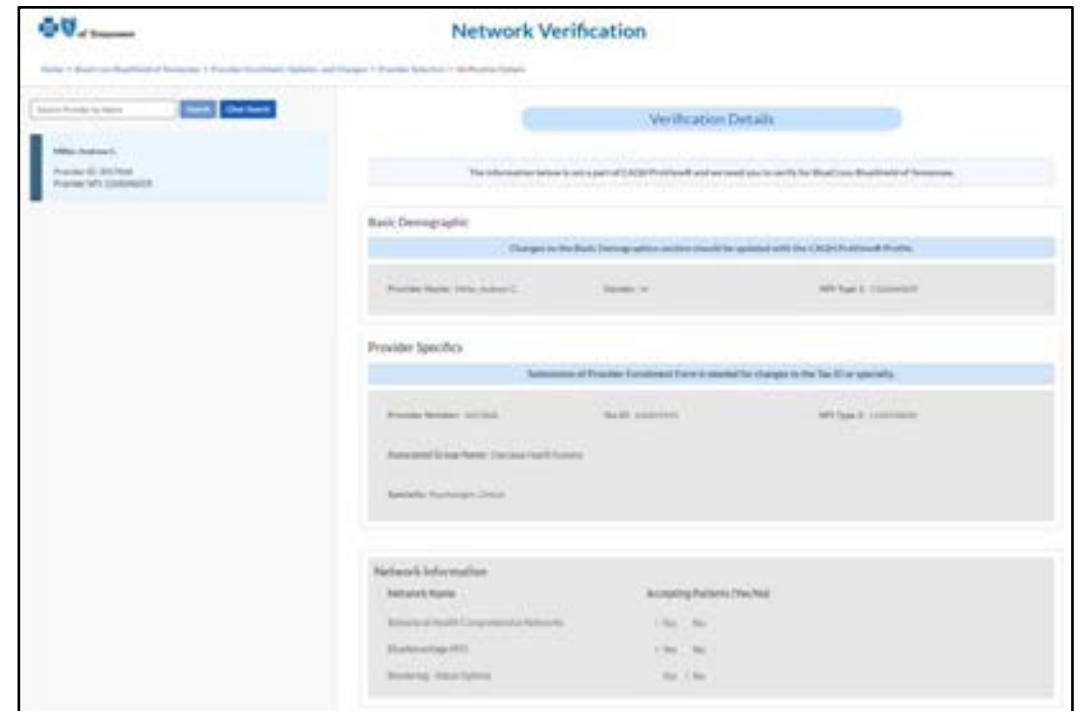
Directory Suppression

- › 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.



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

BLUECROSS 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.

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.

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.

BLUECROSS ENROLLMENT PROCESS

Questions?

- › Providers with questions should contact [Contracts Reqs GM@bcbst.com](mailto: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.



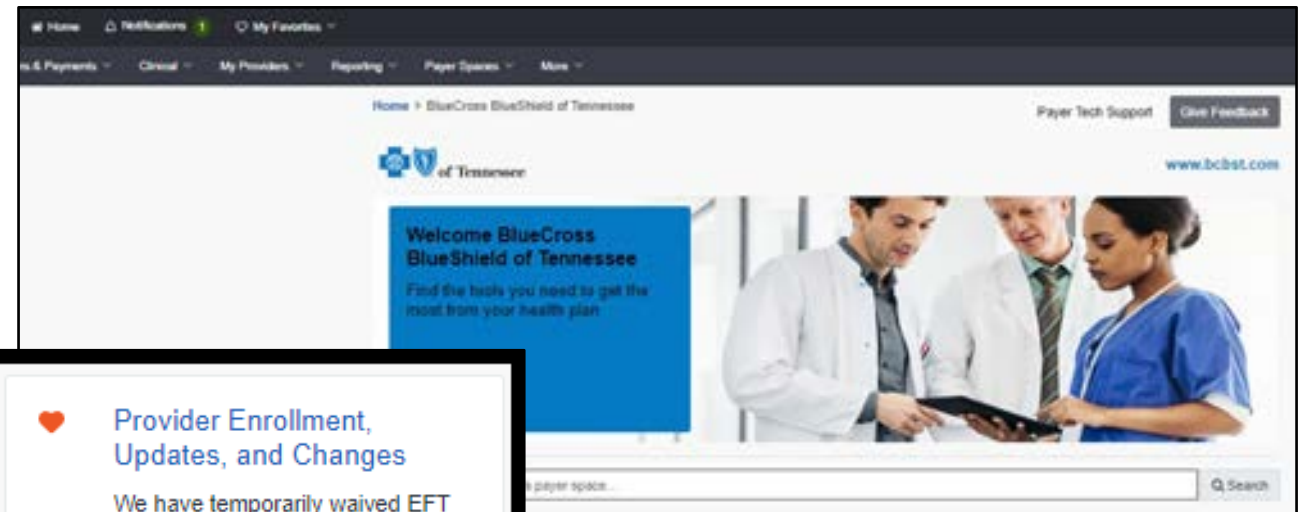
Provider Portal

- › 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.



♥ [Provider Enrollment, Updates, and Changes](#)

We have temporarily waived EFT enrollment requirements. See [News/Announcements](#)

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.

Helpful Hints and Pre-Requisites for Enrollment

- Before enrolling, individual providers should register for their CAQH ID at caqh.org/providers.
- Please make sure all your addresses and supporting documents (licenses, certifications, etc.) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
- Find out more about our Medicaid ID requirements at tn.gov/tenncare.

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**

BCBST will not differentiate or discriminate in the treatment of practitioners or organizations seeking credentialing on the basis of race, ethnicity/national identity, gender, age, sexual orientation, religion, patient type (e.g. Medicaid) in which the practitioner specializes.

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

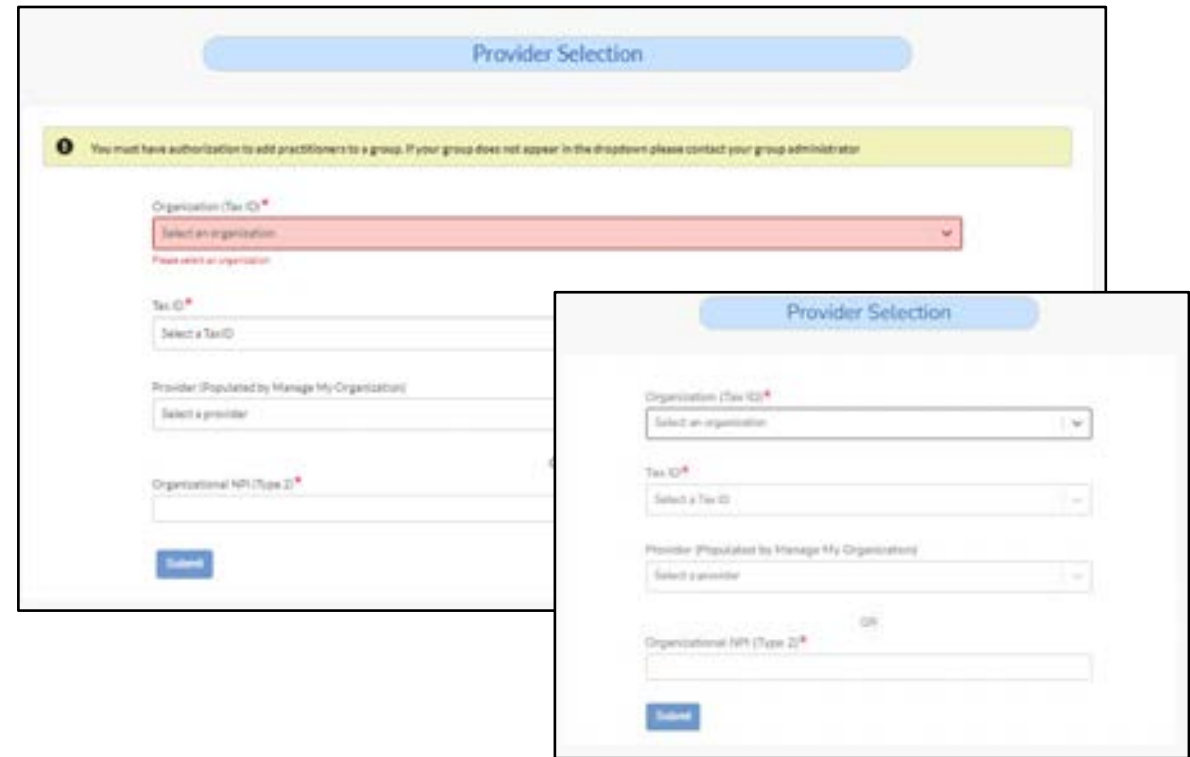
Request Type (Select One):

- 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**

Accessing Providers

Accessing Your Organization

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

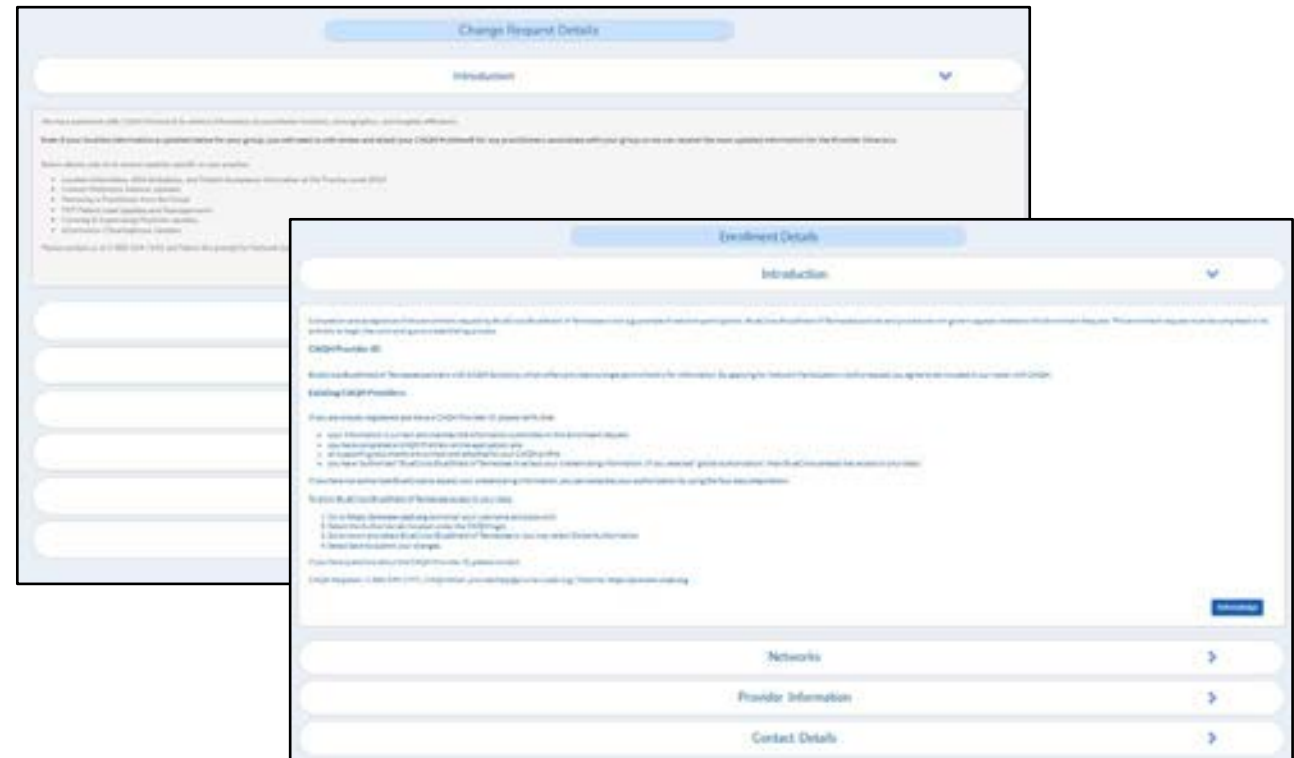


Digital Application – Options

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

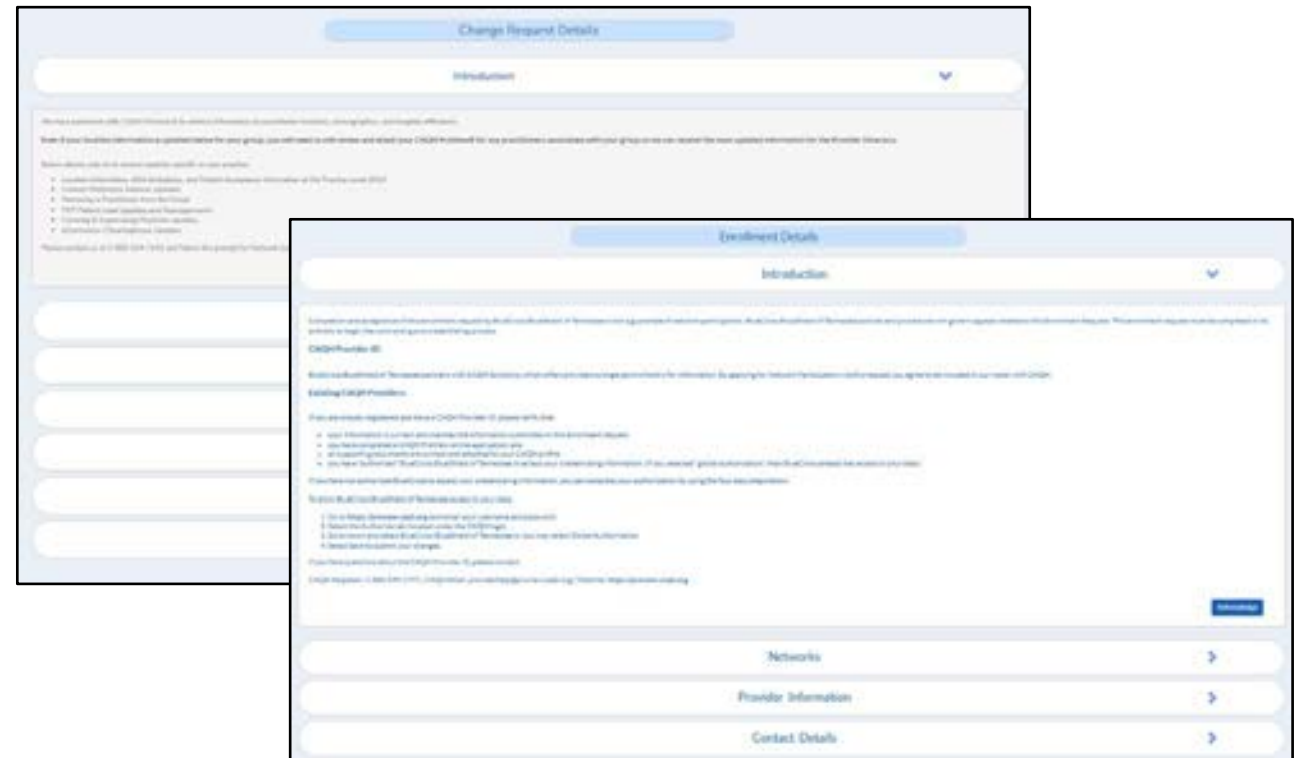


Digital Application – Options

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



NAVIGATING & ACCESSIBILITY – CONTACT PREFERENCES

Contact Preferences

♥ Contact Preferences & Communication Viewer

Update your contact information and view your important messages and documents

Contact Preferences

I want to:

[Update Contact Preferences](#) [View Communications](#)

Contact Type *
Select a Contact Type

Organization *
Select an organization

Tax ID *
Select a Tax ID

Provider
Select a provider

API

[Submit](#)

Contact Type Descriptions:

Contracting - Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies and annual updates to Commercial BlueCross Performance Ratings.

Credentialing - Information about your credentialing status or credentialing appeals inquiries.

Network Operations - Updates about network enrollment and your listing in the BlueCross Provider Directory.

Network Updates - General business announcements, newsletter updates and surveys.

Quality & Clinical - Notifications about Quality Care Quarterly newsletter, available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application.

Financial - Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items.

Contact Type Descriptions:

Contracting - Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies and annual updates to Commercial BlueCross Performance Ratings.

Credentialing - Information about your credentialing status or credentialing appeals inquiries.

Network Operations - Updates about network enrollment and your listing in the BlueCross Provider Directory.

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Financial - Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items.

AVAILITY ENHANCEMENTS – SELF-SERVICE STATUS TRACKER

Enrollment Tracker

Self-Service Tracker – Track a Request

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.

Tax ID	Group NPI	Provider NPI	PEF/GEF ID	Line of Business	Provider Name	Start Date	Latest Status Date	Status	Percentage Complete
			PEF-7863	Discontinued		5/23/2023	5/25/2023	Discontinued	Discontinued
			PEF-8006	Discontinued		7/25/2023	7/31/2023	Discontinued	Discontinued
			PEF-6602	Group Contracts		3/6/2023	5/17/2023	Complete	100%
			GEF-7833	Group Contracts		5/21/2023	6/22/2023	Complete	100%
			GEF-8953	TBD		8/2/2023	8/2/2023	In Process	5%
			GEF-7833	Group Contracts		5/21/2023	6/22/2023	Complete	100%
			GEF-7833	Group Contracts		5/21/2023	6/8/2023	Complete	100%
			GEF-7282	Group Contracts		4/18/2023	5/19/2023	Complete	100%
			GEF-7946	Group Contracts		5/30/2023	6/22/2023	Complete	100%
			GEF-8109	Group Contracts		6/8/2023	7/19/2023	Complete	100%
			GEF-8367	TBD		6/22/2023	7/7/2023	Pended, ple	Pended to provider for more info
			GEF-8999	TBD		7/31/2023	7/31/2023	In Process	5%
			GEF-8615	TBD		7/12/2023	7/19/2023	In Process	15%
			GEF-7833	Group Contracts		5/21/2023	6/8/2023	Complete	100%
			GEF-8284	TBD		6/29/2023	8/5/2023	Pended, ple	Pended to provider for more info
			GEF-8533	Group Contracts		7/8/2023	7/21/2023	In Process	60%
			GEF-7861	Group Contracts		5/23/2023	6/29/2023	Complete	100%
			GEF-8706	Group Contracts		7/18/2023	7/21/2023	In Process	60%
			GEF-8615	Group Contracts		7/14/2023	8/1/2023	In Process	60%
			GEF-8953	TBD		8/2/2023	8/2/2023	In Process	5%

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](mailto: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 [Avality](#) & complete your enrollment application or change form.

REFERENCES

Provider Network Operations (cont.)

Important Links

- › [Provider News and BlueAlerts](#)
- › [Provider Quick Reference Guide](#)
- › [Availity](#)
- › [CAQH Preview](#)
- › [Find My BlueCross Contact](#)

A young woman with dark hair, wearing a blue top, is leaning over a table and smiling as she points to a document. An elderly woman with short white hair, wearing a striped shirt, is sitting at the table and looking at the document. The background is a bright, slightly blurred indoor setting. The entire image is overlaid with a semi-transparent blue gradient.

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 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



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



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association

A photograph of a hospital hallway. In the foreground, two female nurses in blue scrubs are talking; one is holding a tablet. In the background, a male nurse in blue scrubs and a doctor in a white lab coat are walking. The hallway has blue doors and a green wall on the right.

Breakout Session
EPIISODES OF CARE (EOC)

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 (ICD-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.

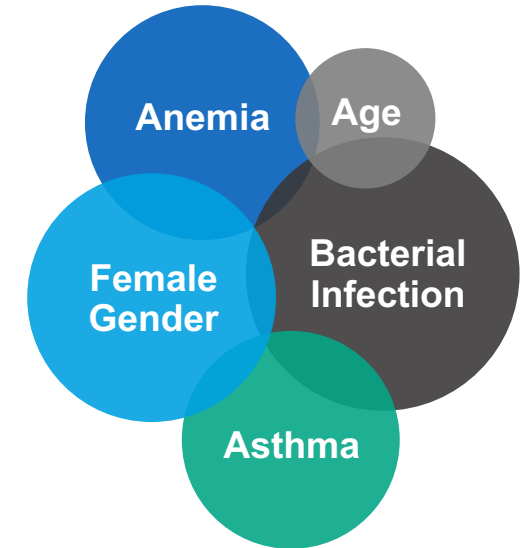
A	B	C	D	E
Member ID	Episode of Care	Actual Episode of Care Cost	Risk Factor	Adjusted Count Amount
12345	TJR	\$17,498.23	1.271	\$13,767.29
54321	TJR	\$15,321.12	0.98	\$15,633.80
49123	TJR	\$18,167.97	1.02	\$17,811.73

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.



$$\begin{array}{|c|} \hline \text{Age 21} \\ \hline 0.042 \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Female Gender} \\ \hline 0.706 \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Anemia} \\ \hline 0.038 \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Asthma} \\ \hline 0.055 \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Bacterial Infection} \\ \hline 0.042 \\ \hline \end{array} = \begin{array}{|c|} \hline \text{Episode Risk Score} \\ \hline 0.883 \\ \hline \end{array}$$

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

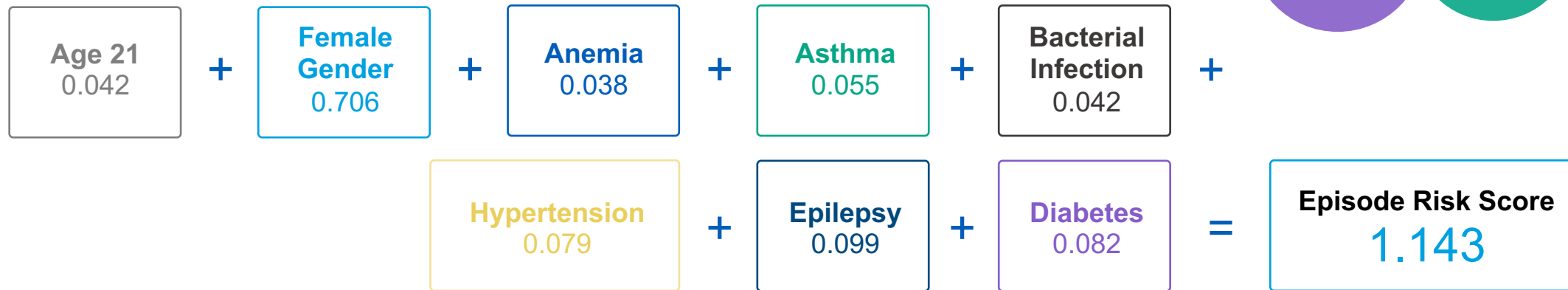
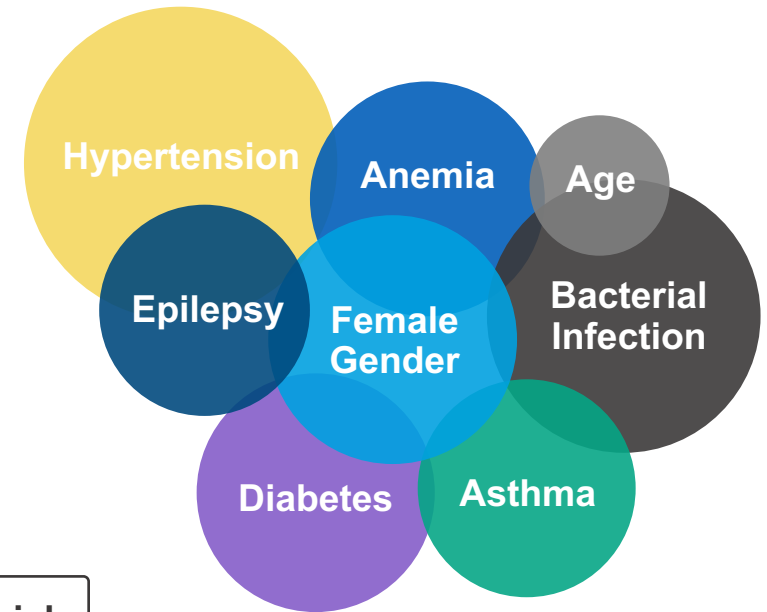
\$6,540

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.



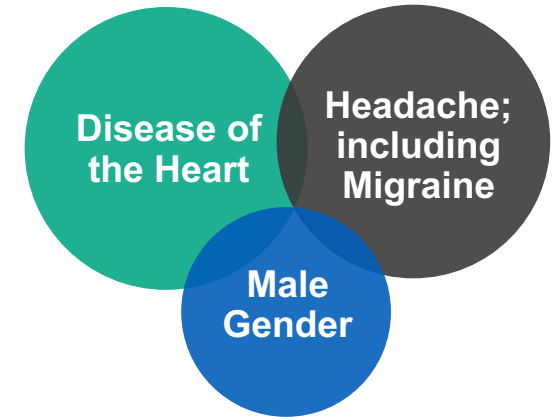
The member's risk adjusted episode cost is $\$5,775 / 1.143 =$

\$5,052*

*Cost difference of \$1,488

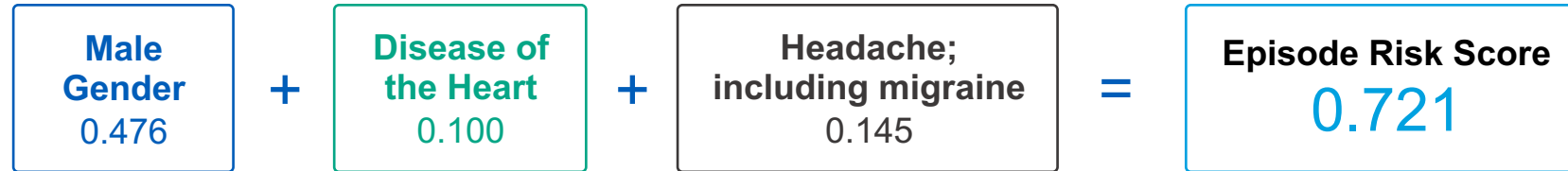
EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

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.



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

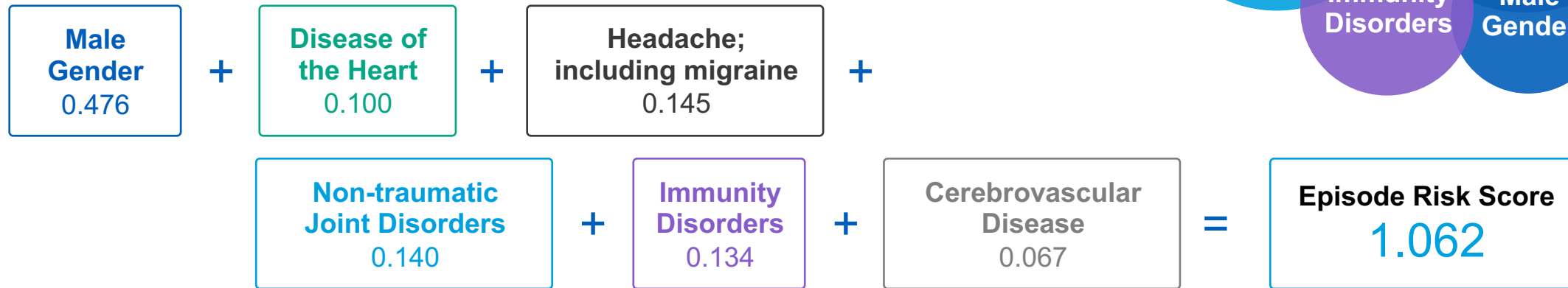
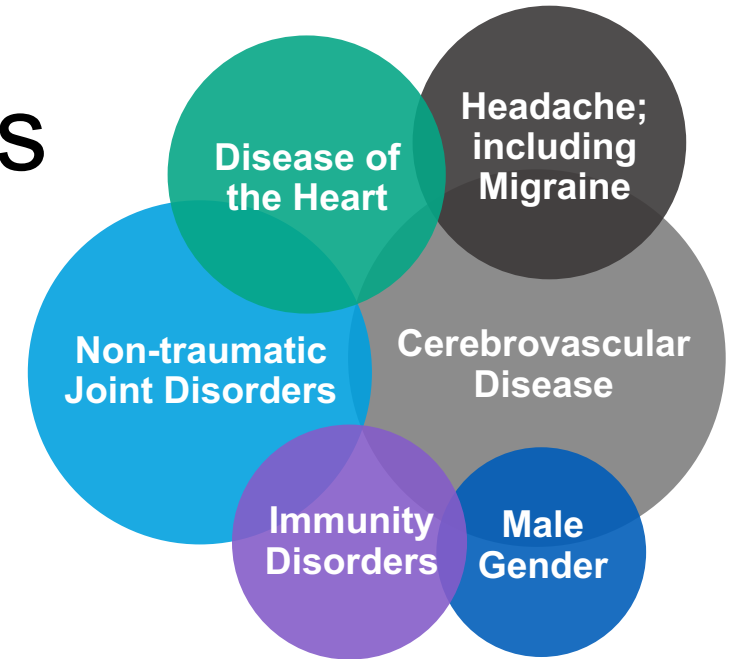
\$1,544

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.



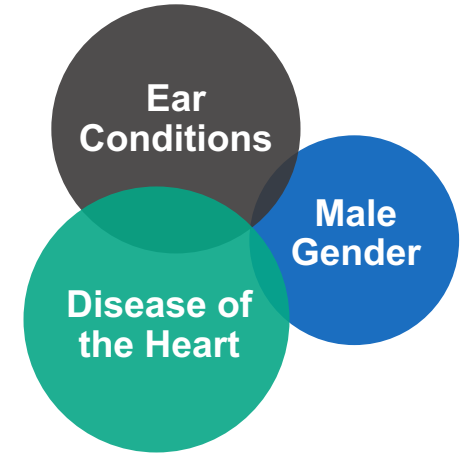
The member's risk adjusted episode cost is **\$1,113/1.062 =**

\$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 $\$84/0.936 =$

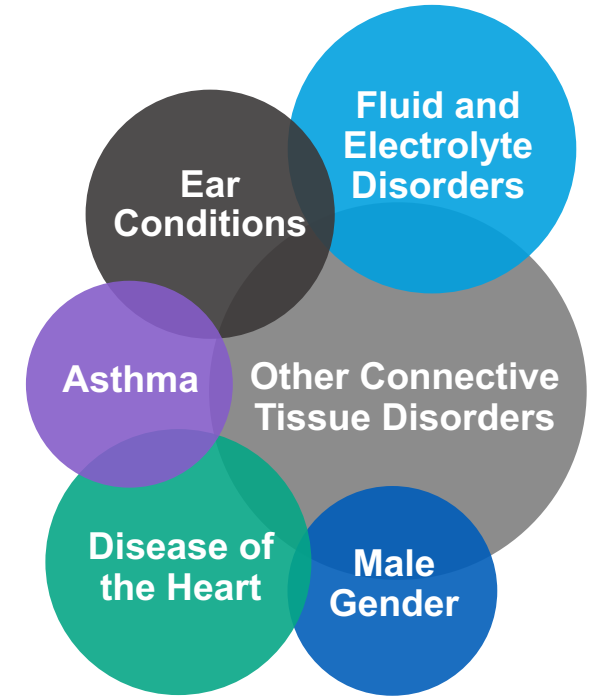
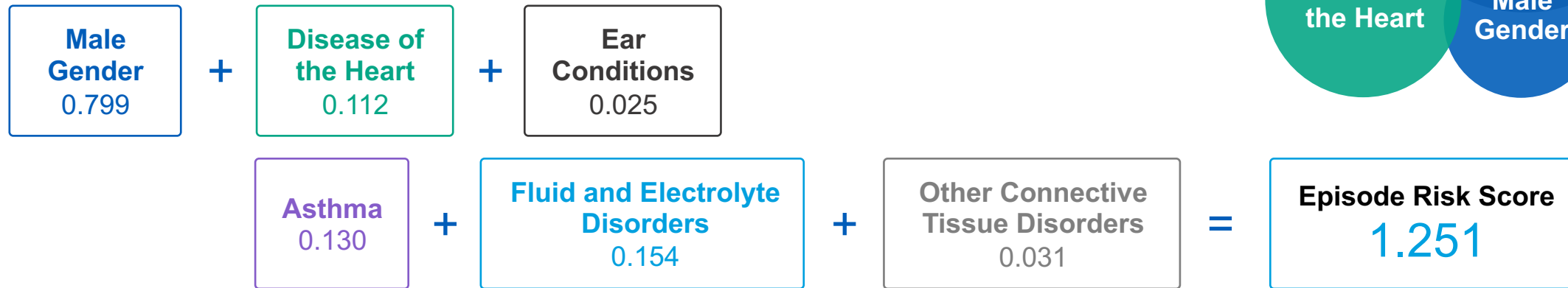
\$90

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.



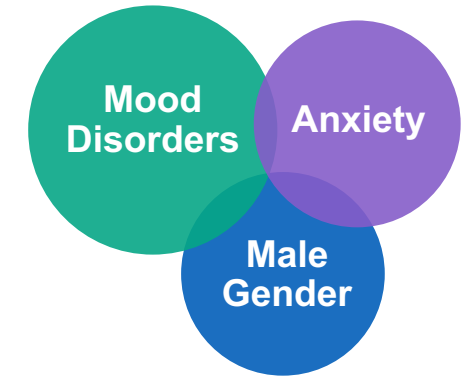
The member's risk adjusted episode cost is $\$84 / 1.251 =$

\$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.

$$\begin{array}{|c|} \hline \text{Male Gender} \\ \hline 0.950 \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Anxiety} \\ \hline 0.094 \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Mood Disorders} \\ \hline 0.075 \\ \hline \end{array} = \begin{array}{|c|} \hline \text{Episode Risk Score} \\ \hline 1.119 \\ \hline \end{array}$$

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

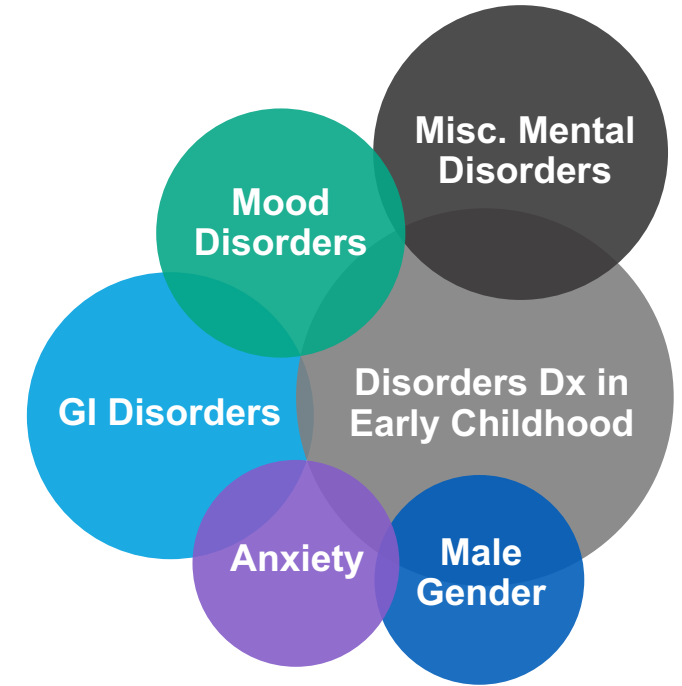
\$223

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.



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?



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association



Breakout Session

BEHAVIORAL HEALTH



General Reminders

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)

GENERAL REMINDERS

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)

GENERAL REMINDERS

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.

GENERAL REMINDERS

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.

GENERAL REMINDERS

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

CODING CHANGES & REMINDERS

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:

CODING CHANGES & REMINDERS

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

CODING CHANGES & REMINDERS

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

CODING CHANGES & REMINDERS

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

CODING CHANGES & REMINDERS

BlueCare/TennCareSelect

As a reminder, we updated BlueCare and TennCareSelect 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



The image shows a screenshot of a software interface tile. It features a red heart icon to the left of the text 'Fee Schedule Viewer'. Below this, there is a line of text that reads 'View your fee schedules for BlueCross contracts'. The tile has a light gray background and a thin black border.

♥ Fee Schedule Viewer

View your fee schedules for BlueCross contracts

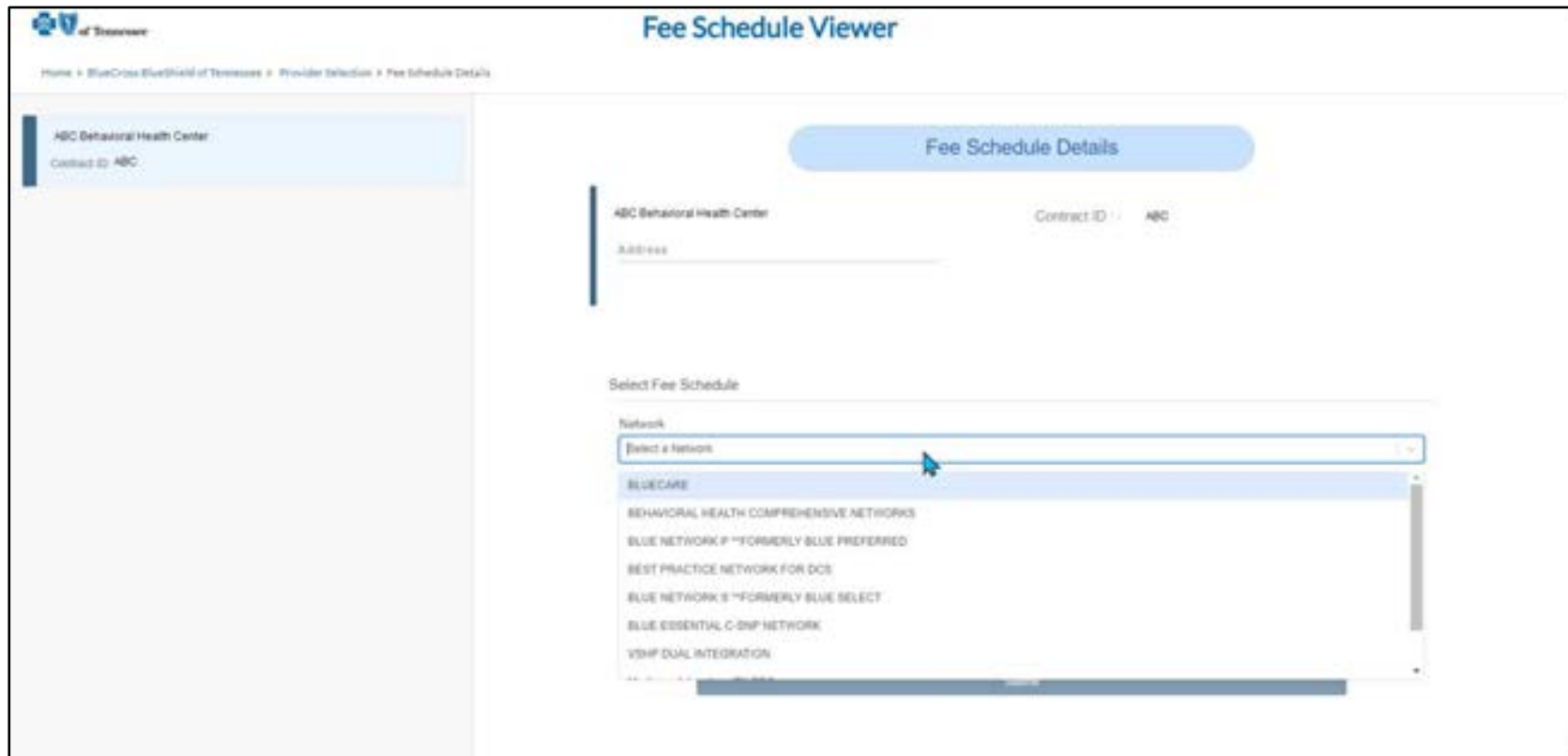
FEE SCHEDULE VIEWER

BlueCare/TennCareSelect

The screenshot shows the 'Fee Schedule Viewer' interface. At the top left is the BlueCross of Tennessee logo. The title 'Fee Schedule Viewer' is centered at the top. Below the title is a breadcrumb trail: 'Home > BlueCross BlueShield of Tennessee > Provider Selection'. A yellow information box contains a note: 'Please note that changes to fee schedules will be reflected in Availability the Monday following the effective date of the change. Example: BCBST Base Fee Schedule for facilities are updated yearly on April 1st. If April 1 falls on a Monday, it will be available the following Monday.' Below this are four input fields: 'Organization *' with a dropdown menu showing 'Select an organization'; 'Tax ID *' with a dropdown menu showing 'Select a Tax ID'; 'Provider' with a dropdown menu showing 'Select a provider'; and 'NPI' with a text input field containing 'Enter NPI'. A blue 'Submit' button is located at the bottom of the form.

FEE SCHEDULE VIEWER

BlueCare/TennCareSelect



FEE SCHEDULE VIEWER

BlueCare/TennCareSelect

Select Fee Schedule

Network
BEHAVIORAL HEALTH COMPREHENSIVE NETWORKS

Agreement
XXXXXX - BEHAVIORAL HEALTH **1**

I agree that the information in this fee schedule is considered confidential pursuant to my BlueCross BlueShield of Tennessee agreement. Unauthorized disclosure of this fee schedule is not permitted.

Submit

ABC Behavioral Health Center
Contract ID: ABC **3**

Provider Details

Search Fee Schedule: 90647 OR/AND Search Effective Date (MMDD/YYYY): From To Search Clear Search

Fee Schedule Details

Level	Procedure Code	Rate	Indicator *	Site of Service	Age Range	Effective Date
All Levels	90647			Facility	All Ages	04/01/2021
All Levels	90647	\$92.89		Non-Facility	All Ages	04/01/2021

Previous Page 1 of 1 Next

* Please review documents and reference materials available in the subject file.

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

CODING CHANGES & REMINDERS

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.



CODING CHANGES & REMINDERS

Notification of Upcoming Changes

The screenshot shows a dashboard with six notification tiles arranged in a 2x3 grid. The tiles are:

- Fee Schedule Viewer**: View your fee schedules for BlueCross contracts.
- Health Starts TN**: Review community programs available to BlueCare members.
- Medication Assisted Treatment**: Review your BESMART Quality Metrics Report - Q2 2022 Reports are now available.
- National Consumer Cost Tool Reports**: Q2 2022 Data available - Review data submitted for member cost tools.
- Print/View Your Remittance Advice**: Review and print copies of your legacy remittance advices.
- Provider Enrollment, Updates, and Changes**: Enroll or make changes to a Provider for BlueCross BlueShield of Tennessee. This tile is highlighted with a red border.

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:

smartsheet

Data Verification and Attestation Form for Buprenorphine Medication Assisted Treatment Prescribers

This form must be completed and submitted by the prescriber. As confirmation of submittal, select "Send me a copy of my responses" option at the bottom of the form and enter the prescriber email address as the recipient. Then, forward the email confirmation to MAT_Referral_CM_UM@bcbst.com as well as any of your office/practice staff who need confirmation of submittal.

Prescriber Last Name *

Prescriber First Name *

Prescriber Email Address *

This email address must belong to the prescriber and is for attestation purposes and interaction specifically regarding the MAT program, including routine requests for information about appointment availability.

Alternate Email Address

This field is for any alternate or proxy email address for interaction with prescriber/practice specifically regarding the MAT program, including routine requests for information about appointment availability.

Prescriber NPI *

Taxpayer Identification Number *

Primary Specialty *

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.

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

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Middle Region

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Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association



Breakout Session

ANCILLARY



ALL Blue 2024

Agenda 2024

Presenters

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

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

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

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.”

The image shows a portion of a CMS-1450 form, specifically Block 80, which is highlighted in yellow. The form contains various fields for patient information, including name, address, and Medicaid number. The Medicaid number field is highlighted in yellow, indicating its importance for hospice billing.

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.

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.



**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 423-626-4270 option 2 or emailing eBusiness_marketing@tcbs.net.

(1/2)

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.

BlueCare Tennessee, an Independent Licensee of the Blue Cross Blue Shield Association

(2/2)

22PED1951700 (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 is a 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 EQUIPMENT
PO BOX 260 • RIFTON, NY 12471
www.rifton.com

A Division of 232323232323, LLC
Phone: 518-711-8138

Invoice no: [REDACTED]

Date: 12/06/2023

Printed on: 12/16/2023

Terms of Sale: F20 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
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

Send 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: 800-871-8138
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



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association



Breakout Session

COMMERCIAL QUALITY



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

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)



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](https://www.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](https://www.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)



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](https://www.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.)

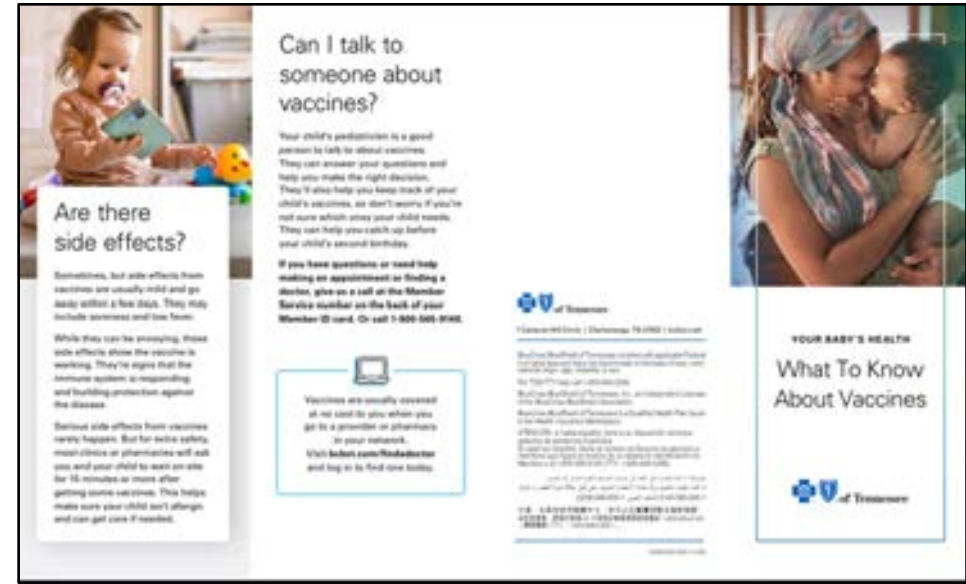
Quality Improvement Internal Resources (cont.)

> 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.)

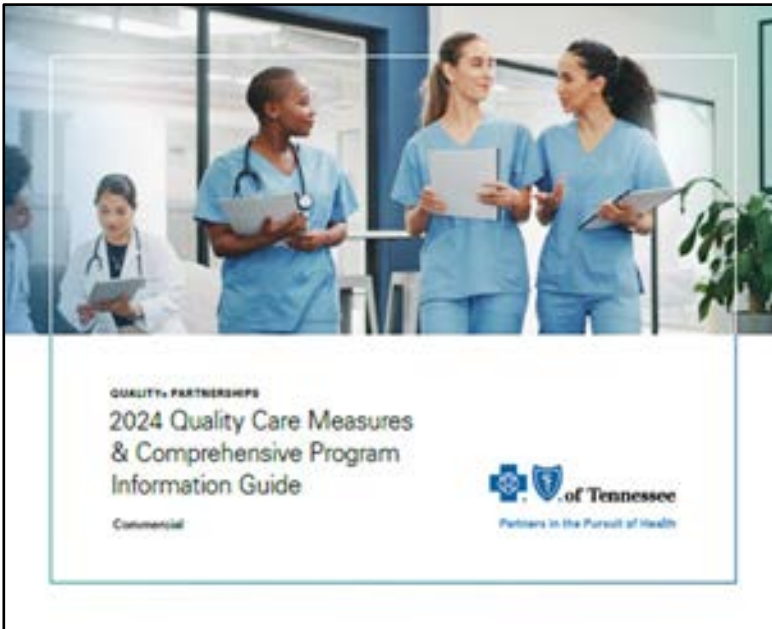
Quality Improvement brochures to address childhood, adolescent and adult vaccinations and hesitancy:



VACCINATIONS 2024

Resources (cont.)

Additional vaccine resources:



Behavioral Health



Follow-Up Care for Children Prescribed ADHD Medication (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)



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)



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 MEASURES

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 MEASURES

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 MEASURES

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 MEASURES

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

SCREENING MEASURES

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.

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.



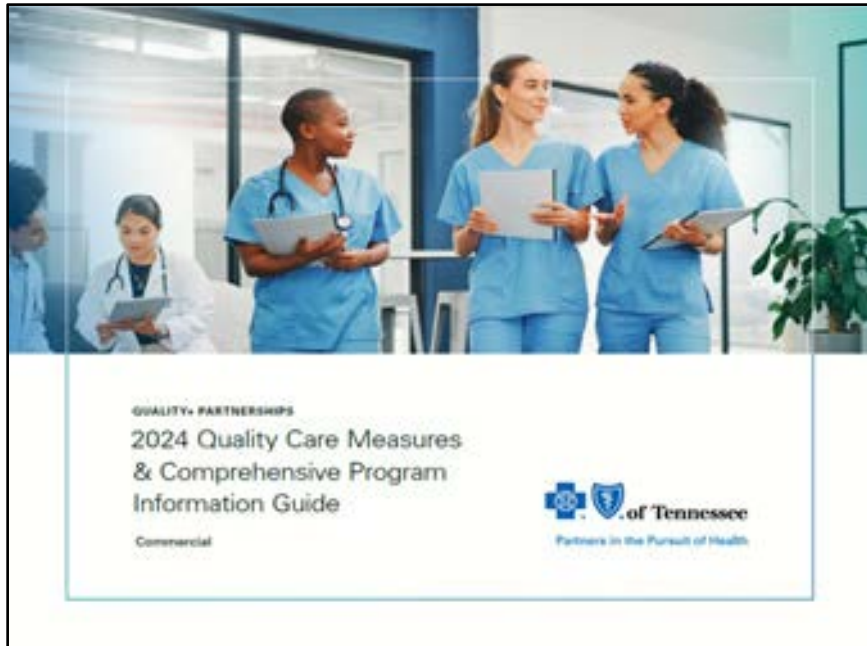
Educating Our Members

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 BlueAlertSM 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

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



Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of BlueCross BlueShield Association