of Tennessee
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2022 All Blue Workshop℠ Provider Questions

Thank you for you attending the 2022 All Blue Workshop. We received a number of questions during this years' presentations, and we've compiled them below for your reference. We hope you find this helpful.

Will the CareTN programs offer tobacco cessation help for children who vape? If so, are there any age restrictions?
The Division of TennCare pays for medication and over-the-counter products to help smokers stop smoking. This includes all FDA-approved tobacco cessation aids.

Do providers need to use the 95 modifier when billing for telehealth for BlueCare patients?
When billing for telehealth, applicable service codes, diagnostic codes, modifiers and units should be reported with Place of Service 02, 10 or your normal Place of Service code with a 95 modifier appended to the CPT/HCPCS code. This will let us know you've treated our member using telehealth. You can find this information in our BlueCare provider FAQs at bcbstupdates.com.

Will a provider's internal cultural competency training satisfy BlueCare requirements for all MCO's? And is it an annual requirement?
It is an annual requirement. Internal programs and/or programs from any of the BlueCare MCO's will satisfy the BlueCare cultural competency training requirement.

Can hospitals submit prior authorization requests for out-of-state Blue plans through Availity®?
You can find more information about plans to align the Blue plans' strategy in regards to the proposed Provider Burden Reduction rules issued here. Our long-term goal to automate authorizations between plans the way we do with claims, benefits and claim status transactions.

What would be the average turnaround time when messaging?
Five business days or less.

Are there plans to make an online chat instead of messaging?
No, we do not have a chat feature available for our Provider Service teams at this time. Our eBusiness Service Team is available by chat, when choosing "Chat With Payer" within Availity, at the top of the *payer spaces* page.

Some providers are receiving error messages when selecting BlueCross from Availity Payer Spaces.
If you have a technical (system) question or issue, please contact our eBusiness Service Team by calling (423) 535-5717 and pressing option 2 or email at eBusiness_Service@bcbst.com.

Can providers check Preventive Care benefits in Availity?
You can use the Eligibility & Benefits tab in Availity to search for specific benefits and service types, such as routine physicals, office visits and more. If you can't find what you're looking for, try clicking the Give Feedback button and include the transaction ID number and let us know what's missing. You can also use FastPath to speak with a dedicated representative about specific benefits.

Are there any updates in the works to provide mental health benefits, especially for out-of-state plans? Also, are there plans to allow providers to check benefits/eligibility by specific CPT® code?
Member eligibility information should be obtained by accessing BlueCross BlueShield of Tennessee payer spaces in Availity.

When will sleep studies be available to generate reference numbers or initiate prior authorization?
Sleep studies for Commercial do require prior authorization as of Oct. 1, 2021. However, some self-funded employer group plans may not require prior authorization. If authorization is required, please include a reference number.

Why can't providers verify member information with a Medicare ID?
We don't receive Medicare enrollment information for all members with Medicare plans so we can't build a universal search feature that would find members by this identifier.

How should in-network Tennessee providers bill if the member has BlueCross Blue Shield of Kentucky or Texas?
BlueCard billing requirements depend on several factors, including a provider's contract status with the out-of-state plan, and the contiguous county location of services rendered within Tennessee. For more information on BlueCard billing, please see the BlueCard Provider Manual, located at provider.bcbst.com.

Is there a way for providers to see all the prior authorizations for a patient, both medical and behavioral health?
Prior Authorizations obtained by your provider can be viewed in BlueCross BlueShield of Tennessee payer spaces in Availity.

What's the best way to file a tertiary claim, since it can't be filed electronically?
When submitting paper claims, please be sure to include tracking information. For more information on submitting claims, please see our Provider Administration Manuals at provider.bcbst.com.

Does BlueCross have information on reimbursement for the new Monkeypox CPT® 87593?
Unfortunately, we don't have any updated information on Monkeypox CPT 87593 at this time. Please keep an eye out for upcoming issues of our BlueAlert newsletter for updates.

Which code should be submitted for the Provider Assessment Form (PAF) in 2022?
You can find information about PAFs in our Provider Administration Manual. We'll reimburse the service as E/M Code 96160 or 96161, depending on the submission method.

How do quality measures apply to pain management providers?
You can find more information in the Back/Neck Pain Episode Executive Summary here. And you can find more general information about the Tennessee Health Care Innovation Initiative here.

How can a primary care clinic our Medicare Advantage patients who come in for a wellness exam get their gift cards?
Please use the following codes for our member enrolled in the My HealthPath and Rewards program: GO402, GO438, GO439 plus E/M codes appropriate for the Annual Wellness Visit or use 99387, 99397, 99385, 99386, 99396, 96160 or 96161 (Provider Assessment Form).

Can all Behavioral Health/Psychiatry visits be performed via telehealth or do Commercial, Medicare Advantage and BlueCare need in-person visits?
You can find information about our telehealth guidelines for all BlueCross lines of business in the provider FAQs at bcbstupdates.com. Additionally, you can review our telehealth guides for Medicare Advantage plans here and our Commercial plans here.

Do providers need to split a telehealth claim if the provider is working from home and the patient is in the office and receives an X-ray?
No. You don't need to split the claim for this situation. You do need to make sure to include the correct place of service code, modifier, etc.

Is the Professional Provider Associated Professional Listing in the BlueCross grid still required upon enrollment?
Newer contracts have been updated to let providers know it applies to all in the group. The grid only applies to older contracts. Please contact your Principal or Associate Principal for additional questions as it pertains to your BlueCross agreements.

Are providers allowed to add more than one person for a specific contact type – for example a contracting administrator?
You can receive BlueCross communications by email for several contact types: Contracting, Credentialing, Network Operations, Network Updates, Quality and Clinical Information, and Financial Updates. To set specific contacts for each of these types, visit BlueCross BlueShield of Tennessee payer spaces in Availity, and choose Contact Preferences & Communications.

Do providers still need to complete both the BlueCross Data Verification Form in Availity and the CAQH attestation every quarter?
We've aligned with the CAQH provider database to receive this information. However, you do need to confirm electronically any information not currently collected by CAQH and that's specific to BlueCross. We've sent a provider notification about this change and explained how to verify your information in Availity.

You'll also need to visit the CAQH website each quarter to attest your information is up to date for each provider and location. Anytime you have changes, please remember to update CAQH ProView with those changes. Currently, this process is not available for Ancillary providers and Facilities. These providers will still receive Data Verification Forms that must be returned each quarter so our provider directories are up to date.

How do we find out more information for billing in regard to the No Surprises Act?
You can find more details about the No Surprises Act, Consolidated Appropriations Act, 2021 by visiting our website here and scrolling down.

Regarding the No Surprises Act/Transparency in Coverage, is there a way to a) inform all payers that we'll continue to use our SSN instead of changing to an EIN, and b) request that our SSN not be used, and use our NPI instead?
We can only speak for BlueCross and not other payers, but we recommend changing to an EIN instead of using your SSN. Please see the article pasted below from recent issues of our BlueAlert newsletter for more information.

New Transparency Requirements – Transparency in Coverage Rule
The law requires us to also publish the provider Tax ID Number (TIN) in these files, which would be a Social Security Number (SSN) for those using it as their TIN. For these providers, we'll publish the National Provider Identifier (NPI) if we have the SSN on file. However, if you're currently using an SSN as a TIN, we recommend you apply for a TIN.

Please continue to check future issues of BlueAlert for updates.

Is there a way to show that a parent has refused a vaccine or service in regards to closing HEDIS gaps?
There are currently three dots to the right of each measure in the QCR. Select and choose "Add Barriers." There is also an option in the Barriers section to note that the patient refused the service. Although this won't provide additional points for that measure as we are bound to NCQA guidelines, which don't allow for patient refusal as an exception, using that option does allow you to document refusal.

How can we see if a claim cost is not attributed to the cost?
THCII episodes of care reports are built by payers, who use claims data submitted by physicians and facilities. The claims data is compiled into a quarterly report that provides a performance summary as well as quality and cost details related to the episodes of care. The reports identify areas of improvement in

care coordination, costs and practice changes to promote quality patient care. Providers will receive information about what happens to their patients throughout each episode of care – information that has never been available to providers before

We are an OBOT and we do not have any EoC reports. Are we supposed to have these reports as an outpatient treatment facility?
Yes. Please reach out to your Network Manager for more about these reports.

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