of Tennessee

May 2016

BlueAlert SM

BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

Effective June 11, 2016

- Complementary and Alternative Medicine (Revision)
- Cytochrome P450 Genotyping (Revision)
- MRI-guided Laser-induced Thermotherapy for Neurological Indications (New)

Effective June 18, 2016

- Bariatric Surgery (Revision)
- Pembrolizumab (Revision)
- Virtual Colonoscopy (Computed Tomography Colonography (Revision)

Intradialytic Parenteral Nutrition – This medical policy will be archived (i.e., no longer active) 30 days after this BlueAlert notification is issued. This document is no longer utilized by BlueCross' Commercial and BlueCare Utilization Management departments. http://www.bcbst.com/mpmanual/!SSL!/WebHelp/Intradialytic_Parenteral_Nutrition.htm

Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening – BlueCross has decided that it will not implement an investigational medical policy position as initially indicated in the April 2016 BlueAlert article.

Note: These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

NOTICE: National Consumer Cost Transparency Data Available

National Consumer Cost Transparency (NCCT) data is currently available for review on the BlueAccess℠ portal for providers in our commercial networks. The Spring 2016 cost data review period will extend through June 1, 2016.

BlueCross Changing Opioid Prescription Policy July 1

BlueCross is supporting the growing national effort toward more appropriate use of opioids by issuing a new administrative policy. Effective July 1, 2016, patients covered by BlueCross Commercial plans must have prior authorization (PA) before filling a prescription for long-acting opiate pain medications. This PA applies only to your patients who are new to long-acting opioid drug therapy. The new administrative policy will assist in the therapeutic treatment of chronic pain and prevent misuse of opioid analgesics.

This change will not apply to patients with BlueAdvantage and BlueCare Tennessee plans or patients who are already on prescriptions for long-acting opioids. However, further changes regarding opioid prescriptions are likely later this year and in early 2017.

To view the new policy on the Use of Opioids in Control of Chronic Pain, please see http://www.bcbst.com/UpcomingMPs/upcoming_mps.htm

New Regulations for Improved Provider Directory Data Quality

The federal government, states and other regulatory bodies require health plans to contact participating health care providers on a quarterly basis to review, update and confirm their information in provider directories.

If you receive a Data Verification Form, please verify your demographic information, sign and return the form

promptly even if all information on the form is accurate. If the Data Verification Form requires changes, please mark through the incorrect information, print the correct details in the space beside that field and fax to (**423) 535-3066**. We ask that all providers respond promptly to update the information required for provider directories.

If you have any questions, or need assistance with the Data Verification Form, please call the Provider Service Line† at **1-800-924-7141**. To help ensure your call is routed to the appropriate department, select the option "Provider Network Services" when prompted.

We are assessing more efficient means of electronic verification, including working with the Council for Affordable Quality Healthcare (CAQH) to help meet these requirements by using **CAQH ProView™**. We plan to implement more improvements to help simplify the process of updating provider directories throughout 2016.

Update: BlueCross Telehealth Billing Guidelines

BlueCross allows telehealth services statewide for all appropriate providers in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines and defers to CMS for establishing the following telehealth definitions:

- **Originating Site Provider**— providers who manage member care at the time/location the service furnished via a telecommunications system occurs.
- **Distant Site Provider**— providers at the distant site who may furnish and receive payment for covered telehealth services.

Please note, however, that BlueCross **does not** apply the CMS guideline that limits originating site reimbursement to rural settings.

Ancillary Reminder: Disposable Elastomeric Pain Pumps

Post-operative disposable elastomeric pain pumps are considered a bundled service when inserted at the time of surgery. These items are not separately reimbursable and are considered paid for as part of the appropriate facility grouper payment.

Reminder: Electronic Claims Submission

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call eBusiness Technical Support† if you need to discuss your office's transition or any barriers that may prevent you from filing electronic claims.

Reminder: Clinical Information Required for Prior Authorization Requests

When submitting Commercial prior authorization requests, please provide clinical information at the time of the request. This information is used to help determine the appropriate response to the request for prior authorization. If complete clinical information is available on the initial call, fax or web submission, the authorization can be completed without delay.

BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding CoverKids and dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise

See BlueCare Tennessee Member PCP Assignments in Real Time with BlueAccess

Using BlueAccess, you can now verify, in real time, if a BlueCare Tennessee member is assigned to your practice. The following reports are also available online anytime and updated Tuesday of each week:

- **Previously Assigned Members**
  Lists members assigned to the provider on the previous membership listing
- **Members Transferred from Provider**
  Lists members transferred to another PCP or MCO
- **Disenrolled Members**
  Lists members who have either changed MCOs or are no longer eligible for TennCare

If you have questions about BlueAccess or if you would like to use the secure provider section of our website, we can help. Please contact the eBusiness Solutions staff† member in your region.

West Tennessee – Debbie Angner
Phone: (901) 544-2285
Email: Debbie_Angner@bcbst.com

Middle Tennessee – Faye Mangold
Phone: (423) 535-2750
Email: Faye_Mangold@bcbst.com

East Tennessee – Faith Daniel
Phone: (423) 535-6796
Email: Faith_Daniel@bcbst.com

Quest Diagnostics: Exclusive Lab for BlueCare Tennessee

Quest Diagnostics is the exclusive in-network lab provider for BlueCare Tennessee. To help ensure your BlueCare Tennessee patients receive all the benefits of using an in-network lab provider, tests must be ordered directly through Quest Diagnostics and not through any other laboratories.

It is easy to place lab orders for Quest through Care360® Lab & Meds, a free online tool that allows you to order labs electronically and access results on a PC, tablet or smartphone. Quest interfaces with most electronic health record systems. Ordering lab services directly through Quest ensures timely access to results, which will be sent directly from Quest to the ordering provider.

With Quest Diagnostics, you have more resources to meet your goal of improving patient health outcomes. A broad array of more than 3,500 tests—from routine to advanced genetic, molecular and specialty tests—are at your fingertips. Online appointment scheduling and a network of more than 2,200 patient service centers make it easy for your patients to complete testing. You can also receive professional support from more than 700 MDs, PhDs and genetic counselors to help select and interpret appropriate tests.

To learn more, please visit Quest Diagnostics website.

Report Unexpected Deaths of Members Under Age 21*

If a BlueCare Tennessee/CoverKids member under age 21 dies unexpectedly, please report this to us as soon as possible after the death. Providers should use the following criteria to determine if the death of the member is unexpected:

- **Accidental**
- **Medical**
- **Suicide**
- **Mistreatment/Abuse/Neglect**
- **Homicide**
- **Suspicious**

Report unexpected member deaths by phone or by email.

Email:
BCQultyCaseOversight@bcbst.com

Phone:

BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141

If reporting by email, include the Unexpected Member Death Form available on our website. As part of the Quality Review Process, medical records related to the death may be requested.

TennCare MCOs Adopt Universal PCP Change Form*

BlueCare Tennessee, Amerigroup and United Healthcare are now using a universal primary care provider (PCP) change form. While each MCO has adopted the universal form, each MCO has a specific version of the form. For example, BlueCare Tennessee versions of the form should only be used for BlueCare Tennessee members.

The form is ready for use and available at bluecare.bcbst.com.

Reminder: It is not necessary to submit a PCP change form if a member changes providers within your practice. Our covering provider logic will apply.

Three Options to Ensure Your Covering Information is Correct

1. Call the Provider Service† line at 1-800-468-9736 for BlueCare or 1-800-276-1978 for TennCare*Select*.

2. Submit your covering provider listing on business letterhead by faxing to (423) 535-3066 or (423) 535-5808.

3. Mail your covering provider listing on your business letterhead to:
   BlueCare Tennessee
   Attention: Provider Network Enrollment 2.4
   1 Cameron Hill Circle
   Chattanooga, TN 37402

Denials for NICU Claims from Non-NICU Facilities Begins in June*

Babies born with certain life-threatening conditions at a standard birth facility should be transferred to the nearest neonatal intensive care units (NICU) facility. The facility should code the claim for the care provided as: stabilization of the baby for the purpose of transferring the child to a NICU facility (DRG 385/789; Discharge Status 02 or 05). Beginning June 1, 2016, BlueCare Tennessee will deny claims for NICU services (DRG 386/790) billed by a non-NICU facility.

The Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities set new standards for neonatal intensive care units in April 2014. If your birth facility does not meet the NICU standards, please make sure your claims do not include codes for NICU-level care. BlueCare will monitor

adherence to this requirement through medical record review and billed claims.

CoverKids ASH Benefits and Requirements to Change June 1*

CoverKids benefits will include coverage for abortions, sterilizations and hysterectomies (ASH) beginning June 1, 2016. The benefits, rules and required forms will match those in place for BlueCare Tennessee members. While members will have new benefits at the start of June, the federal and state guidelines for waiting periods and forms submissions that apply for the procedures must still be followed. (Example: there must be 30 days between a member signing the sterilization consent form and the procedure.)

To review the ASH guidelines that apply to BlueCare Tennessee members, please see the current Provider Administration Manual. The 2016 second quarter Provider Administration Manual update will indicate the same ASH guidelines to apply to CoverKids members.

CoverKids Reminder: File Routine Nursery Care for Newborns to Mother's ID

CoverKids member benefits include routine nursery care and physician charges for newborns while the mother is confined to the hospital. This care should be filed under the mother's CoverKids membership ID.

Reminder: Register and Revalidate Medicaid ID with TennCare

The Bureau of TennCare℠ requires providers to register for a Medicaid ID and revalidate the ID number every three years. If you have not registered for a Medicaid ID or revalidated within the past three years, please do so soon. If you do not have a valid Medicaid ID on file, the Bureau of TennCare intends to remove you from all TennCare Managed Care Organization networks.

To be reimbursed for the care you provide to BlueCare, TennCare*Select* and CoverKids members, your Medicaid ID must be active for all dates of service.

Providers can easily register or revalidate online at the TennCare Provider Registration website.

Reminder: Timely Filing for Corrected Bills

Corrected bills must be submitted within 120 days of the BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. For more information about corrected bills see the Billing and Reimbursement section of the BlueCare Tennessee Provider Administration Manual.

Medicare Advantage

This information applies to BlueAdvantage (PPO)℠ and BlueChoice (HMO)℠ plans. BlueCare Plus (HMO SNP)℠ is excluded unless stated otherwise.

Vanderbilt Facilities Out of Network for BlueAdvantage and BlueChoice Members

Effective Jan. 1, 2016, Vanderbilt Medical Center facilities were no longer included in the BlueCross Medicare Advantage network. However, some BlueCross members are still being referred to Vanderbilt facilities for care. Please remember that your patients will receive the highest level of benefits by accessing care at an in-network facility.

BlueCross appreciates your willingness to encourage your patients to seek care from a participating network provider. If you have questions, please call Medicare Advantage Provider Service†, or contact your local provider relations consultant. Additionally, our "Find A Doctor" tool on bcbst.com is another good resource to help you locate network providers.

Steps to Scheduling a Peer-to-Peer Review

Follow the steps below to request a physician peer-to-peer review by phone. The review must be requested within two days of receiving fax notification of an adverse determination. You must provide two dates and times during which the requesting physician has availability.

To schedule:
1. Call 1-800-924-7141.
2. Choose voice by saying "voice" or touch tone by pressing 1.

3. Choose option 1 for providers or say "provider."
4. Enter provider ID/NPI/tax number.
5. Enter the contact phone number.
6. Press 1 for information on a specific member, or say "member."
7. Disclaimer information will be given.
8. Say the member ID number including the alpha prefix. Verify the member ID by pressing 1.
9. Enter the member's date of birth.
10. Press 9 to schedule a peer-to-peer review.

Host the BlueCross Mobile Unit On Site

The BlueCross Mobile Unit is available to support your efforts to provide quality care. For BlueCross Medicare Advantage members, the mobile unit staff can provide information about their plan benefits, including our partnership with SilverSneakers® to help seniors remain active. Members also have the opportunity to receive some of their needed screenings like bone density and retinal eye exams, kidney function tests and HbA1c blood sugar screenings for diabetic patients.

The member's attributed provider/practice receives quality score credit for these screenings. To find out more about how hosting the Mobile Unit can help your BlueCross Medicare Advantage patients, please contact Carmen LeVally at (423) 535-8325. Scheduling is subject to availability.

Clarification of Claim Filing Guidelines for Inpatient Readmissions Reduction Program

As you know, BlueCross BlueShield of Tennessee began a Medicare Advantage specific Readmissions Reduction program in September 2014. As a reminder, if a member is readmitted to the same contracted entity (facility or health system) within 3 to 31 days of discharge with a same or similar diagnosis and evaluation of a modifiable or preventable cause, facilities are only reimbursed for a single inpatient DRG (the higher weighted of the two admissions) with approved days from the opposite stay being treated as additional days of the approved DRG claim.

Submitting a corrected bill or combining the services from the readmission with those of the initial admission will result in all services on the claim being disallowed. Also, billing with a "leave of absence" revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim.

A same or similar diagnosis readmission to the same contracted entity that occurs within 48 hours of an acute care hospital discharge will not be reimbursed regardless of the length of stay or the intensity of services.

Submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate, and services will be disallowed.

Reminder: Members Auto-Enrolled in SilverSneakers Gym Membership

It's no secret that remaining physically active is an important part of longevity and quality of life for senior citizens. That's why BlueCross includes a SilverSneakers membership with every BlueAdvantage, BlueChoice℠ and BlueCare Plus health plan we offer.

SilverSneakers provides access to hundreds of fitness facilities across Tennessee, including:

- Group exercise classes designed specifically for older adults
- A variety of fitness equipment, pools, saunas and more
- Guidance and assistance from a program advisor
- Access to a variety of social activities with other older adults

Members are automatically enrolled in SilverSneakers when they join BlueCross and will receive a welcome kit from SilverSneakers that outlines the benefits. Members can also check for participating facilities and class schedules online at the SilverSneakers website or by calling 1-866-584-7389.

Reminder: Female Patient with a Fracture? Schedule a Bone Density Test within Six Months

As you know, often the first symptom of osteoporosis in an older patient is a broken bone. Because seniors, especially senior women, are susceptible to osteoporosis, it is important to schedule a bone density test for any patients who have suffered a fracture.

According to the Centers for Medicare & Medicaid Services (CMS), women between the ages of 67 and 85 who have had a fracture should receive either a bone density test or prescription to treat osteoporosis (if documented) within six months post fracture.

Best Practices:

- Advise your patients to include adequate amounts of calcium in their diet.
- Recommend regular weight-bearing exercises like walking or dancing.

- Talk to your patients about risk factors for falls.
- Measure height annually.
- Perform a bone mineral density test on women 65 and older and men 70 and older.
- Prescribe appropriate medication for patients with a documented hip or vertebral fracture.

Reminder: Guidelines for Submitting a Provider Assessment Form

In 2016, physicians are eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage and BlueChoice patients.

BlueAdvantage will reimburse the service as E/M Code 99420 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2016
- $200 for dates of service between April 1 and June 30, 2016
- $175 for dates of service between July 1 and Sept. 31, 2016
- $150 for dates of service between Oct. 1 and Dec. 31, 2016

Note: The incentive will be paid for a claim billed with 99420 only one time in the calendar year for each eligible member.

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the fillable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be placed in your patient's chart as part of his or her permanent record.

QUALITYCARE REWARDS

This information applies to all lines of business unless stated otherwise.

COMING SOON: Member Scorecards Highlight Needed Care

BlueCross and BlueCare Tennessee members will soon receive a scorecard outlining specific preventive screenings that are appropriate for their age and gender and needed in 2016. These scorecards are intended to encourage your patients to contact you to get the care they need to stay healthy this year – and in the future.

The scorecard is customized for each member by highlighting screenings they've already received in 2016 and screenings that are still needed in 2016. The goal is to empower members to play an active role in their health.

Note: Medicare Advantage and BlueCare Plus members may also earn rewards from BlueCross by completing the recommended tests. To be eligible for any incentives in 2016, these members must complete an annual wellness visit and have a claim filed with one of the following codes: G0402, G0438, G0439, 99387, 99397.

Medication Management for Asthma

The Medication Management for Asthma quality measure focuses on making sure people ages 5 through 85 with persistent asthma remain compliant with their asthma medication and ensuring these patients are taking the right medicine to manage their conditions. Please review medications, techniques and adherence at each follow-up visit, and confirm your patients with persistent asthma understand:

- The importance of asthma self-management, identifying triggers and the importance of adhering to the medicine to prevent asthma flare ups.
- Some medicines help prevent asthma symptoms, however that patient needs to follow their treatment plans and asthma action plans all the time, even when they feel well.

Quality asthma care involves not only initial diagnosis and treatment to achieve asthma control, but also long-term regular follow-up care to maintain control. That means taking the right medicine at the right time using the proper technique.

As the incidence and prevalence of asthma continues to increase across the country, the importance of appropriate disease monitoring and medication therapy is essential to help combat the major causes of morbidity and mortality for this population.

Help Your Patients Manage their Depression

It is important to encourage your patients age 18 or older who have recently been diagnosed with major depression and are undergoing treatment with antidepressant medications to remain on their prescribed medications for at least 180 days during treatment.

The American Psychiatric Association advises that physicians only use a diagnosis of major depression if a patient has experienced at least five of the following nine symptoms for two weeks or more, almost every day:

- Depressed or irritable mood for children and adolescents
- A significantly reduced level of interest or pleasure in most or all activities
- A considerable loss or gain of weight when not dieting, and/or an increase or decrease in appetite
- Difficulty falling or staying asleep or sleeping more than usual
- Agitated or slowed down behavior that others can observe
- Feelings of fatigue or diminished energy
- Thoughts of worthlessness or extreme guilt
- Reduced ability to think, concentrate, or make decisions
- Frequent thoughts of death or suicide, or attempt of suicide

The biggest barrier to successful treatment of depression is medication non-adherence. Patients who receive extra support from their provider, such as counseling or written materials, are typically more compliant and have better outcomes.

TNAAP EPSDT and Coding Training Resources

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) offers resources and reference materials that can help you improve the quality of the preventive health screenings you perform, maximize reimbursement, reduce administrative costs and improve audit outcomes.

TNAAP's resource and reference materials include:

- Free Early and Periodic Screening, Diagnosis and Treatment (EPSDT) training programs at your office
- Downloadable age-specific chart documentation forms
- Sample forms and
- A comprehensive EPSDT manual.

Post-Hospitalization Mental Illness Follow up

Completing a **follow up appointment within 7 days of discharge** from an acute inpatient stay **due to a mental health disorder** is an essential component in helping ensure high quality health care for your patients. A few **sample diagnoses** that would warrant this follow up include:

- Dementia
- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- PTSD
- ADHD
- Other mental illnesses.

Here are a few quick tips to **help increase patient follow-up visits after discharge:**

- Schedule follow up appointments with patients right after discharge and within 7 days.
- Ensure hospital staff is aware of a member's discharge needs/identify any barriers so they can assist at discharge if needed.
- Ensure the member understands the discharge plan and the importance to keeping aftercare appointments.
- Advise office staff/schedulers about the importance of making sure members have an appointment that falls within the 7-day window.
- Follow up with "no-shows" and attempt to reschedule.

Thank you for partnering with us to help ensure your patients receive the best quality care.

Reminder: Diabetes Screenings that Can Affect Your Quality Score

The Centers for Medicaid & Medicare Services (CMS) has several measures in place related to diabetes that can affect your quality score. According to CMS, everyone between the ages of 18 and 75 with a diabetes diagnosis should receive the following each year:

- HbA1c blood test
- Diabetic retinal eye exam
- Kidney function screening

We understand it sometimes can be hard to get elderly and disabled BlueAdvantage and BlueChoice patients into your office. That's why we offer in-home services for each of these diabetic screenings. Our health partners can mail in-home kits to your diabetic patients for HbA1c and kidney function screenings, and schedule in-home eye exams as well. And if you are the patient's attributed provider, you get the quality credit for the service.

Be sure your CAQH ProView™ profile is kept up to date at all times.

IMPORTANT REMINDER

CAQH Solutions | PROVIEW™

Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386 العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Archived editions of BlueAlert are available online at http://www.bcbst.com/providers/newsletters/index.page?

*** C**hanges will be included in the appropriate 2Q 2016 provider administration manual update.

Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

Commercial Service Lines 1-800-924-7141
Monday–Friday, 8 a.m. to 6 p.m. (ET)

Commercial UM 1-800-924-7141
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

Federal Employee Program 1-800-574-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)

BlueCare	**1-800-468-9736**
TennCare*Select*	**1-800-276-1978**
CoverKids	**1-800-924-7141**
CHOICES	**1-888-747-8955**
BlueCare Plus℠	**1-800-299-1407**
BlueChoice℠	**1-866-781-3489**
SelectCommunity	**1-800-292-8196**

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

BlueCard
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueAdvantage 1-800-841-7434
BlueAdvantage Group 1-800-818-0962
Monday–Friday, 8 a.m. to 6 p.m. (ET)

eBusiness Technical Support
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 6 p.m. (ET)
Friday, 9 a.m. to 6 p.m. (ET)

BlueCross BlueShield of Tennessee