DECEMBER 2021

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

Throughout the COVID-19 pandemic, we've made changes to help our members and providers stay safe. Please continue to visit the Provider FAQs at **BCBSTupdates.com** for up-to-date guidelines on how we have updated our policies to help you care for our members.

INSIDE THIS ISSUE

News About Upcoming Telehealth Updates

During the pandemic, we greatly expanded our telehealth coverage so providers could continue providing quality care to our members. We're deeply invested in supporting telehealth and will broadly cover many telehealth services even after this public health emergency has passed. We're also reviewing codes to make sure we don't cover services that need to take place in a provider's office and will start denying inaccurate telehealth claims beginning Jan. 1, 2022. We've been monitoring claims over time, and a small number (fewer than .01%) appear to have been billed incorrectly so far. We don't believe these changes will affect many providers.

Some examples of telehealth claims mistakenly received that we'll deny:

- Comprehensive physical exams
- Urinalysis
- Eye exams or X-rays
- Vaccinations

Please continue to visit our telehealth section at **bcbstupdates.com** for the latest information. We'll also notify you about coding and coverage changes in future issues of the BlueAlert.

Submit Secondary Claims Through Availity® for Faster Payment

Are you still submitting printed copies of your explanation of benefits (EOBs) for secondary claims? Did you know if you include your primary EOB payment data with your claim electronically, your claim will be processed quicker? Billing secondary claims online will reduce manual pending claims and help processing times.

We've made it easy for you to submit claims electronically through Availity. To do this, you'll need an Availity account with a "Claims" user role and be set up as an electronic provider with us.

Simply follow these steps to get started submitting your claims:

1. Log in to **Availity**.
2. Click the **Claims & Payments** drop-down list.
3. Under **Claims**, select your claim type (Professional, Facility or Dental*).
4. Enter your claim information on the claim form.
5. Once you've completed the form, click **Submit**.

If you need help or would like training, you can use the **Submitting Secondary Claims Electronically** guide or call your **eBusiness Regional Marketing Consultant**. If you have any technical issues, please call the eBusiness Service team at **(423) 535-5717 (option 2)**.

* Dental providers filing services that require submission of X-rays for clinical review or secondary-filed claims should continue submitting claims through their current method at this time.

Self-Service Options Available for Claims Status Inquiry*

To find the status of your claims, please use one of the following self-service options:

Electronic Data Interchange (EDI)

- **Electronic Remittance Advice (ERA) (HIPAA X12 835)** – When claims are final, their status will be available via 835 ERA transactions, which also allow you to post claim results to your billing system.
- **Blue CORE (HIPAA X12 276/277)** – You can work with your vendor to connect with us to get claims status in real time without exiting your system workflow.

Availity

- **Remittance Advice** – The same ERAs that you receive for posting are available in Availity's **Remittance Viewer**. To view the status, log in to Availity and select the **Claims & Payments Remittance Viewer**. If you want to see your legacy remittance, select the BlueCross **Payer Spaces** and click on the **Print/View Remittance Advice** tile.
- **Claims Status** – To check the status of a claim, log in and select the **Claims & Payments** tab, then click **Claims Status**. An easy way to check status is to look for the colors associated with the claim: green is processed, yellow is pending and red means denied.

Automated Claims Status Option

- Call the appropriate Provider Service line (phone numbers are on the last page of this newsletter) and choose the option for **Automated Claims Status**.

After you've found the status of the claim using one of the above methods, our customer service representatives are still available to answer specific questions you may have about a claim payment or denial. Please note, when you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number. If you have questions or need help with Availity or EDI, you can contact eBusiness at **(423) 535-5717, option 2**. If you'd like training on Availity, please contact your **eBusiness Regional Marketing Consultant**.

* This also applies to outsourced vendors acting on a provider's behalf.

BlueCross to Stop Accepting Provider Change Information by Email

Earlier, we posted news that we'd soon require all providers to use CAQH ProView for all updates to provider directory information, including office locations, hours, hospital affiliations and contact numbers. Starting Jan. 1, 2022, we'll return emails for requests to update provider data information and attach instructions on how to complete the process using CAQH ProView.

If you'd like to make updates to your information, please visit our BCBST Payer Space on Availity, and then click the **Provider Enrollment, Updates and Changes** tile. You can also update your information by logging into the **CAQH ProView application** directly. For more information, please call **1-800-924-7141** and follow the prompts to our Network Contracts and Credentialing team.

BlueCross Now Using Change Healthcare for EFT/ERA Enrollment

BlueCross is transitioning to a new source for provider payment information. In the past, we used CAQH's EnrollHub® but CAQH is retiring this tool. As of Dec. 2, 2021, you'll be able to submit Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) changes and enrollments through **Change Healthcare's Payer Enrollment Services** portal, which is accessible through Availity® and **provider.bcbst.com**.

If your information is correct in EnrollHub, you'll continue receiving payments and remittance advice as you always have. If you have questions, please call our Network Contracts and Credentialing service team by following the prompts on our Provider Service Line at **1-800-924-7141**.

Please note, we'll continue using CAQH ProView® for our provider enrollment, credentialing and directory efforts.

Commercial

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

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning Feb. 1, 2022, CPT® code 0208U will no longer require prior authorization through eviCore's Genetic Testing Program. However, the following codes were added and will need prior authorization:

0285U	0290U	0296U	81349
0286U	0291U	0297U	81523
0287U	0292U	0298U	
0288U	0293U	0299U	
0289U	0294U	0300U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity** and clicking **Patient Registration**, then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity. You can also fax eviCore at **1-888-693-3210** or call them at **1-888-693-3211**.

Anesthesiology Services Reminder

We wanted to remind you that we've made some changes to how we calculate time for anesthesiology services. In the past, we rounded up anesthesia time units to the next whole unit. For example, 1.11 units were rounded up to 2 units. Effective July 1, 2021, we started rounding up anesthesia time units to the nearest tenth to better align with industry standards.

For example, we round:

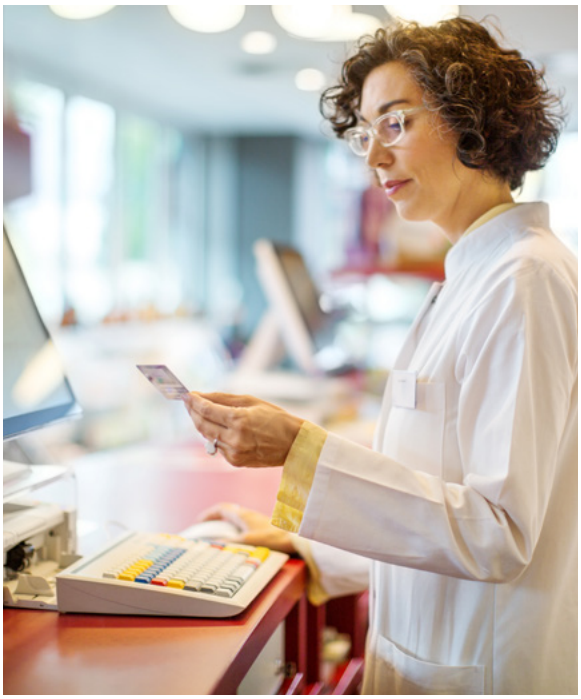
- 1.41 units up to 1.5 units
- 1.91 units up to 2 units
- 1.61 units up to 1.7 units

Please note that anesthesia time doesn't apply to Daily Hospital Management Services. For more details, please refer to your **Provider Administration Manual**. **This change also applies to BlueCare Tennessee.**

Speech Therapy Additional Benefit Information

Please use the Fast Path option in Availity for benefits and eligibility. Many Commercial plans have limitations on what conditions are eligible for speech therapy. Make sure your patient is eligible for speech therapy prior to services being rendered.

If you need help registering for Availity, call **1-800-282-4548**. For navigation help, please contact our eBusiness department at **(423) 535-5717** or call **1-800-924-7141** and follow the prompts to eBusiness Support.



Advanced Specialty Benefit Management (ASBM) Program Pharmacy Expansion

Starting Jan. 1, 2022, we're expanding our ASBM program to all Commercial fully insured plans, both group and Marketplace. This program only affects specialty drugs administered in a provider's office or facility, not self-administered specialty drugs delivered to members' homes. The prior authorization and claim submission processes in place for members in our self-funded ASBM groups will apply to members in fully insured group and Marketplace plans. Providers who chose our TransactRx specialty drug billing option can expect to receive calendar-year 2022 contracts in mid- to late-fall, just like last year.

We began sending letters in November to all members and their providers who have an open authorization for one of the affected drugs to make sure they're aware of and understand this change. If you have questions, please contact your Provider Network Manager.

Changes to Commercial Prior Authorization Requirements

Beginning Feb. 1, 2022, CPT® codes 53430, C1813 and C2622 will require prior authorization. CPT® codes 57295, 57296 and 57426 will no longer require prior authorization. These CPT® codes are for Gender Reassignment and only require prior authorization when being billed with the gender reassignment diagnosis codes.

You can submit authorization requests through the **Authorization Submission/Review application** tile in Availity, by faxing them to Commercial Utilization Management at **1-866-558-0789** or calling our Provider Service Line at **1-800-924-7141**.

Member Telephone Numbers Needed for Online Utilization Management Authorizations

When submitting utilization management authorizations through the Provider Authorization Tool in Availity, please make sure to add the member's telephone number in the **Patient Phone** field. Although this isn't a required field, including a telephone number for the member helps our Case Management team with any needed outreach or member care services. If you have questions, please call the Provider Service Line at **1-800-924-7141**.

Changes to Commercial the Lab-based Sleep Study

Beginning Jan. 1, 2022, CPT® code 95805 will be added and require prior authorization through Commercial's Lab-based Sleep Study Program. Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity** and clicking **Patient Registration** then **Eligibility** and **Benefits Inquiry**. You can submit authorization requests through the **Authorization Submission/Review** application tile in Availity, by faxing them to Commercial Utilization Management at **1-866-558-0789** or calling our Provider Service Line at **1-800-924-7141**.

Consolidated Appropriations Act Requirements Beginning Jan. 1, 2022

Many of the health care requirements outlined in the **Consolidated Appropriations Act (CAA)** go into effect on or after Jan. 1, 2022. The requirements listed below are based on the provisions as we currently understand them and may change with future guidance from the government.

Member ID Cards

One of the provisions of the CAA requires that health insurance companies and group health plans (groups) include new information on member ID cards. Beginning Jan. 1, 2022, you may start seeing health insurance ID cards with this additional information. However, only new cards issued or digital cards downloaded/printed on or after Jan. 1, 2022, will include this additional information:

- In-network and out-of-network (OON) deductibles
- Out-of-pocket maximum amounts
- Websites and phone numbers for members to get more information

Below are two sample cards for typical plans – a preferred provider organization (PPO) plan and a high-deductible health plan (HDHP) with in-network and out-of-network benefits. Actual cards may differ based on plan specifics.

Sample PPO Card

Sample HDHP Card

Provider Directory

FAQs issued in August indicated that federal agencies will be issuing regulations to fully implement this provision, but not until after Jan. 1, 2022. In the meantime, we're working toward implementing the requirements as we best understand them. New requirements outline specific processes to:

- Verify and update provider directory information at least every 90 days (name, address, phone number, specialty and digital contact information).
- Update certain provider data within two business days.
- Respond to requests for in-network provider information.
- Establish a procedure to remove providers from our provider directory who don't validate their data.

Beginning Jan. 1, 2022, the CAA also requires providers to submit provider directory information to contracted health plans in a timely manner. New requirements outline when providers should submit their information:

- When the provider enters into or terminates their provider agreement with the health plan
- When there's a material change to their provider directory information
- At any other time, including when requested by the health plan

To meet these requirements, individual providers should continue using CAQH to validate their data. Facilities and ancillaries should continue using Data Verification Forms. Information in CAQH must be reviewed and validated every 90 days and a response must be returned for every Data Verification Form.

If you're removed from the directory for non-compliance, you can attest your information to be added back in the directory.

Surprise Billing Protections

Beginning Jan. 1, 2022, the CAA includes new protections that prohibit OON providers from billing members for more than their cost-share in:

- Emergency services received at an OON hospital emergency department or independent freestanding emergency department
- Non-emergency services received from an OON provider at an in-network facility, except non-ancillary services, when the member receives notice of and agrees to treatment by the OON provider and balance billing
- OON air ambulance if the services would've been covered if provided by an in-network air ambulance provider

Delayed Enforcement of Advance Cost Estimates for Health Care Services – Effective Date to be Determined

On Aug. 20, 2021, the federal agencies overseeing CAA implementation issued **FAQs** addressing several provisions of the law and won't enforce certain provisions until a future date. This includes the advanced explanation of benefits (AEOB).

As a reminder, the AEOB cost estimates will require actions by BlueCross and providers:

- You'll need to send BlueCross a good faith estimate of the costs. This includes billing and diagnostic codes for the scheduled care, as well as anything expected to be offered by other providers or facilities.
- We'll give our members information on the:
  - Provider's network participation and rates
  - Member's remaining deductible and out-of-pocket balances
  - Member's expected financial responsibility (good-faith estimate)

The FAQs indicate that the federal agencies plan to issue regulations to fully implement this provision, including establishing appropriate data transfer standards. For more information about the CAA, please click this **link**.

BlueCare Tennessee

This information applies to BlueCare [SM], TennCareSelect and CoverKids plans unless stated otherwise.

Emergency Room Benefit Update

Effective Jan. 1, 2022, the emergency room copay will decrease from $10 to $8.20 for BlueCare Tennessee members with incomes at/or between 100-199% of the federal poverty level. BlueCare members will only pay this copay if they aren't admitted to the hospital.

Maternity Care Updates Beginning Jan. 1

Beginning Jan. 1, 2022, coding changes will take effect for postpartum care. According to the American College of Obstetricians and Gynecologists (ACOG), every mother should be screened at least once for depression and anxiety during the perinatal period using a standardized validated tool. In response to ACOG's recommendations, TennCare is making changes to its model of postpartum care. The following applies for all deliveries (liveborn and non-liveborn) and all risk categories. The length of the postpartum period will be increased to 84 days.

Maternity Care Management Form (formerly Pregnancy Notification Form)

- Code 0500F should be billed with one of these CPT® codes: 99202-99205, 99211-99215.
- We'll no longer use CPT® code 99201.
- The additional reimbursement for submitting the form will increase from $10 to $25.

Postpartum visit for uncomplicated, routine care

- Code 0503F should be billed with CPT® code 59430.
- We'll allow for reimbursement of two claims and payments during the 84-day postpartum period.
- The additional payment for completing these visits will increase from $10 to $75 per visit.

Mental health screening with validated tool

- Bill CPT® 96160 with a TH modifier to show you completed this service.
- You'll receive an additional reimbursement of $28.35 for performing this screening.
- No specific diagnosis code is required for payment.

Process Reminder: Submitting Provider Appeals for Payment Disputes

When disputing a provider payment, please follow the Provider Dispute Resolution Procedure in the **BlueCare Tennessee Provider Administration Manual**. If you've filed a provider payment (non-specialty pharmacy) dispute reconsideration and aren't satisfied with the response, please send appeal requests to BlueCare Tennessee, **not** the Division of TennCare.

To file a payment dispute appeal, please complete the **Provider Appeal Form** and fax it to (**423) 535-1959** or mail it to:

BlueCare Tennessee/
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste. 0039
Chattanooga, TN 37402

For more detailed information about our appeal and reconsideration process, please see the **BlueCare Tennessee Provider Administration Manual**.

Mileage Reimbursement for BlueCare Tennessee Members

We contract with Southeastrans to handle non-emergency medical transportation to and from covered TennCare services. Depending on a member's location, transportation options may include a shared ride service, bus pass or mileage reimbursement.

Mileage reimbursement is a convenient option for members who have access to a vehicle or a friend/relative willing to drive them to their appointment. Members who choose mileage reimbursement will receive a form that you'll need to sign confirming they visited your office. They'll then send the form to Southeastrans, which will reimburse them for the cost of fuel.

Scheduling transportation

All transportation requests should be made at least 72 hours (three calendar days) before the appointment. Your patients who need to travel less than 90 miles can contact Southeastrans at the appropriate number below to schedule their transportation:

BlueCare. **1-855-735-4660**

TennCareSelect **1-866-473-7565**

If your patient needs to travel more than 90 miles, please ask them to call the **Customer Service line** for their plan:

BlueCare. **1-800-468-9698**

TennCareSelect **1-800-263-5479**

Our Utilization Management department will review the request and may help the member find a closer provider, if applicable, to reduce travel time and distance.

For more information about these transportation benefits, please visit **bluecare.bcbst.com** and select **Get a Ride**.

Note: These transportation benefits don't apply to CoverKids members.

Be on the Lookout for Southeastrans Information Requests

When BlueCare and TennCareSelect members use Southeastrans, the carrier conducts regular pre- and post-trip audits to make sure the transportation is only for covered services and the visits go as scheduled. As part of these audits, Southeastrans may call your office to verify your patients' appointments. This is a normal part of Southeastrans' process, and you may release the requested information.

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

Resources to Support Pediatric Care

We want to support you as you continue to welcome families back to your office and encourage well-child care. You can find a variety of resources about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams on the Provider pages of **bluecare.bcbst.com**:

1. **BlueCare Tennessee Provider Administration Manual (PAM)** – Our PAM is updated quarterly and provides comprehensive information about your BlueCare Tennessee patients' benefits.
2. **TennCare Kids Tool Kit** – Our TennCare Kids Tool Kit contains information about the TennCare Kids program and links to resources, such as our EPSDT Provider Booklet and reference materials for patient outreach.

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) also offers guidance about delivering well-child care, including EPSDT visits and coding. For more information, visit **tnaap.org**.

Be on the Lookout for More Opportunities to Connect in 2022

Next year, we'll be hosting focus groups for providers in certain areas of the state. The goal of these sessions will be to get feedback on barriers that may be preventing kids from getting needed care and share information on how we can work together to improve EPSDT screening rates.

We'll be meeting with providers in **Giles, Lawrence, Perry, Lewis and Wayne counties** on **Jan. 7 from 9:30 to 11 a.m. CT (10:30 a.m. to 12 p.m. EST)** and with providers from **Obian, Gibson, Lake, Crockett and Dyer counties** on **Jan. 18 from 12 to 1:30 p.m. CT (1 to 2:30 p.m. EST)**. Providers in these areas will receive more information about the focus groups soon. If you're a provider in one of these counties and would like to learn more or register to attend, please email **CommunityEngagement@bcbst.com**.

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

Ownership Disclosure Reporting for BlueCare Tennessee Providers

All contracted and non-contracted providers, groups and facilities who participate in the BlueCare and TennCareSelect networks and/or receive TennCare funds must comply with federal ownership disclosure requirements. These requirements also apply to referring, ordering and prescribing providers who serve TennCare members, even if they don't participate in our networks.

According to the guidelines, providers must submit routine disclosures during initial contracting and at least every three years afterward. You may need to submit a disclosure sooner than three years if:

- You renew your contract
- Information on the disclosure form changes
- There's a change of ownership

In cases of change of ownership, the revised disclosure must be submitted within 35 business days.

To satisfy these requirements, we encourage you to update your TennCare provider profile any time there are changes to your practice's office manager or others with an ownership stake in your practice. This includes updating your information if someone associated with your practice is convicted of a crime. To change the information in your provider profile, visit **tn.gov/tenncare/providers/provider-registration.html**

Review Your Updated Episodes of Care Reports in Availity

We want to make sure you have the information you need to succeed in the Episodes of Care program, so we recently made a significant enhancement to your quarterly reports.

All Excel reports have been combined into one workbook, which contains both included and excluded episodes. We hope this improvement makes it easier for you to access, review and download your reports. If you have questions about using Availity, please call **(423) 535-5717** and press option 2 or email **eBusiness_Service@bcbst.com**.

Free Shared Decision-Making Tools in Availity

Shared decision-making (SDM) is a model of two-way communication that involves providers and patients discussing health care options with evidence-based information, the provider's knowledge, and the patient's preferences. Please take a moment to access your free SDM tools, or printable handouts, in Availity. These guides may be helpful for OB/GYN providers when discussing a higher risk of complications during childbirth or orthopedic providers when discussing joint pain.

SDM aids on the Availity portal include:

- Pregnancy: Your Birth Options After Cesarean
- Pregnancy: Birth Options if Your Baby is Getting Too Big
- Hip Osteoarthritis: Is it Time to Think About Surgery?
- Knee Osteoarthritis: Is it Time to Think About Surgery?

To use these resources, simply log in to Availity and go to the **BlueCross Payer Space**. From there, choose the **Resources** tab and click the link to show all resources. Select the SDM tool you want to view, and it will open in a new browser tab for you to review with your patient and/or print. If you have questions about using the Availity portal, please call your **eBusiness Regional Marketing Consultant**.

Important Announcement from TennCare: Providers CARE Survey

Good health outcomes start in the communities where your patients live, so we invite you to take the Providers CARE Survey. The CARE survey will ask you about the needs of your patients, your experiences, and learning opportunities that can assist your practice team.

Our goal is to help you improve your patients' health by:

C = Connecting them with community resources (like food pantries and housing help)

A = Acting for better health by teaching them about their care needs

R = Reducing differences

E = Encouraging them. Take the time to listen to your patients. Treating them with kindness and support can help them take the steps they need for better health.

To fill out the survey, please visit **tn.gov/tenncare/providers/social-and-health-needs.html**. Your answers won't have your name on them and will be combined with information from other providers.

Benefit Changes for Formula and Incontinence Supplies

Formula and incontinence supplies are now covered retroactively (as of Jan. 1, 2021) for CoverKids members. Authorization requirements and limits apply, which you can learn more about on the next page.

Formula Coverage

Food supplements and substitutes including formulas are now covered. This includes parenteral nutrition formulas, enteral nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat phenylketonuria for members age 21 and older. Oral liquid nutrition may also be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight and physically incapable of consuming a sufficient food intake.

All enteral and oral formula requires authorization except for total parenteral nutrition.

Incontinence Supplies Coverage

Incontinence supplies are covered exclusively through Medline and have a limit of 200 per month. Requests for brand name products and supplies over 200 per month require authorization. Incontinence supplies (diapers/liners/under pads) not needed for a medical condition aren't covered for children age three and younger. For more information on incontinence supplies, contact Medline:

Phone: **1-877-853-7558**

Fax: **1-866-557-2737**

Email: **BlueCareTennessee@medline.com**

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ and BlueEssential (HMO-SNP)℠ plans.

BlueEssential (HMO C-SNP)℠ Closure Update

BlueEssential (HMO C-SNP)℠ won't be offered in 2022. It was launched as a chronic special needs plan for individuals with diabetes in 2020 and expanded to those with cardiovascular disease in 2021. The plan included a limited network with key hospitals, primary care providers, and specialist groups in Chattanooga, Jackson, Knoxville, Memphis, Nashville and the Tri-Cities (30 Tennessee counties).

Please contact your Medicare Advantage Provider Quality Outreach Consultant if you have questions about this plan. Current C-SNP members have options to enroll in our PPO plan during the Annual Enrollment Period until Dec. 7, 2021.

Update to the 2022 Provider Assessment Form (PAF) Program

On Jan. 1, 2022, Medicare Advantage will change our existing PAF program, providing two options for PAF submission:

- **Electronic PAF:** A new, brief, hierarchical chronic condition (HCC)-focused PAF is in the Quality Care Rewards (QCR) application in Availity. You can complete it in the QCR application, export it for completion, and then upload it to the QCR or fax it.
- **Non-Standard PAF:** Providers/groups that have an approved non-standard PAF with BlueCross in 2021 may continue to submit these assessments for 2022 either by uploading it into the QCR or by fax.
- Please note the current PAF form will be retired and not accepted after Dec. 31, 2021.
- A copy of the PAF form used should also be part of the patient's permanent medical record.

Providers will submit the **appropriate CPT® code** once per calendar year after the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code. A face-to-face visit is still required for PAF documentation. Also, during the National Public Health Emergency, a telehealth visit will also suffice for PAF documentation. No modifier is needed.

- **Electronic PAF:** CPT® code **96161** (new code beginning in 2022)
- **Approved Non-Standard PAF:** CPT® code **96160**

Reimbursement for completion of a PAF will be based on the PAF submission option outlined above.

- **Electronic PAF: $225** Jan. 1 through Dec. 31
- **Non-Standard PAF: $100** Jan. 1 through Dec. 31

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information about these PAF program updates.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage, BlueEssential and BlueCare Plus plans unless specifically identified below.

Special Needs Plan Model of Care Training

Providers participating in BlueCare Plus, BlueCare Plus Choice and BlueEssential special needs plans are contractually required to complete our Model of Care training after initial contracting and every year afterwards. This training highlights how coordinated care for our members with complex, chronic or catastrophic health care needs can lead to better health outcomes. The training is a requirement from the Centers for Medicare & Medicaid Services (CMS). You can access the online self-study training and attestation by **clicking here**.

Patients with Diabetes Need Statin Medication Fill

American College of Cardiology and American Heart Association guidelines state patients with diabetes **should receive a statin medication** to help reduce the incidence of heart disease and stroke.

One of the Centers for Medicare & Medicaid Services (CMS) star measures – Statin Use in Persons with Diabetes (SUPD) – looks at Medicare Advantage Prescription Drug plan members who:

- Are between the ages of 40 and 75;
- Have filled at least two prescriptions for a medication to treat diabetes during the plan year; and
- Have received a prescription for a statin medication

This measure doesn't include a minimum dosage requirement. Members who have end-stage renal disease or are receiving hospice services are excluded from this measure.

Additionally, new **exclusions** were added by CMS to the measure specifications for 2021:

- Rhabdomyolysis
- Drug-induced myopathy
- Myopathy, unspecified
- Hepatic failure, unspecified, without coma
- Adverse effect of antihyperlipidemic and anti-arteriosclerotic drugs, initial encounter
- Myositis, unspecified
- Pre-diabetes
- Polycystic ovary syndrome (PCOS)

For a Medicare Advantage Prescription Drug (MAPD) plan member to be excluded from the measure, the treating physician must include the ICD-10 diagnosis code for the applicable exclusion condition on the claim submitted to the plan. **Documentation of a statin intolerance or contraindication in the chart alone won't exclude the member from this quality measure.**

Clinical decisions regarding whether a statin medication is appropriate are between the treating physician and their patient. Please note that when making prescribing decisions with patients who are MAPD plan members, all generic statins are included in the BlueCross Medicare Part D drug list when filled at preferred pharmacies. Copays range from $0-$1 for a 90-day supply depending on the member's specific plan type.

Pharmacy

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

New Pharmacy Benefits Manager Coming in 2022

Beginning Jan. 1, 2022, we're changing our pharmacy benefits manager from Express Scripts to CVS Caremark (CVS).

Although this change should have little-to-no impact on your day-to-day operations, we wanted to highlight some key points:

- We'll continue managing our **formularies** and notify you of major changes in BlueAlert.
- Our **2022 formularies** are online.
- More than 66,000 pharmacies are included in our national pharmacy network, so member disruption will be minimal. We'll notify members whose pharmacy won't be in-network as of Jan 1, 2022.
- Please send all mail order prescriptions to CVS Caremark. Current mail order refills will be automatically moved to CVS. The only step members will need to take is to update their payment information by calling:
  - Commercial mail order: **1-844-740-0604**
  - Medicare mail order: **1-844-740-0602**
- Continue submitting prior authorizations through Availity.
- We'll provide two years of pharmacy claims to CVS for seamless utilization review.
- You can check your patients' pharmacy benefits, see utilization management requirements and point-of-care costs in real-time through the e-prescribing workflow.
- CVS will oversee certain clinical programs. You may get communications from CVS Caremark on behalf of BlueCross members.

Members will receive new ID cards next month. We understand you may have some questions about joining the CVS retail network. If so, please **click here**. For questions about our preferred specialty pharmacy network, reach out to your Provider Network Manager.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Correction for New Prior Authorization Requirements on ADHD Medications

New prior authorization requirements on attention-deficit/hyperactivity disorder (ADHD) medications beginning Jan. 1, 2022, apply **only to members 19 years and older**. We erroneously sent disruption letters to all members prescribed ADHD drugs, including those under 19. We've sent correction letters to all impacted members. Moving forward, ADHD medications for those younger than 19 won't require prior authorization.

Updates to Key Online Resources

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Latest Information and Changes for Coding Updates, Provider Administration Manuals (PAMs) and Medical Policies

You can easily find the latest information and the changes on the way for several key items that are important to providers:

- **Commercial Provider Administration Manuals (60-Day Preview Version):** Access the Commercial Preview PAM 60 days before the effective date in the **Manuals, Policies & Guidelines** section at **provider.bcbst.com**.
- **Medical Policies, Administrative Services Policies, Utilization Management Guidelines (UMG):** View upcoming BlueCross policy or guideline changes at **provider.bcbst.com/coverage**. If you have questions, please send an email to **medical_policy@bcbst.com**.
- **Coding Updates:** Find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page.

If you have questions, please call us at **1-800-924-7141** and follow the prompts to Network Contracting and Credentialing.

Quality Care Rewards

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

BlueCross Medicare Advantage 2022 Quality Program Measures

To align with changes from the CMS Quality Rating Program for MA plans beginning Jan. 1, 2022, Medicare Advantage will make updates to the quality measures included in the Quality+ Partnerships program:

- Controlling Blood Pressure (CBP) will move to a three-weight measure
- The Member Experience CAHPS and HOS measures will move to two-weight measures
- Medication Reconciliation Post-Discharge (MRP) will be one of four components included in a new Transitions of Care measure

2022 Program Year Measures (in order of weight)	Source	Weight
Comprehensive Diabetes Care (CDC) - HbA1c Control <9%	HEDIS	3
Controlling High Blood Pressure (CBP)	HEDIS	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS	3
Member Experience — CAHPS	CMS Member Survey	2
Member Experience — HOS	CMS Member CAA	2
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Comprehensive Diabetes Care (CDC) - Eye Exam	HEDIS	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Transitions of Care (TRC)	HEDIS	1

If you have questions about the included 2022 measures, contact your Medicare Advantage Provider Quality Outreach Consultant.

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Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
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Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

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

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

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