APRIL 2023

BlueAlert℠

of Tennessee | 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. With the National Public Health Emergency ending on May 11, 2023, we'll be taking steps to return to some of our original policies and procedures. Please continue to visit the Provider FAQs at **bcbstupdates.com** for up-to-date guidelines to help you care for our members.

INSIDE THIS ISSUE

Recommended Immunization Schedule Updates

The Advisory Committee on Immunization Practices has approved the **2023 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger**. Notable updates for 2023 include adding the COVID-19 vaccine to the routine vaccination schedule.

For more information, please see the **For Healthcare Providers** section of the Centers for Disease Control and Prevention's **Immunization Schedules web page**.

2023 Virtual All Blue Workshop℠ Set for Aug. 3

Save the date for this year's All Blue Workshop on Aug. 3, 2023. We're livestreaming again this year with a few updates for 2023. All Blues will again be a full-day event, but this year we're offering four breakout sessions instead of two. Please check upcoming issues of BlueAlert for registration information and more details.

Refer Your Patients with BlueCross Coverage to Network Providers

Our members get the most from their health benefits when they visit participating network providers. As one of our network providers, please remember you're contractually obligated to refer your patients with BlueCross coverage to contracted network providers. This is especially important when referring patients to hospitals or for lab work, durable medical equipment and any other ancillary service.

Our **Find Care** tool on **bcbst.com** can help easily locate other participating network providers. Please keep in mind that genetic testing not performed by a network provider requires prior authorization, and other out-of-network services may require review.

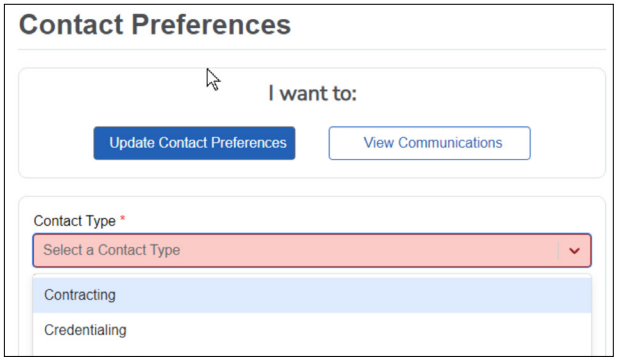
Get Contracts and Fee Schedule Updates Quicker

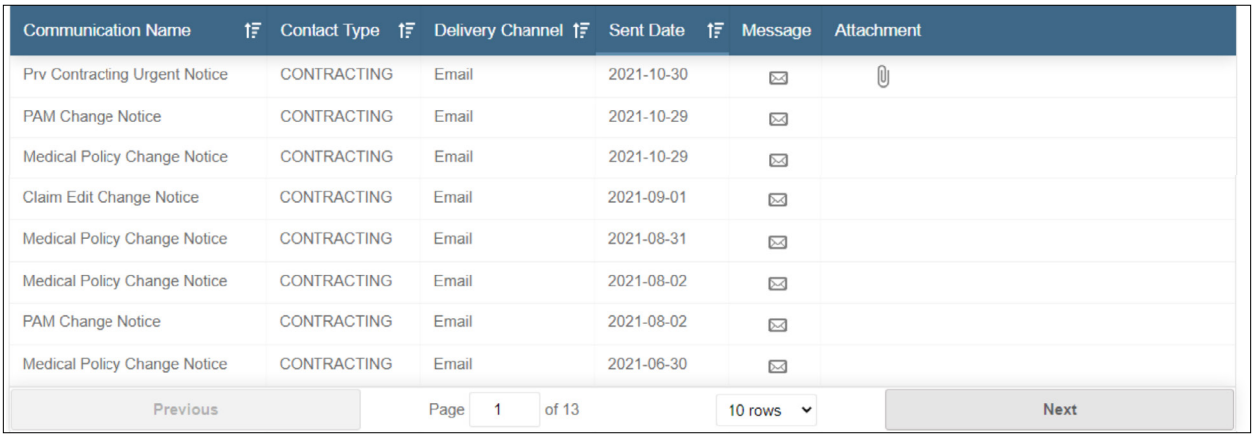
Did you know you can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email? Simply update your **Contact Preferences** through our Payer Spaces in **Availity®** and make email your preferred **contracting** communication type. Here's how:

1. Log in to **BlueCross Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose **Contracting** as your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verify your **Provider Name** and **National Provider Identifier (NPI)** and click **Submit**.
   - For the **Contracting contact**, you may have multiple provider names in the left pane, so select the name(s) you want to update.
   - If you don't see your name in the drop-down list, add your provider through the **Manage My Organization** dashboard.
5. Follow the remaining cues, including checking the email **Opt-In** box and making sure email is the first option in the **Communication Preference** list on the right side. Then, click **Save & Submit**.

   You can apply the same updates to other contact types by checking additional **Contact Type** boxes – or the **Select All** box.

You can also view a record of past email communications by clicking the **View Communications** button from the **Update Contact Preferences** screen.





Communication Name	Contact Type	Delivery Channel	Sent Date	Message	Attachment
Prv Contracting Urgent Notice	CONTRACTING	Email	2021-10-30	✉	📎
PAM Change Notice	CONTRACTING	Email	2021-10-29	✉	
Medical Policy Change Notice	CONTRACTING	Email	2021-10-29	✉	
Claim Edit Change Notice	CONTRACTING	Email	2021-09-01	✉	
Medical Policy Change Notice	CONTRACTING	Email	2021-08-31	✉	
Medical Policy Change Notice	CONTRACTING	Email	2021-08-02	✉	
PAM Change Notice	CONTRACTING	Email	2021-08-02	✉	
Medical Policy Change Notice	CONTRACTING	Email	2021-06-30	✉	

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From the **Communication Name** list, you can click the envelope icon ✉ (**Message** column) to download the actual message. If a paper clip icon 📎 is displayed in the Attachment column, you can download the attachment that was included with that message.

For more information about Contact Preferences, please refer to the *Contact Preference Quick Reference Guide* under the **Payer Spaces Resources** tab in Availity. If you need help accessing your fee schedules for BlueCross contracts, you can also find a *Fee Schedule Viewer Quick Reference Guide (QRGs)* under the **Resources** tab.

If you have questions, contact our eBusiness Service team at **(423) 535-5717 (option 2)**. Or, you can call the Provider Service line at **1-800-924-7141** and follow the prompts to **Contracting and Credentialing**.

Fee Schedule Viewer on Availity®

We've made it easy for you to view and download your network fee schedules on Availity. You can access the most updated schedules online, any time at your convenience.

If you need help accessing your fee schedules for BlueCross contracts, you can find a *Fee Schedule Viewer Quick Reference Guides (QRGs)* available under the **Resources** tab.

If you'd like to receive notices by email, please register your **preferred contracting** email address under the contact preference tile in **Availity**. You can reference the *Contact Preference QRG* to learn how to update your contact information and view your important messages and documents on Availity.

Providers Must Register for Electronic Funds Transfer

As of September 2022, providers are required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're currently receiving electronic payments and remittance advice as intended, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Technical Support. You can also contact your Provider Network Manager.

News About Digital Member ID Cards

This year, more of our members are using digital Member ID cards. While we've offered the option for some time, we're now encouraging increased use of these IDs for many of our members.

You can find the same information as that listed on the plastic Member ID card. Simply ask your patients to share their digital ID through our BlueCross BlueShield of Tennessee app or Apple Wallet. You can also find useful Member ID information in Availity®.

Avoid Delays with the Group Enrollment Form

Understanding our network participation enrollment process provides a more efficient experience for providers. Providers with only an Entity Type 1 National Provider Identifier (NPI) should use the Provider Enrollment Form (PEF). If a provider has an Entity Type 2 National Provider Identifier (NPI), in addition to their individual Entity Type 1 NPI, a Group Enrollment Form (GEF) must be submitted to avoid any delays in the enrollment process. For example, an individual (Type 1 NPI) joining a group (Type 2 NPI) must complete and submit a GEF. Click **here** for CMS definitions of Entity Type 1 and Entity Type 2.

The GEF allows up to 15 practitioners per application, and we pre-populate many fields to save time for the applicant. You can find the PEF and GEF on Availity under the **Provider Enrollment, Updates and Changes** tile.

Beginning in mid-March, we'll reject PEFs for individual providers if the provider belongs to or joins a group with a Type 2 NPI.

If you have questions or need help with the enrollment process, reach out to your Provider Network Manager.

Member Service Resource Team for Tennessee Providers

To help support Tennessee-based providers and members, we've assigned a specially trained member service team to answer provider questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who are facing a non-viable pregnancy. These representatives are also able to provide information about behavioral health benefits, coverage and eligibility.

To reach the team, please call **1-866-268-3502**, from 8 a.m. to 6 p.m. ET.

Commercial

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

Availity Offers Fastest Turnaround Time for Behavioral Health Prior Authorizations

Providers requesting prior authorization for Psychiatric/Substance Use Intensive Outpatient Therapy, or a Psychiatric/Substance Use Partial Hospitalization Program should use Availity for a streamlined authorization process. If providers meet the criteria for an authorization, they will receive an auto-approval.

If you have questions about this process, call our eBusiness Technical Support team Monday-Thursday, 8 a.m. to 6 p.m. ET and Friday, 9 a.m. to 6 p.m. ET at **(423) 535-5717, option 2**.

Changes to Musculoskeletal (MSK) Program Prior Authorizations for Commercial Plans

Beginning **May 1, 2023**, CPT® codes 22860 and 0775T will be added to the MSK program prior authorization list and will require prior authorization for those members with the MSK program benefit.

CPT® code 0163T will be removed from the MSK program prior authorization list effective **May 1, 2023**, for those members with the MSK program benefit.

Changes to Genetic Testing Program Prior Authorization

Beginning **June 1, 2023**, the following codes will be added to the Genetic Testing Prior Authorization List and will require prior authorization through the EviCore Genetic Testing Program.

0364U	0369U	0374U	0379U	0384U
0365U	0370U	0375U	0380U	0385U
0366U	0371U,	0376U	0381U	0386U
0367U	0372U	0377U	0382U	
0368U	0373U	0378U	0383U	

These two codes will be removed from the Evicore Genetic Testing Prior Authorization List: 0324U and 0325U (3D Predict tests)

The following codes have revisions to the code description:

- 0022U: Revised to remove the cholangiocarcinoma indication for OncomineDX Target testing
- 0095U: Had inconsequential wording edits

To reach the team, please call **1-866-268-3502**, from 8 a.m. to 6 p.m. ET.

BlueCare Tennessee

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

Make Sure Your Patients Are Ready for Medicaid Reverification

The Division of TennCare started the reverification process for Tennesseans with BlueCare, TennCare*Select* and CoverKids coverage on April 1. As part of this process, over the next year, TennCare will review each member's eligibility to continue receiving benefits.

To help make sure your patients don't experience a gap in coverage during this process, please encourage them to:

- Sign up for **TennCareConnect**, the state's free, online portal. There, they can select how they want to receive communications (text, email or mail) about their benefits
- Verify their contact information in TennCare Connect or by calling **1-855-259-0701**
- Open and respond to all mail from TennCare

For more information, please visit the Division of TennCare's **Preparing for Renewals web page**.

Make Sure All Patients Benefit from Well-Child Care

Children and teens with special needs often receive extra care and visits to specialists or primary care practitioners. Even though they see their providers frequently, these young patients also need a TennCare Kids well-child checkup every year.

Your patients with BlueCare or TennCare*Select* coverage are eligible for well-child care on the same schedule recommended by the Bright Futures/American Academy of Pediatrics Periodicity Schedule. For more information about pediatric preventive care and to review a copy of the Periodicity Schedule, see our **TennCare Kids Tool Kit**.

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

Expanded Dental Benefits Now Available

The Division of TennCare has expanded dental benefits for patients with Medicaid coverage. Effective Jan. 1, 2023, all patients with BlueCare or TennCare*Select* coverage have dental benefits. Previously, benefits were only available to members:

- Under the age of 21
- Who are pregnant (and for 12 months after giving birth)
- Who enrolled in Employment and Community First CHOICES or a 1915(c) waiver

Please let your patients know about this coverage expansion. If you have questions or would like more information, you may visit **bluecare.bcbst.com** or **dentaquest.com**. DentaQuest handles dental care and claims for our BlueCare Tennessee members.

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

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid dual-eligible special needs plans.

2023 Special Needs Plan Model of Care (MOC) Training Now Available

Providers participating in BlueCare Plus special needs plans are contractually required to complete our MOC training after initial contracting, then every year after. This training promotes quality of care and cost effectiveness through coordinated care for members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**.

Use NIA-Magellan for High-Tech Imaging Authorization Requests

Prior authorization is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization reviews for these cases are processed by our high-tech imaging vendor, NIA-Magellan, on our behalf. Prior authorization isn't required for imaging procedures performed during an inpatient admission or ER visit.

Procedures requiring prior authorization include, but aren't limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology

To request prior authorization for any of the previously listed radiology procedures, call NIA-Magellan at **1-888-258-3864**.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)SM plans unless stated otherwise.

Provider Star Ratings Now Available in Availity

The Medicare Advantage Quality+ Partnerships Program offered providers enhanced reimbursement for 4-STAR and above quality scores and coding accuracy completed during the 2022 measurement period (Jan. 1 – Dec. 31, 2022). Participating providers may view their 2022 Star rating in Availity by accessing the Quality Care Rewards application, clicking on the **Scorecards** tile, then the **Prior Year Scorecards** link under the **More Information** tile. The rating is located at the top of the scorecard.

Star ratings, calculated by the previous year's performance, impacted each provider's current reimbursement rates (effective April 1, 2023). Providers should refer to the rate attachment provided with their rate adjustment notification letters mailed at the end of March 2023 to see their new fee schedules.

Contract amendments contain information about their base rate, the quality escalator and total earning potential.

100-Day Supply of Tier 1 Preferred Generic Medications

All Medicare Advantage members, no matter which plan, can now receive a 100-day supply of Tier 1 preferred generic medications. If this is a feasible option for your patient, simply indicate on the prescription that the medication is for a 100-day supply. Pharmacies are unable to increase the quantity of a 90-day prescription to 100 days, so without this step, your patient won't receive an increased quantity. Copays are outlined below:

- 100-day supply of Tier 1 preferred generics at preferred retail pharmacies or mail order pharmacies: Copay $0
- 100-day supply of Tier 1 preferred generics at standard retail pharmacies: Copay $15

To meet compliance in the medication adherence measures, members must fill their prescriptions often enough throughout the year to have coverage 80% of the time they're supposed to be taking the medication. With a 100-day supply, members will require fewer fills to achieve compliance.

Note: If the pharmacy receives a prescription with a quantity of 100 for a medication that doesn't qualify for this benefit (a non-preferred generic), the pharmacy will simply reduce the quantity to the appropriate 30/60/90-day supply without the need to contact the provider office for approval.

New Over-the-Counter Program

Medicare Advantage members have access to a new over-the-counter program. This program provides them with a fixed dollar amount each quarter to buy over-the-counter medications and products (e.g., bandages, pain relievers, cold medicine, antihistamines or toothpaste). The available allowance depends on the member's plan and ranges from $100 to $200 quarterly and doesn't carry over to the next quarter.

To use their allowance, members can simply present their ID card at the store check-out. No additional card is required. When approved items aren't available in-store, **cvs.com/otchs/bcbstma** is the recommended option to find supplies.

If your patients are interested in using this program, they can request to have a catalog mailed to them (one per member per contract year) by calling **1-888-628-2770, TTY 711**.

Member Attribution Process

Our members with Medicare Advantage coverage are attributed to a provider based on the following process:

- **Member Selection** – The member has informed us who their primary care provider (PCP) is. This ensures the member won't be reassigned to another provider unless they choose to be.
- **Medical Claims** – If the member sees several providers, the provider with the highest number of claims is attributed.
- **Pharmacy Claims** – The prescriber with the highest number of claims for the member receives attribution.
- **Vendor Interaction** – If a member visits a mobile clinic or receives care from a home-care vendor, the member can inform them about their PCP.

A PCP change request can be signed by the member. Providers may have a member sign it to add them to their roster. Please allow four to six weeks for this change to be reflected on your member roster in the Quality Care Rewards (QCR) application. Member rosters are updated monthly in the QCR after the 15th of each month.

Note: The provider listed on the Member ID card isn't always the current PCP we have on file. The PCP listed on their ID card is who they were attributed to when the card was issued. If the member hasn't indicated a PCP, their attribution is subject to change based on who they see for care throughout the year. We recommend your patients indicate a PCP with us by signing a PCP change form or contacting us at the number listed on the back of their ID card.

Exercise Band Toolkits are Available for Your Patients

Our Health Outcomes Survey (HOS) workgroups developed a tangible tool that addresses several of the HOS measures, including:

- Fall prevention/balance
- Monitoring physical activity
- Urinary incontinence/improving bladder control

The tool includes a BlueCross-branded exercise/resistance band (light resistance) and an informational insert to use with the band. The informational insert includes:

- A sample exercise using the resistance band
- Messaging around balance/fall prevention and urinary incontinence
- Silver & Fit information promoting physical activity
- A message noting the importance of discussing these topics with their doctor
- Additional resources

You can order these exercise bands and inserts in bulk to distribute to your patients with Medicare Advantage coverage when discussing these HOS measures. Not only will this help strengthen the message to your patients, but it can help improve health outcomes as well. To place an order, contact your Provider Engagement Representative.

Prevent Delays for Outpatient Service Authorizations

The COVID-19 National Public Health Emergency Declaration is set to end on May 11, 2023. Updated clinical documentation will be required for all concurrent authorizations of home health and outpatient therapy. For all home health and durable medical equipment authorizations, face to face encounters, qualifying oxygen saturations and all other clinical documentation previously waived will be required.

To prevent delays for outpatient service authorizations, a signed written order and current clinical documentation must be included with each request.

Pharmacy

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

Using SureScripts® and CoverMyMeds® for Coverage Review*

Starting May 1, 2023, you can use **SureScripts** for self-administered medication coverage review inquiries. You can also use the BlueCross or CVS coverage review form in **CoverMyMeds**. If you have questions, please contact the **Provider Service Team**.

*** Note:** Information in this article applies to Commercial members only.

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.

Tips for Coding Professionals

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.

Applied Behavior Analysis (ABA) Code Reminder

As of January 2023, providers are required to use dedicated ABA CPT® codes.

All authorizations obtained before Jan. 1, 2023, will be automatically transferred to the new codes for dates of service beginning Jan. 1, 2023. Providers don't need to get a new authorization for these new codes. If you have questions, please contact your Provider Network Manager.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under Coding Updates in the **Coding Information** section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers (option 1).

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

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

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

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	1-800-572-1003
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
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–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
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**.