of Tennessee

AUGUST 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 made changes to help our members and providers stay safe. Now that the National Public Health Emergency has ended, we're 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

Ensure Vaccine Administration Meets Mature Minor Doctrine Clarification Act Requirements

Earlier this year, the Tennessee legislature passed the **Mature Minor Doctrine Clarification Act**. This law requires providers to get informed consent from a parent or legal guardian before administering a vaccine to minors under age 18. It applies to all vaccines, including the COVID-19 immunization. Additionally, such consent must be in written form for the administration of the COVID-19 immunization. Proof of consent for each vaccine must then be included in the minors' medical record documentation.

As you know, vaccinations are an essential part of providing preventive care, and we cover vaccines for children and teens in line with the **Centers for Disease Control and Prevention's Immunization Schedule**. During appointments, consider talking with parents about the vaccines their child may need during the visit and the benefits of vaccination. Then, get the appropriate consent for each vaccine before administering the shots.

Updates to Find My BlueCross Contact

We want to make it as easy as possible for you to work with us, so we've made a few updates to the **My BlueCross Contact page**. Now when you visit the page and type your information into the search box, you'll find detailed explanations about who to contact:

- For questions about an existing contract, you'll be directed to our Provider Contracting team via a drop-down menu based on region.
- For non-contracting questions, you'll be directed to your assigned Provider Network Manager.

For all other provider service-related questions, please call our Provider Service line at **1-800-924-7141.**

Providers Must Register for Electronic Funds Transfer

Providers must register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. Later this year we'll require a "completed" and "approved" application with Change Healthcare before we can accept a request for enrollment through Availity®.

To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**.

What this means for you:

- You'll need to allow up to 10 days to receive approval from Change Healthcare.
- Attempts to enroll new Groups or Providers that don't already have an established EFT record on file with us will be rejected.
- Once you receive your approval confirmation, please go to our Availity **Provider Enrollments and Changes** section.
- For questions about the progress of your Change Healthcare application, please visit **payerenrollservices.com**.

If you're already an in-network provider and currently receive 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.

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, you must submit a Group Enrollment Form (GEF) to avoid any delays in the enrollment process. 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. Since mid-March, we've rejected 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, please reach out to your Provider Network Manager.

New Laboratory Testing Code Reimbursement Policy Delayed to Sept. 1

In the **July 2023 Commercial Preview PAM**, we published a new **Laboratory Testing Code Reimbursement Policy** for certain lab services billed on a professional or institutional claim form. We planned for the policy, which applies to all lines of business, to take effect July 1, 2023.

We've delayed the effective date for this policy, and we're now planning to implement the policy on **Sept. 1, 2023**. We'll let you know in advance if we plan to change this date. To review the reimbursement policies for laboratory testing, please see the **Coverage & Claims** page of **provider.bcbst.com**.

About the Provider Exclusion Screening Process

The health and safety of our members and your employees are important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are "ineligible persons," and therefore, excluded from participation in the Medicare or Medicaid programs. At minimum, registry checks should include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, HHS-OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and the Tennessee Terminated Providers List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

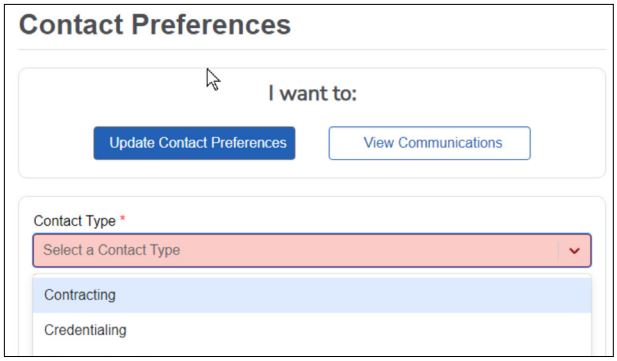
If you have questions, please refer to the "Provider Networks - Federal Exclusion Screening Requirement" section of the **BlueCross BlueShield of Tennessee** and **BlueCare Tennessee Provider Administration Manuals**.

Get Contracts and Fee Schedule Updates Quicker

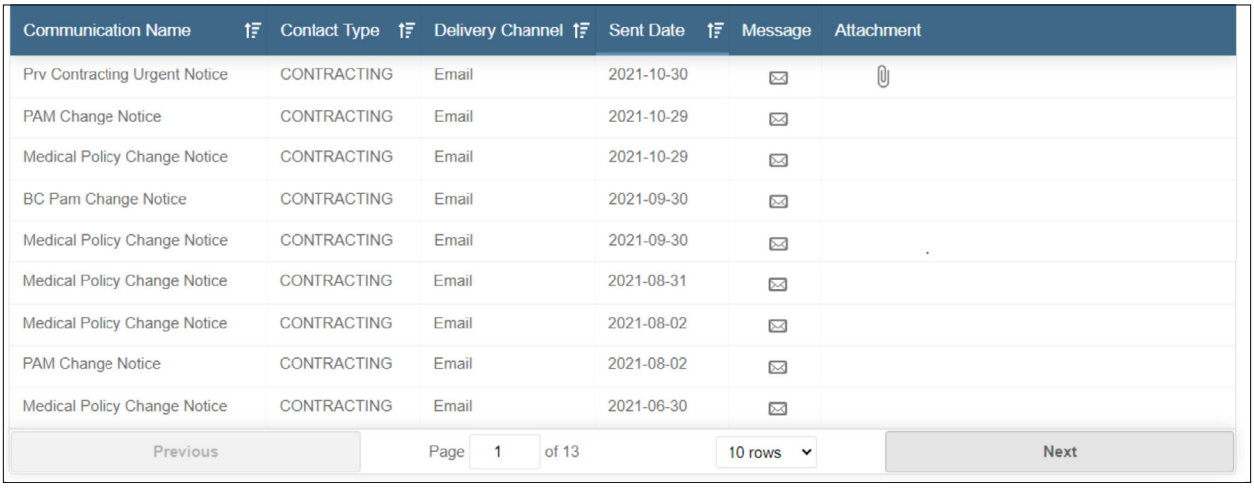
You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. Simply update your **Contact Preferences** through our Payer Spaces in Availity and make email your preferred **contracting** communication type. Here's how:

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 **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	✉	
BC Pam Change Notice	CONTRACTING	Email	2021-09-30	✉	
Medical Policy Change Notice	CONTRACTING	Email	2021-09-30	✉	
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**.

Commercial

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

Correct Use of CPT® 97535 for Self-Care/Home Management Training

To avoid denials when using CPT® 97535 for billing, make sure you're choosing the appropriate code for the specific services provided.

You should use this code for activities of daily living (ADL) and compensatory training for ADL, safety procedures and instruction in the use of adaptive equipment and assistive technology at home. ADL means activities related to living independently in the community, such as meal planning and preparation, managing finances, shopping for food and other essential items, performing essential household chores, and traveling around and participating in the community.

Examples of services not covered by 97535

You shouldn't use this code globally for all home instructions. When instructing patients in a self-management program, use the code that best describes the focus of the self-management activity.

For example:

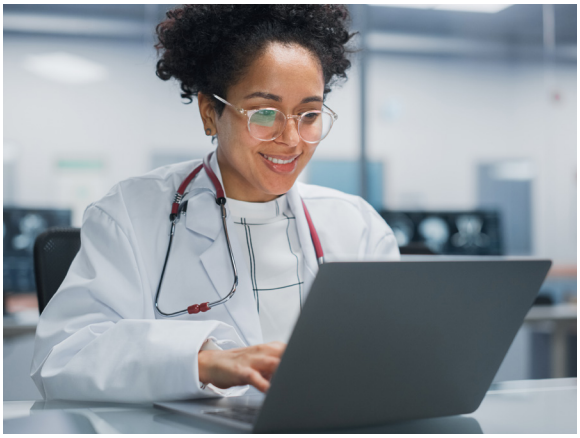
- Use 97110 for instruction on exercises done at home to improve range of motion or strength.
- Use 97112 for instructing patients in balance or coordination activities at home.
- Use 97113 if teaching the patient aquatic exercises to use as an independent program in the community pool.

For questions about this code, refer to the Centers for Medicare and Medicaid Services (CMS) Guide or contact your Provider Service Team.

Out-of-Network Authorizations for Diagnosis-Related Group (DRG) Facilities

If a member is in an out-of-network facility, we'll review the authorization per diem, not according to the typical length of stay associated with the DRG. Requesting the DRG length of stay of eight days could slow down the authorization review process.

You may see an immediate approval if you're within the goal length of stay and meet the clinical guidelines. We'll only authorize initial out-of-network authorization approvals for the clinical guideline goal length of stay. Requests for additional days, outside of the goal length of stay, will require updated clinical information. You can submit clinical updates in Availity.



Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning **Sept. 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:

0388U	0391U	0395U	0397U	0400U
0389U	0392U	0396U	0398U	0401U

The following code will be removed from the Evicore Genetic Testing Prior Authorization List, effective **Sept. 1, 2023**:

0053U

BlueCare Tennessee

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

Join Us for the August 2023 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Virtual Coding Workshop

We're hosting the second virtual workshop of 2023 on Aug. 23 from 11:30 a.m. to 1:30 p.m. CT (12:30 p.m.-2:30 p.m. ET). The two-hour session will feature representatives from the Tennessee Chapter of the American Academy of Pediatrics. We'll cover topics similar to those covered during our June workshop, including:

- An overview of EPSDT
- Submitting appropriate diagnosis codes and billing procedures
- Submitting claims with appropriate codes and modifiers
- EPSDT documentation requirements
- BlueCare Tennessee resources

To register, please fill out the webinar registration form **here**. Each practice that has a representative attend will be entered into a drawing to win an Apple iPad.

We hope you can attend and look forward to connecting with you.

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

Process Reminders for *Select*Kids Members: Financial Responsibility and Obtaining Informed Consent

Foster parents aren't financially responsible for their foster child's medical care and shouldn't list themselves as the person responsible for payment on medical forms. If you have questions about payment, please contact the child's Department of Children's Services (DCS) representative.

DCS also facilitates the informed consent process for children and teens in state custody so they get appropriate health care. This means a child's DCS representative may consent to care or delegate consent to the person who cares for the child daily (foster parents, legal guardians).

To review the related DCS policy, please click **here**. More information about obtaining informed consent is also available in our **Provider Administration Manual**.

Member Transportation Available for Pharmacy Visits

BlueCare and TennCare*Select* members can get a free ride to the pharmacy from our transportation vendor, Verida. If you plan to write a new prescription for a patient or know they'll need to get a prescription refill after their appointment, please remind them to plan ahead. Your patients can pick up prescriptions at the pharmacy the same day as their visit if they've scheduled transportation for both for the same day.

In most cases, transportation requests must be made three days in advance. Your patients with BlueCare Tennessee coverage can schedule transportation online at **member.verida.com** or by calling the Verida customer service number for their plan:

- BlueCare Verida – **1-855-735-4660**
- TennCare*Select* Verida – **1-866-473-7565**

You can also schedule transportation on a patient's behalf in the Verida facility/provider portal at **provider.verida.com**. To get started using the portal, call the appropriate number above for your patient's plan.

To learn more about these benefits, visit **bluecare.bcbst.com** and select **Get a Ride**.

Use Availity or the Updated PCP Change Form to Change a Member's PCP

As announced in **previous BlueAlert newsletters**, primary care providers (PCPs) can now change members' PCPs in Availity. Moving forward, we recommend using the Availity **PCP Change Maintenance** application instead of submitting the **PCP Change form**.

We recently revised the PCP Change form to add information and make it easier to submit online. If you're unable to use the **PCP Change Maintenance** application and must complete the form, please make sure you're using the up-to-date version and email it to **FAX_pcp@bcbst.com**.

For more information about using the **PCP Change Maintenance** application, please review the quick reference guide in the **Resources** section of Availity **Payer Spaces**.

BlueCare Tennessee Inpatient Prior Authorization Notification Requirement Update

Effective Aug. 1, 2023, requests for urgent (emergent) hospital admissions are no longer required within 24 hours or by the next business day after the inpatient admission order. Inpatient facilities can now send admission, discharge and transfer (ADT) data directly to BlueCare Tennessee. We're notified in real time when a member is admitted to an inpatient facility, so inpatient hospital providers won't be issued a denial for non-compliance.

Please note: This update excludes inpatient behavioral health facilities, which are still required to submit authorization requests within 24 hours or one business day.

Other prior authorization guidelines remain the same

Inpatient admissions continue to require authorization for claims payment, and facilities must submit clinical information to ensure inpatient care is medically necessary. Sending clinical information in a timely manner will help us assist you with discharge planning needs. You can submit clinical information several ways:

- Online: **Availity.com**
- Phone: **1-888-423-0131**
- Fax: **1-800-292-5311**

Post-acute authorizations (skilled nursing facilities, inpatient rehabilitation facilities and long-term acute care facilities) and elective (scheduled) inpatient admissions will still require prior authorization before the member is admitted or transferred.

Clarification on Buprenorphine Coverage Updates

The Division of TennCare recently made changes to prior authorization (PA) requirements for preferred buprenorphine/naloxone products. These updates took effect May 15, 2023:

- **Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) Program providers** can now prescribe up to 16 milligrams (mg) of preferred buprenorphine/naloxone tabs and films throughout the induction, stabilization and maintenance therapy phases as needed without a PA. **Note:** Authorization is still needed for doses greater than 16 mg, and PAs currently in place for more than 16 mg per day will not be affected by this update.
- **Non-BESMART providers** participating in our TennCare networks can prescribe an initial five-day supply of buprenorphine/naloxone tabs of 16 mg or less once every six months for therapy induction without a PA.

These changes **only** apply to **preferred** buprenorphine/naloxone products in the chart below. All **non-preferred** agents, including single buprenorphine containing products, **will remain subject to PA requirements.**

Preferred Drugs	Non-Preferred Drugs
BESMART Program Providers	
buprenorphine/naloxone tabs buprenorphine/naloxone film	Bunavail®, Suboxone® film, buprenorphine, Zubsolv®
All other BlueCare Providers	
Buprenorphine/naloxone tabs	Bunavail®, Suboxone® film Buprenorphine, Zubsolv® buprenorphine/naloxone film

For questions about coverage and PAs, please call **1-866-434-5524**. To learn more about our BESMART Program, email **MAT_Referral_CM_UM@bcbst.com**.

Tips for Promoting Childhood and Adolescent Vaccines

Vaccines are a key element of EPSDT TennCare Kids exams. Delivering vaccines on schedule not only protects your patients' health, but also lowers the risk of vaccine-preventable disease outbreaks. This is especially true for children age 2 and younger.

August is National Immunization Awareness Month, which highlights the importance of vaccinations. Consider using the month of August to encourage families to get caught up on EPSDT visits and routine vaccinations before or at the beginning of the school year. Reviewing your medical records and the information in our **Quality Care Rewards** application can help identify patients who need preventive care and ensure they're up to date.

Important vaccine considerations

Tennessee law requires that providers get, informed consent from a parent or legal guardian before giving a vaccine to a minor under age 18. For more information, see the article **Ensure Vaccine Administration Meets Mature Minor Doctrine Clarification Act Requirements** in the **BlueCross BlueShield of Tennessee, Inc.** section of this newsletter. You can view the relevant law **here**.

When administering and submitting claims for immunizations, please use the following CPT® codes:

Immunization Administration

CPT® Code	Description
90460	IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid component administered (Do not report with 90471 or 90473)
+90461*	IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered
90460 and 90461 are reported when the patient is 18 years or younger and the physician or other qualified health care professional performs face-to-face vaccine counseling	
90471	IA, one injected vaccine (Do not report with 90460 or 90473)
+90472	IA, each additional injected vaccine
90473	IA by intranasal/oral route; one vaccine (Do not report with 90460 or 90471)
+90474	IA by intranasal/oral route; each additional vaccine
90471-90474 are reported when the patient is over the age of 18 or when counseling is not performed	

***Please note:** CPT® code 90461 will only be reimbursed for vaccines that aren't administered through the Vaccines for Children program.

We've included links to information from the Centers for Disease Control and Prevention and American Academy of Pediatrics you can use when talking with patients about and administering vaccines.

- **Click here** to review a comprehensive list of all codes commonly administered for pediatric vaccines.
- Review the **immunization schedules** for children and adolescents.

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

Medicaid Reverification and How to Help Members Avoid Gaps in Coverage

TennCare started the reverification process for Tennesseans with BlueCare, TennCare*Select* and CoverKids coverage on April 1, 2023. This process will continue through early next year as TennCare reviews 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 **TennCare Connect**, 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

You can find more information by visiting TennCare's **Preparing for Renewals web page**.

How patients can find alternative coverage

We offer a wide range of affordable Marketplace health plans – and are ready to help individuals and families find the plan that best suits their needs. If a patient needs assistance, they can call us directly at **1-866-886-6545** or shop plans online at **shopbcbstplans.com**.

Stay Up to Date on the Provider Appeals Process

If you disagree with the amount we paid you for a particular claim, you may use our claims reconsideration and appeal process to request a second look. We've put together a few reminders to help make sure reconsideration and appeal requests are processed quickly and correctly. Please note that the below process differs from the process used for utilization management and clinical authorization appeals.

Step 1: Reconsideration – We must receive Reconsideration requests within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration, including all supporting medical records, by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or multiple claims.**

Please note, you must file a request for reconsideration before submitting an appeal unless your request is related to a non-compliance denial. We may deny a claim for non-compliance if prior authorization guidelines aren't followed before giving care. You can read more about non-compliance denials and the process for appealing them in our **BlueCare Tennessee Provider Administration Manual (PAM)**.

Step 2: Appeal – We must receive an appeal in writing with all supporting medical records within 60 days after receiving the other party's response to its inquiry/reconsideration. Please use the **Provider Appeal Form** to submit appeal requests. Like the Provider Reconsideration Form, each document should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeal process, please see the **BlueCare Tennessee PAM**.

Coming Soon: Abortion, Sterilization or Hysterectomy (ASH) Claims Review

In late 2023, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2022, and June 30, 2023.

The retrospective ASH review includes an in-depth look at documents that may not have been required at the time claims were submitted. If you submitted a claim with an ASH code between July 2022 and June 2023, we may contact you for additional records. **Note:** We may recover payment if we don't receive records within the requested time frame.

If you have questions about the ASH review or ASH claims guidelines, please see the **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

Clarification: Changes to the Process for Requesting Certain Transportation Services

In the **June 2023 BlueAlert**, we shared some process updates for requesting transportation. In the article, we inadvertently included incorrect phone numbers for requesting out-of-state trips or trips for minors without an escort.

Our members or their representatives should call us (not Verida) at the Customer Service number for their plan if they need to travel out of state or if a minor needs to travel without a family member, friend or other escort:

- BlueCare: **1-800-468-9698**
- TennCare*Select*: **1-800-263-5479**

We regret the error and apologize for any confusion this may have caused. To learn more about our members' transportation benefits, please visit **bluecare.bcbst.com** and select **Get a Ride**.

Resources to Support Lactation Care

As announced in **previous newsletters**, your patients with BlueCare, TennCare*Select* and CoverKids coverage now have lactation consultant benefits. The Division of TennCare and TennCare managed care organizations recently hosted a webinar for providers to share information about the new benefit, how to code the services, and more. You can review the meeting recording on TennCare's **Lactation Providers web page**. If you have questions not covered by the webinar, please contact the Provider Service line for your patient's plan or review the frequently asked questions on our **Maternity Care Program page**.

To help your patients find a lactation provider within our network, click **here** and search for **Lactation**.

BlueCare Plus (HMO D-SNP)SM

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

Include CPT® II Codes on Claims for A1C Testing

When billing lab codes that indicate an A1C result, please include the appropriate CPT® II code on your claim. Since the Star measure now focuses on A1C control, we want to make sure you get credit for helping patients adequately manage their diabetes and closing the gap in care.

Billing the CPT® II code will also help reduce the number of calls, faxes and medical records requests you get from us to verify claims data and the number of outbound calls we make to our members.

For more information about our quality measures, please see our **Quality Program Information Guide**.

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**.

Medicare Advantage

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

New CKD/ESKD Healthy Living Support Program for Medicare Advantage Members

We're now offering a renal disease support program for eligible members with chronic kidney disease (CKD) and end-stage kidney disease (ESKD). It's designed to help improve their quality measures and clinical outcomes, with a goal of more healthy days.

Through this program, our eligible members, with or at risk of CKD/ESKD, have access to a personal support team of health professionals to help them manage their kidney disease and actively follow your treatment plan.

We're working with **Somatus**, a leading value-based kidney care organization, for delivery of this program, with the goal of keeping patients out of the hospital, improving their quality of life, and slowing or stopping disease progression.

The renal disease support program is a component of the Somatus healthy living program, which is already part of the insurance package for our Medicare Advantage members and available to them at no extra cost. To find out which patients in your practice are eligible for this program, please email **provider@somatus.com**.

The Somatus team supports your patients through:

- One-on-one care to help manage their kidney disease and comorbidities and address social determinants of health
- Personal health coaching based on their condition, treatment options and diet
- Help transitioning safely from hospital to home
- Guidance exploring transplant options, if appropriate
- The 24/7 Somatus Care Hotline at **1-855-851-8354, ext. 9**

We appreciate your support encouraging your eligible patients to engage in this healthy living program. Working together, we can improve the quality of life and health of these patients.

If you have questions about Somatus and the renal disease support program, please contact Somatus directly at **1-855-851-8354**, Monday through Friday, from 8 a.m. to 8 p.m. ET, or email **provider@somatus.com**.

* Somatus is an independent company administering a renal disease support program on behalf of BlueCross BlueShield of Tennessee.

Encourage Your Patients to Get a Bone Mineral Density Screening

Bone mineral density (BMD) tests, which screen for osteoporosis and osteopenia, are especially important in those who've had a fracture. To meet the requirements of the Osteoporosis Management in Women Who Had a Fracture (OMW) HEDIS® measure, women 67-85 years of age who've had a fracture should have a BMD test within six months of the fracture.

Sometimes, patients refuse a BMD test after a fracture because they don't think they need it or understand that getting a test after a fracture can still add clinical value. Consider these tips to promote BMD testing in your practice and help make sure patients get the care they need:

- Talk about the benefits of screening after a fracture, which include confirming the diagnosis of osteoporosis, predicting the chance of future fractures and determining the rate of bone loss.
- Discuss available options for testing (X-rays, dual-energy X-ray absorptiometry (DEXA or DXA) or a CT scan to determine bone density of the hip or spine).
- Review common risk factors so patients can manage their risk of low bone mass. In addition to advancing age, these include smoking, excessive alcohol use, certain medical conditions (including rheumatoid arthritis, type 1 diabetes, liver disease, kidney disease, hyperthyroidism or hyperparathyroidism), a family history of hip fracture, and using steroids long-term.
- Let patients know that treatment is available, and starting treatment early helps minimize bone loss and prevent future fractures.

For more information about the OMW measure, including helpful tips, see our **Quality Program Information Guide**.

Update Registered Taxonomy Codes for Skilled Nursing, CHOICES and Rehabilitation Services

Please make sure all registered taxonomy codes have been updated in the **National Plan and Provider Enumeration System (NPPES) National Provider Identifier Registry**. Using the appropriate taxonomy codes helps make sure you get paid correctly:

- Skilled nursing (SNF)
- CHOICES (NFAC)
- Inpatient/outpatient rehabilitation (OPR)

If you have questions, please contact your Provider Network Manager.

Over-the-Counter (OTC) Program

Medicare Advantage members have access to an OTC program, which is new for 2023 plans. This program provides them with a fixed dollar amount each quarter to buy certain OTC medications and products (i.e., 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 Member ID card at the store check-out. No additional card is required. When approved items aren't available in-store, **bcbstmedicare.com/OTC** 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**.

Pharmacy

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

Changes in Coverage of GLP-1 Drugs

The spike in demand for GLP-1 drugs, due to its side effect of weight loss, has increased off-label prescriptions for weight loss purposes. This is leading to shortages, limiting access for members who need the medications to manage their diabetes.

Starting July 1, 2023, we'll only cover GLP-1 drugs for our Commercial and Marketplace members if clinical documentation of diabetes type 2 is provided.

While we trust the documentation from our providers, we've found some deficiencies in patients' medical and claim histories – and even potential cases of fraud. We're asking all providers to make sure their clinical documentation is complete and accurate to ensure appropriate access and use, and to reduce fraud in the health care system.

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.

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).

Quality Care Rewards

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

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program Reports Available in August

Episodes of Care quarterbacks in the Medicaid and Commercial programs will be able to review their final performance reports for the 2022 performance year on Aug. 17, 2023. These reports will be published in Availity.

If you have trouble accessing your reports in Availity, please call **(423) 535-5717 (option 2)** or email **eBusiness_Service@bcbst.com** for assistance.

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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.**

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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**.