of Tennessee

DECEMBER 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

Behavioral Health Providers – Please Renew Your Contracts

Recently, we emailed new contractual agreements to our Behavioral Health network providers. We're still waiting to hear from some of you, and it may be because we have an old email address.

If you haven't received this important email, or if you have questions about your updated contract, please contact your Provider Network Manager as soon as possible. You can find their information on our **provider site**. We want to make sure your information is correct in our system, so that members can find you and we're able to provide the best possible service to your practice.

Coding Updates for COVID-19 and Respiratory Syncytial Virus Products

Please see below for coding updates for COVID-19 and respiratory syncytial virus (RSV) products. Our existing coverage and reimbursement policies for each line of business apply to these codes.

New and Existing Codes for RSV Vaccines and Monoclonal Antibodies

- **90378** *(Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each)*– Effective **Jan. 1, 2000**, with description changes **Jan. 1, 2001**, and **Jan. 1, 2010** – Brand name: **Synagis®**
- **90380** *(Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use)*– Effective **July 17, 2023** – Brand name: **Beyfortus™**
- **90381** *(Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use)*– Effective **July 17, 2023** – Brand name: **Beyfortus™**
- **90678** *(Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use)*– Effective **Jan. 1, 2023, (FDA approval May 31, 2023)** – Brand name: **Abrysvo™**
- **90679** *(Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use)*– Effective **May 3, 2023** – Brand name: **Arexvy**

For more information about monoclonal antibodies and vaccines for RSV prevention, please see **Guidance for Preventing RSV** in the **BlueCare Tennessee** section of this newsletter.

Updated COVID-19 Vaccine Codes

- **91304** *(Severe acute respiratory syndrome coronavirus 2 (SARS**[1]**CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use)* – Revised Code Effective **Aug. 14, 2023** – Brand name: **Novavax Covid-19 Vaccine**
- **91318** *(Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use)* – Effective **Sept. 11, 2023** – Brand name: **Pfizer Covid-19 VAC-TRIS 6M-4Y**
- **91319** *(Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use)* – Effective **Sept. 11, 2023** – Brand name: **Pfizer Covid-19 VAC-TRIS 5-11Y**
- **91320** *(Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use)* – Effective **Sept. 11, 2023** – Brand name: **Comirnaty 2023-2024 12 and Up**
- **91321** *(Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use)* – Effective **Sept. 11, 2023** – Brand name: **Moderna Covid-19 Vaccine 2023-2024 ages 6MO<12YRS**
- **91322** *(Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use)* – Effective **Sept. 11, 2023** – Brand name: **Spikevax 2023-2024 formula**

New COVID-19 Vaccine and RSV Products Administration Codes

- **90480** *(Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV**[1]**2) (coronavirus disease [COVID-19]) vaccine, single dose)* – Effective **Sept. 11, 2023**
- **96380** *(Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional)* – Effective **Oct. 6, 2023**
- **96381** *(Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection)* – Effective **Oct. 6, 2023**

Please note: Providers should use the existing administration codes 90460 and 90471 for the administration of Abrysvo, depending on the member's age. Only 90471 should be used for administration of Arexvy since its administration is limited to those age 60 years and older.

Submitting Correct Dates for Member Claims

As a friendly reminder, future dates can't be submitted when filing claims for members. If the date of service listed is after the date we receive the claim, we'll return it for correction.

Note: This applies to Commercial, Medicare Advantage and BlueCare Plus (HMO D-SNP)℠ only.

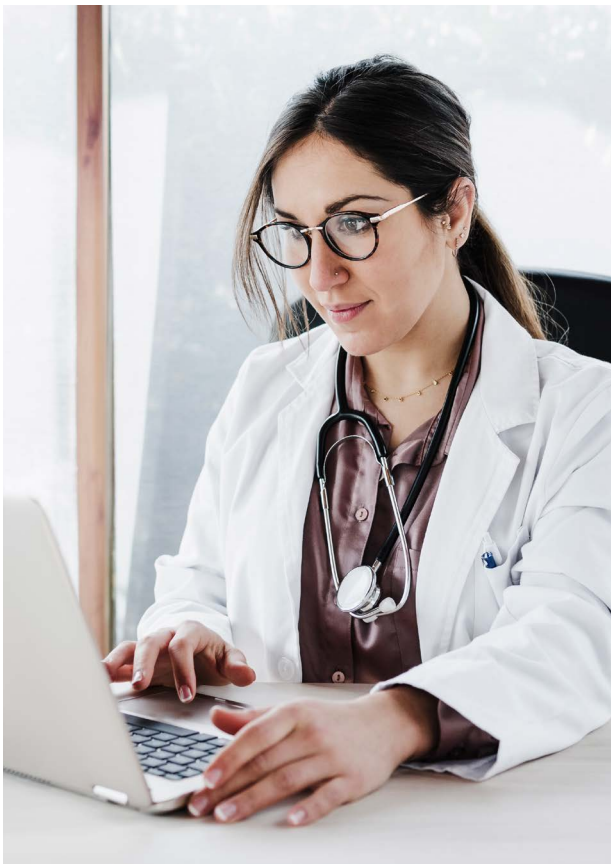
Help Prevent Coordination of Benefits Denials

You can help prevent coordination of benefits (COB) denials on claims by reviewing Availity® to determine if the COB has been updated within the past 12 months. If the COB information hasn't been updated, we recommend you have the member complete the entire COB questionnaire and fax it to the number at the top of the questionnaire. This allows us to update the COB information and process the claims.

The forms are located on the following links in both English and Spanish. You can also find the **questionnaire** in **Availity's Payer Spaces** under the **Resources** section. Simply look for the word **Forms** under the **Resources** tab.

- **English Form**
- **Spanish Form**

Note: It's important that the member completes the entire COB form. An incomplete form will prevent information from being updated.



Digital Member ID Cards Coming Soon in Availity

Member ID cards will soon be available in Availity. You will be able to view and print the Member ID cards, which are located under the **Eligibility and Benefits** tab. If you have Availity questions or training needs, contact your **eBusiness Marketing Consultant**.

Referring Out-of-State Providers to Availity

As a reminder, all contracted providers are required to go to Availity for eligibility and benefits status – not to our Provider Service Line.

Previously, out-of-state providers could call our Provider Service line to obtain benefits and eligibility information. However, as of Dec. 1, 2023, we're requiring all out-of-state providers who are contracted with BlueCross to verify benefits through **Availity.com**.

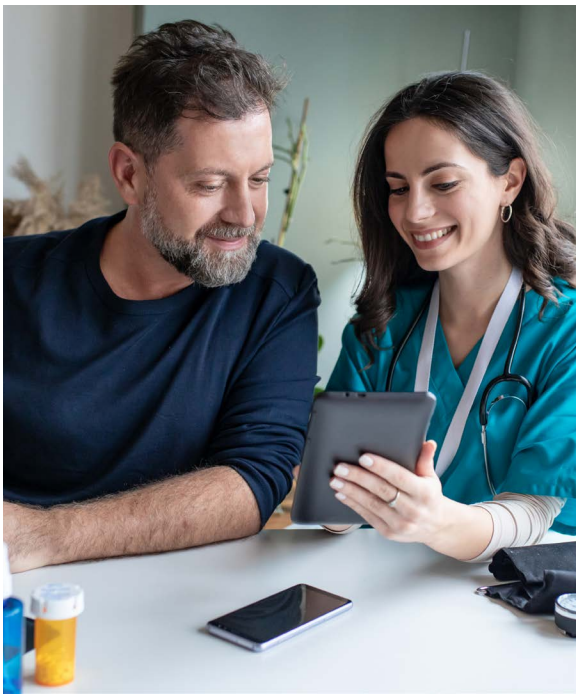
With Availity, you can get the answers you need 24 hours a day, seven days a week. To check eligibility and benefit information, simply log in to Availity and click **Patient Registration**, then **Eligibility and Benefits Inquiry**.

If your office needs help getting started with Availity, contact your **eBusiness Regional Marketing Consultant** for training and education.

For questions about the Availity Web Portal, call Availity Client Services at **1-800-AVAILITY (1-800-282-4548)**, Monday through Friday from 8 a.m. to 7 p.m. ET, excluding holidays.

Submit High Tech Imaging Authorizations through Availity

High Tech Imaging (HTI) authorizations for Commercial and BlueCare Tennessee members should be submitted through Availity. During the authorization process, you'll be transferred to the eviCore website, where you can complete the authorization. It's not necessary to go to the eviCore website or to call eviCore directly to obtain your authorization. You can find a **High Tech Imaging Quick Reference Guide** with step-by-step instructions to help you request initial authorizations for HTI services in the **Resources** section of **Availity Payer Spaces**.



Provider-Administered Specialty Drug Prior Authorizations Changing Jan. 1, 2024

Beginning **Jan. 1, 2024**, we'll no longer use MagellanRX for provider-administered specialty drug prior authorizations. Instead, we'll process these authorizations internally.

The authorization decision and appeal process won't change. The line-of-business-specific appeal processes are included on each authorization notification letter.

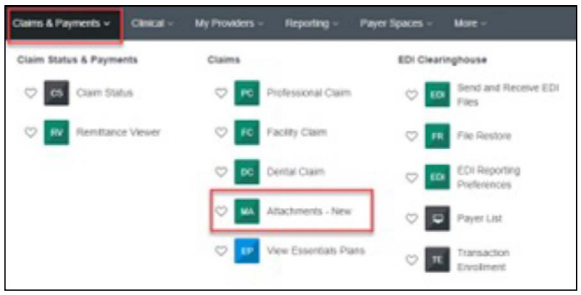
Please continue to submit Specialty Pharmacy Prior Authorizations in Availity's **Payer Spaces** tile for a more streamlined process and to receive a faster response. Often, online authorization submission will be instantly reviewed.

Please reach out to your **eBusiness Marketing Consultant** for your Availity questions or training needs.

Submit PWK Attachments through Availity

We now have an option for providers to submit paperwork (PWK) attachments electronically through Availity. Please note that we're not turning off the fax option, we're simply adding the electronic option because it's more efficient.

You can find the new feature under the **Claims & Payments** tab, then look for **Attachments** under **Claims**. To get started, the person in your office who has the Medical Attachments role will need to register via the **Provider Verification** tab. Once registered, they'll need to complete the required information, attach supporting documentation and then click **Send Attachment**.



If you need help, please contact our eBusiness Technical Support team at **(423) 535-5717, option 2**, Monday-Thursday, 8 a.m. to 6 p.m. ET and Friday, 9 a.m. to 6 p.m. ET. You can also reach our team by calling, faxing or emailing us here:

Toll free: **1-800-924-7141, option 4** – follow prompts then for eBusiness support

Fax: **(423) 535-1922**

Email address: **ebusiness_service@bcbst.com** OR **ecomm_techsupport@bcbst.com**

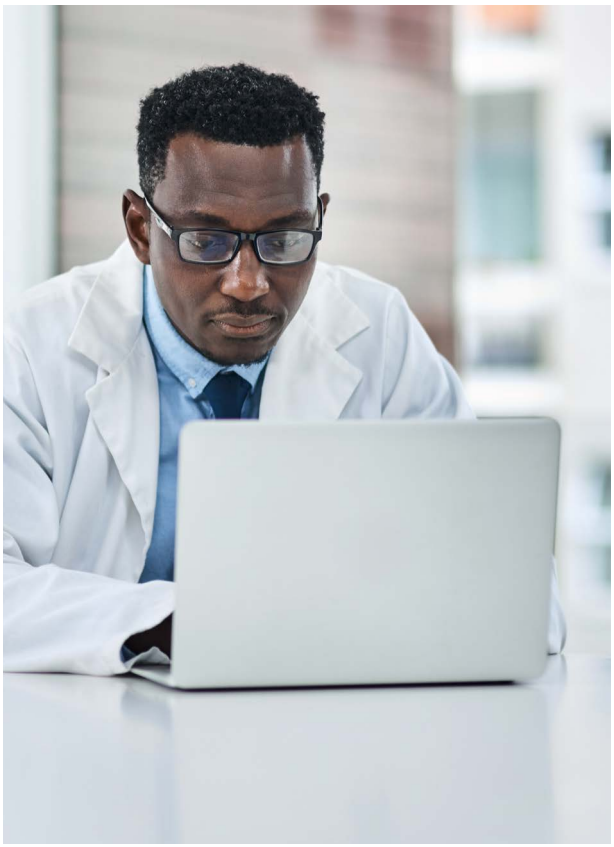
Avoid Delays with the Group Enrollment Form

Understanding our network participation enrollment process offers 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 NPI in addition to their individual Entity Type 1 NPI, they must submit a Group Enrollment Form (GEF) to avoid delays in the enrollment process. Click **here** for the Centers for Medicare and Medicaid Services (CMS) definitions of Entity Type 1 and Entity Type 2.

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

As of mid-March 2023, we're rejecting PEFs for individual providers if they belong to or join a group with an Entity Type 2 NPI.

If you have questions or need help with the enrollment process, please call the provider service line.



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. As of Oct. 11, 2023, we began requiring a **completed** and **approved** application with Change Healthcare before accepting a request for enrollment through Availity.

To sign up, use 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 to complete your enrollment process.
- For questions about the progress of your Change Healthcare application, please visit **payerenrollservices.com**.

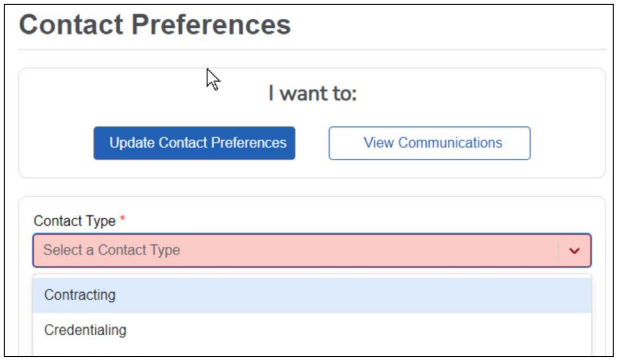
If you're already an in-network provider and currently receive electronic payments and remittance advice as intended, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to **eBusiness Technical Support**. You can also contact your eBusiness Consultant.

Get Contracts and Fee Schedule Updates Quicker

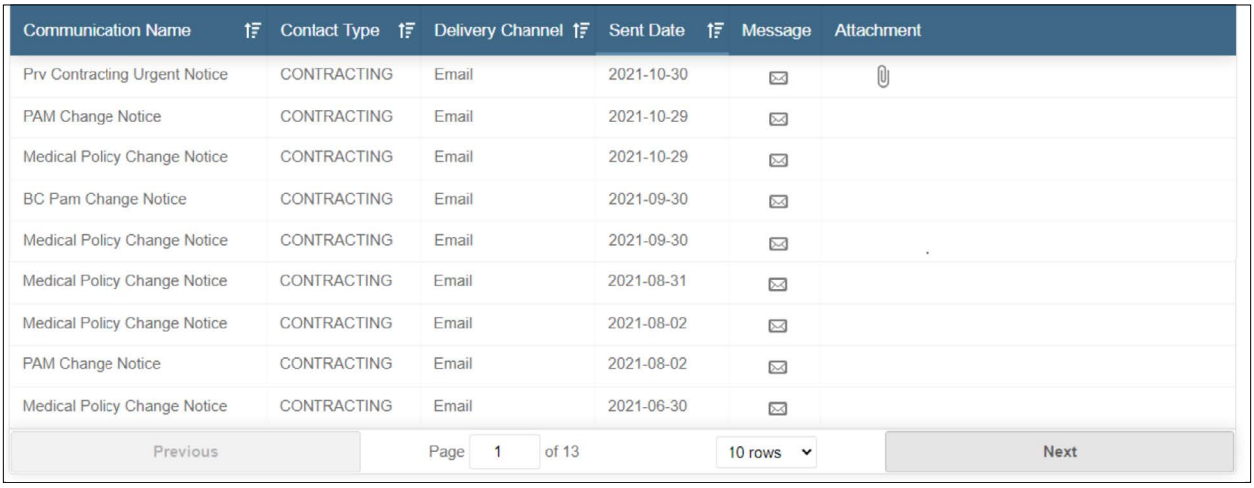
You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. Simply update your **Contact Preferences** through our Payer Spaces in Availity and make email your preferred **contracting** communication type. Here's how:

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	✉	

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.

Allergy Immunotherapy and Injection Guidelines Reminder

As a reminder, we updated our Commercial health plan reimbursement policy for allergy immunotherapy, effective April 1, 2019. The Billing and Reimbursement Guidelines for Allergy & Immunotherapy can be found in the PAM at Section VI.C.(35).

These Guidelines apply to all providers acting within the scope of their licenses, regardless of whether the services are provided by a specialist or a primary care provider. The provider remains responsible for providing the testing and any subsequent services in a medically appropriate and safe manner; for obtaining testing agents (allergen extracts) and antigens for treatment in accord with industry standards; and for providing adequate supervision of any assistants who help the provider to do the testing and treatment. As always, the medical necessity for testing and treatment should be supported by the medical records and must be billed with the appropriate codes.

Reminder About the QuestSelect™ Program

The QuestSelect program is available for our Marketplace members and members who are part of our AmplifyHealth advocacy program. It's also optional for self-funded employer groups.

With this program, members can show their QuestSelect card at their appointment and ask their provider to send their lab work to Quest. This is a voluntary, member-driven program designed to lower member costs for outpatient lab testing. If the member chooses not to use Quest, their normal lab benefits apply.

The testing must be covered and approved by the member's benefit plan, and the provider or lab technician must indicate QuestSelect coverage on a Quest Diagnostics requisition that accompanies the specimens to Quest Diagnostics. Although there's no unique benefit tied to the QuestSelect program, member benefits do vary by plan design. Benefits should always be verified prior to services being performed.

Providers can collect specimens in their office and be reimbursed for the collection by submitting a claim with the office charge. Then, Quest Diagnostics will bill us directly for lab testing services.

Call QuestSelect at **1-800-646-7788** for:

- A faxed copy of the necessary paperwork for your immediate use
- Personalized test order pads for requisitions
- Courier service
- Patient results

If you don't normally collect patient specimens, your patients can call **1-800-646-7788** or visit **QuestSelect.com** to find a Patient Service Center.

Changes to Genetic Testing Prior Authorization for Commercial Plans

Beginning **Feb. 1, 2024**, the following codes will be added to the Genetic Testing Prior Authorization List and will require prior authorization through the eviCore Genetic Testing Program.

0420U	0423U	0426U	0434U
0421U	0424U	0428U	0437U
0422U	0425U	0433U	0438U

New Law for Tennessee Heartbeat Bill Requires Attestation

Gov. Bill Lee signed a new law on April 28, 2023, providing limited exceptions to the Tennessee Heartbeat Law that was passed in 2020.

For us to process these claims, providers are required to attest an abortion was performed according to applicable state and federal law. When submitting this type of claim, please complete and fax the following forms the same day as your claim to **(423) 591-9481**:

1. The Provider Attestation for Abortion Services form, located on the **Provider Forms** page of **provider.bcbst.com**.
2. The **PWK Fax Cover Sheet**, which is also posted on the Provider Forms page.

Payment will be denied if the required forms are not included with these claims.

If you have questions, please call our Specialized Pregnancy line at **1-866-268-3502**.

BlueCare Tennessee

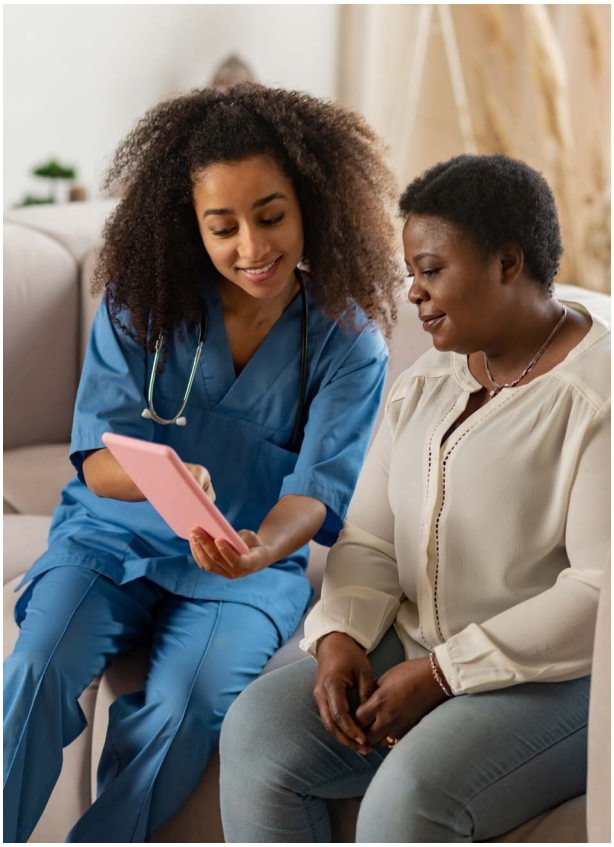
This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless stated otherwise.

Intermittent Home Health Services Notification Requirement

Beginning **Jan. 1, 2024**, providers will need to submit a notification request for all intermittent home health services for BlueCare and TennCareSelect members. You can submit notification requests for these services by phone, fax or in Availity. All requests must include this information:

- Member name
- Member ID number
- Dates of service
- Number of visits requested
- Provider ID number (NPI)
- Ordering provider name
- Provider order for service

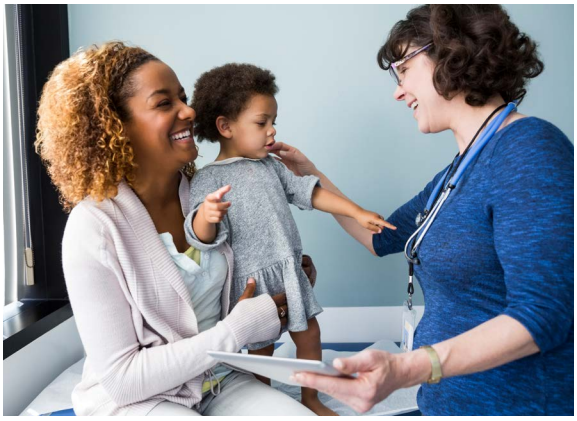
We need this information for electronic visit verification and accurate claims processing and payment, and we'll screen all notification services for non-covered, excluded, out-of-network, investigational services.



Guidance for Preventing Respiratory Syncytial Virus

Respiratory syncytial virus (RSV) is the most common cause of hospitalization in U.S. infants. Most children who contract RSV will be infected before the age of 2. Infection doesn't mean long-term immunity, so continual reinfection is possible throughout a person's lifetime. Monoclonal antibody formulations and RSV vaccines are available to prevent RSV.

The two monoclonal antibody formulations approved for RSV prevention are Beyfortus™ (nirsevimab) and Synagis® (palivizumab). You'll hear them referred to as "vaccines," since they're a form of passive immunization. The Advisory Committee on Immunization Practices (ACIP) recommends nirsevimab for infants younger than 8 months old who were born during or entering their first RSV season and children between ages 8 and 19 months who have an increased risk of severe RSV disease entering their second RSV season.



Palivizumab is indicated for the prevention of RSV infection in high-risk infants and toddlers with:

- A history of premature birth who's 6 months or younger at the beginning of RSV season
- Bronchopulmonary dysplasia requiring medical treatment within the last six months who's 24 months or younger at the beginning of RSV season
- Hemodynamically significant congenital heart disease who's 24 months or younger at the beginning of RSV season

One dose of nirsevimab is given per RSV season, while palivizumab is given monthly during the season – for a maximum of five doses. If high-risk infants receive fewer than five doses of palivizumab, you may give them one dose of nirsevimab and stop palivizumab. Patients who qualify for second-season RSV prevention can get nirsevimab or palivizumab, regardless of the vaccine they got during the prior season.

RSV vaccines in pregnancy

Abrysvo™ is an RSV vaccine approved for the prevention of RSV in pregnant women and helps prevent RSV in newborns via the placental transfer of antibodies. A single dose of Abrysvo should be given between 32 and 36 weeks of pregnancy during September through January.

Other RSV vaccines

Arexvy is an RSV vaccine approved for the prevention of RSV in patients ages 60 and older. Abrysvo is also approved for patients ages 60 and older.

BlueCare Tennessee covers Beyfortus, Synagis, Arexvy and Abrysvo under the medical benefit. Synagis requires prior authorization. For more information, please review these **recommendations from the Centers for Disease Control and Prevention** and see **Coding Updates for COVID-19 and RSV Products** in the **BlueCross BlueShield of Tennessee, Inc.** section of this newsletter.

Source:

Clinical Resource, Preventing RSV. Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights. October 2023. [391002]

Resources for Your Patients Transitioning Out of Foster Care

We're here to make the transition from foster care to adulthood easier for your patients. Our team works closely with the Department of Children's Services (DCS) to ensure these young adults are connected to community resources and other programs, depending on their health needs.

Teens ages 14-16 will work with the DCS Independent Living division to develop an independent living plan, and starting at 17, a transition plan. Depending on each teen's needs and goals, these plans can help with:

- Life skills
- Education – high school and beyond
- Driver's education and getting a license
- Housing
- Employment
- Medical and mental health care
- Applying for Social Security benefits

Your patients aging out of foster care who stay in Tennessee may be able to keep their TennCare health benefits until they turn 26. They can confirm the status of their health coverage by calling TennCare Connect at **1-855-259-0701**, visiting **tenncareconnect.tn.gov** or contacting their DCS representative.

We can also help connect patients to programs that provide extra support, like Employment and Community First CHOICES for people with intellectual and development disabilities, and community agencies that can assist with housing, transportation, food, utilities and dental care.

If you have questions about the resources available to your patients, please visit **bluecare.bcbst.com**. Providers caring for children in state custody can find helpful information about working with us and DCS by visiting **bluecare.bcbst.com/providers** and selecting **Caring for Children in State Custody and With Other Special Needs**.

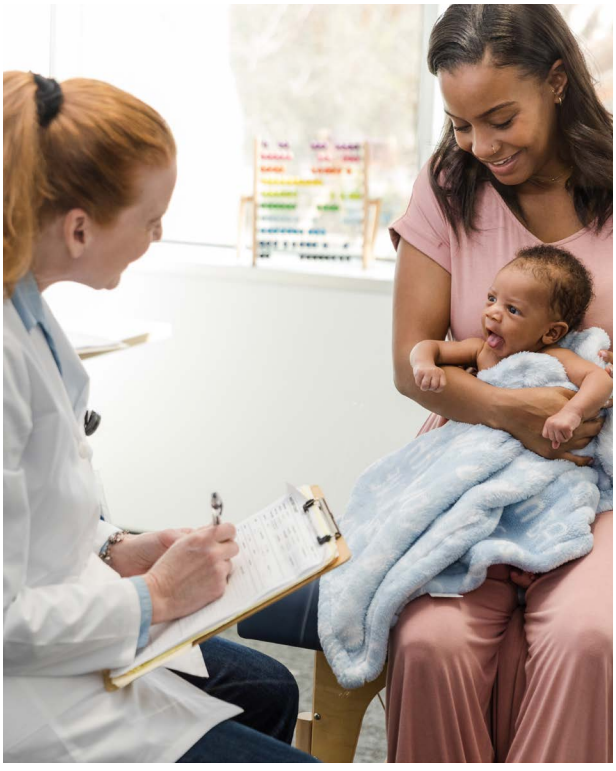
Stay Up to Date on Prenatal Immunization Recommendations

Vaccination during pregnancy helps protect pregnant people and their babies from certain illnesses. The Centers for Disease Control and Prevention (CDC) recommends these immunizations during pregnancy:

- Tetanus, diphtheria and pertussis (Tdap) to protect against whooping cough
- Flu vaccine, if flu season occurs during pregnancy

Flu vaccination helps reduce the likelihood of illness in pregnant people, who have a higher risk of flu-related complications. The transfer of antibodies to babies during pregnancy also helps protect infants from whooping cough and flu – two illnesses to which they're highly susceptible.

Administering these vaccines as recommended can also help you meet quality metrics. The Prenatal Immunization Status (PRS-E) HEDIS® measure assesses the percentage of deliveries in the measurement period in which members got flu and Tdap vaccines. You can learn more about this measure in our **BlueCare Tennessee Quality Measures Guide**.



HEDIS® is a registered trademark of the National Committee for Quality Assurance

Allergy Immunotherapy and Injection Guidelines Reminder

As a reminder, several changes to the BlueCare, TennCareSelect and CoverKids Allergy Immunotherapy and Injection Guidelines took effect July 1, 2019. The Guidelines for Allergy & Immunotherapy Billing and Reimbursement can be found in the PAM at Section V.F.(18).

These Guidelines apply to all providers acting within the scope of their licenses, regardless of whether the services are provided by a specialist or a primary care provider. The provider remains responsible for providing the testing and any subsequent services in a medically appropriate and safe manner; for obtaining testing agents (allergen extracts) and antigens for treatment in accord with industry standards; and for providing adequate supervision of any assistants who help the provider to do the testing and treatment. As always, the medical necessity for testing and treatment should be supported by the medical records and must be billed with the appropriate codes.

Make Behavioral Health Screening Part of Well-Child Visits

Early detection and treatment of behavioral health conditions helps improve outcomes for children and teens. Performing behavioral health screenings as appropriate during Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits can ensure young patients get the behavioral health care they need.

Your patients ages 0-21 years covered by BlueCare and TennCareSelect are eligible for EPSDT visits and screenings according to the **Bright Futures and the American Academy of Pediatrics Periodicity Schedule**.

Consider making age-appropriate behavioral health screening a standard part of visits:

- Behavioral/social/emotional screening is recommended at all ages, starting at the newborn visit through 21.
- Depression and suicide risk screening is recommended starting at age 12 through 21.
- A tobacco, alcohol and drug use assessment is recommended from age 11 through 21.

If you're concerned about substance use or your patient's behavioral health, call us at **1-888-423-0131** to initiate a behavioral health referral.

Maternity Care Payments for Prenatal and Postpartum Care

Through the BlueCare Tennessee and CoverKids Maternity Care Program, obstetric providers can earn payments on top of their regular reimbursement for prenatal and postpartum care and mental health screening. We've included more information about each payment below.

Prenatal Care

Patients with BlueCare, TennCareSelect and CoverKids coverage should have a prenatal visit during the first trimester of pregnancy or within 42 days of enrolling in their health plan. Providers can earn a payment of $25 per patient by completing this visit and submitting the Maternity Care Management Form in Availity within 30 days of the prenatal visit.

Postpartum Care

The postpartum visit should occur between seven and 84 days after delivery. Providers can earn $75 per patient, per claim for up to two visits during the 84-day postpartum period.

Mental Health Screening

Providers can earn a $28.35 payment for using a standardized tool to screen for depression and anxiety at least once during the perinatal period. There's no limit on the number of times providers can complete and bill for a mental health screening if the screening is supported by documentation.

For step-by-step coding guidance, please see our **BlueCare Tennessee and CoverKids Maternity Care Program webpage**.

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 available in Availity 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 **BlueCross Payer Spaces**. 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 platform, please call your **eBusiness Regional Marketing Consultant**.

Correction to BlueCare Tennessee Provider Administration Manual

There was an error on page 267 of our recent update of the BlueCare Tennessee Provider Administration Manual (PAM), incorrectly listing the name of a form and the incorrect link.

It should have stated that the **TennCare & CoverKids Programs Request to Commissioner for Independent Review of Disputed Provider Claim** form is located on the state's website **here**. Additional information regarding the Independent Review process developed by the State of Tennessee Department of Commerce and Insurance are also available online **here**.

This correction will appear in the Jan. 1, 2024, PAM update.

Upcoming Changes to the BlueCare Tennessee Medical Emergency Diagnosis Code List

Effective Jan. 1, 2024, we're updating our medical emergency list with additional diagnosis codes. At that time, you'll be able to access the revised list on the BlueCare Tennessee webpage **here**.

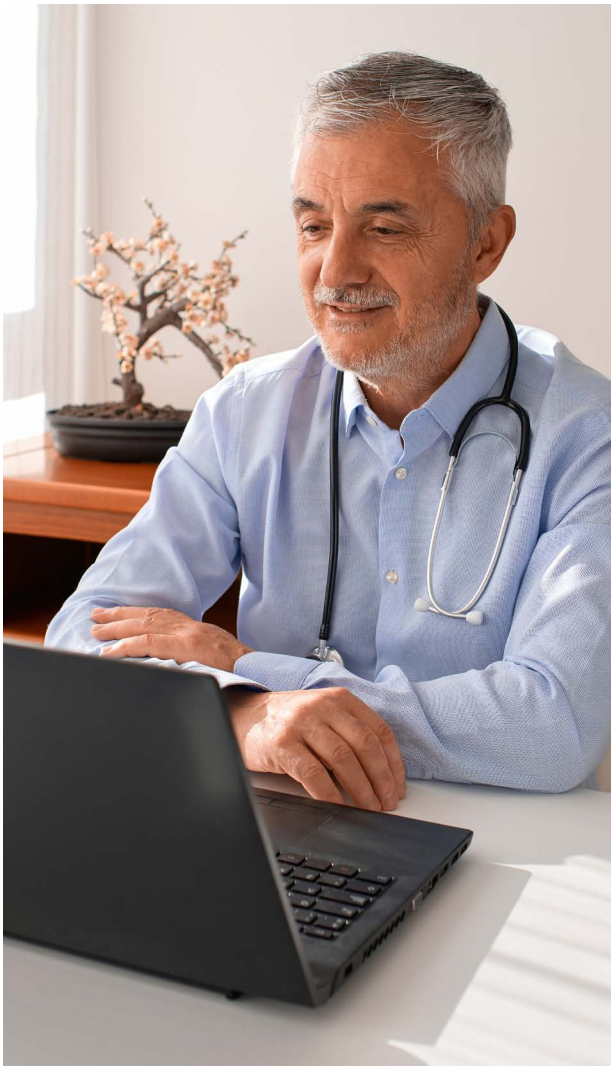
Use Availity to Change Members' Primary Care Provider

In May 2023, we launched the **BlueCare Primary Care Provider (PCP) Change Maintenance** application in Availity. You can read more about the application in the **May, June and July 2023 BlueAlert newsletters**.

The application has been successful, averaging 200-300 PCP changes daily. Due to its success, we're phasing out the existing **PCP Change Request Form**. Beginning **April 1, 2024**, providers will need to use the **BlueCare PCP Change Maintenance** application to change the PCP assignment for a member with BlueCare, TennCare*Select* or CoverKids coverage.

Please note: This only affects the PCP change process providers use. Our members can still change their PCP by calling the Member Service line or through the BlueAccess℠ provider directory.

As a reminder, when you use the application, changes are made in real time. New ID cards are mailed to members automatically as soon as the change is made, and digital ID cards are available immediately in the **BCBSTN** mobile app. For step-by-step instructions for using the new Availity application, review our quick reference guide in the **Resources** section of BlueCross **Payer Spaces**. If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your eBusiness Regional Marketing Consultant.



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 – Reconsideration requests must be received 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. A claim may be denied 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 your appeal in writing with all supporting medical records **within 60 days** after receiving the other party's response to its inquiry/reconsideration. **If we don't receive it within 60 days, your appeal could be rejected as a timely filing denial.** Please use the **Provider Appeal Form** to submit appeal requests. Like the 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**.

Medicaid Reverification and How to Help Members Avoid Gaps in Coverage

On April 1, 2023, the Division of TennCare started the reverification process for Tennesseans with BlueCare, TennCareSelect and CoverKids coverage. This process will continue through early 2024 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**.

Specialized Supported Housing Level of Care

Effective Jan. 30, 2024, we're adding a specialized supported housing level of care to support members with intellectual and developmental disabilities who have BlueCare Tennessee coverage.

We've created the following Medical Necessity Guideline to include:

- Specialized Supported Housing

The guideline will be available at **bcbst.access.mcg.com/index**. If you have questions, please reach out to your assigned BlueCare Utilization Management contact.

Note: This doesn't apply to CoverKids.

BlueCare Plus (HMO D-SNP)SM

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

Clinical Update in Availity Allowed for Home Health and Outpatient Therapy

You can now use Availity to add concurrent clinical updates to/open older authorizations for home health and outpatient therapy services. To do this, simply locate an existing authorization using the authorization number.

We're allowing a 300-day span for providers to access these existing authorizations. If you have questions, please contact your Provider Outreach Consultant.

Step Therapy for Additional Medicare Part B Drugs

Beginning **Jan. 1, 2024**, BlueAdvantage and BlueCare Plus will implement step therapy for additional Part B drugs. This will affect members who are new to therapy.

Prior authorization and step therapy is in line with the Centers for Medicare and Medicaid Services (CMS) regulations and will be required for the following Part B drugs:

- Evenity
- Eylea HD
- Somatuline Depot
- Udenyca
- VPRIV

The following Part B drugs will no longer require step therapy, but will continue to require prior authorization:

- Cerezyme
- Fulphila
- Prolia
- Treanda

You can find our Part B Step Therapy guide **here** and on provider.bcbst.com by navigating to documents and forms and clicking the **Part B Step Therapy Provider Reference Guide**.

Please reach out to the provider team with any questions.

2023 Special Needs Plan Model of Care Training Now Available

Providers participating in BlueCare Plus special needs plans are contractually required to complete our Model of Care (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.

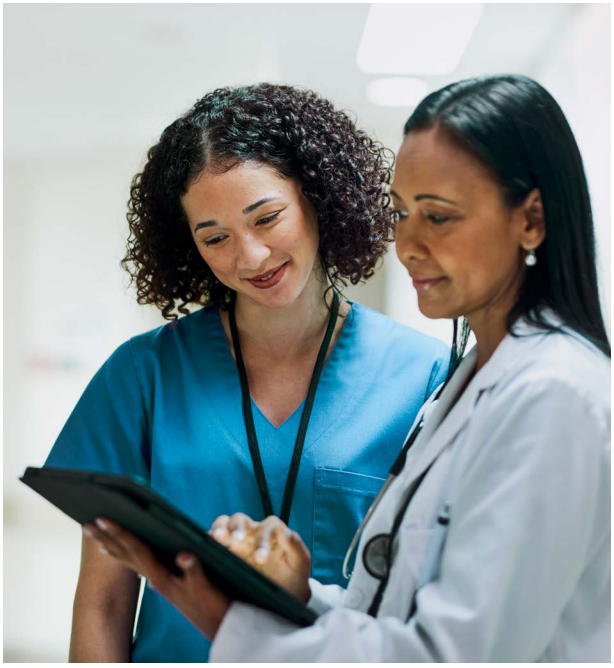
Please Complete Your 2023 Provider Assessment Forms

It's not too late to complete Provider Assessment Forms (PAFs) for this year. PAFs must be completed during a face-to-face or telehealth visit (using both video and audio components). PAFs may be completed in conjunction with a Medicare Annual Wellness Visit (AWV) or any other office visit type. There are two options for PAF submission:

- **Electronic PAF:** The 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 upload it to the QCR, or fax it.
- **Non-Standard PAF:** Providers that have an approved non-standard PAF may continue to submit these assessments for 2023 dates of service either by uploading it to the QCR or by fax.
  - **Note:** The non-standard PAF won't be accepted for 2024 dates of service.

Submit the **appropriate CPT®** code once the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code. No modifier is needed.

- **Electronic PAF Completed In/Exported From the QCR:** CPT® code **96161**
- **Approved Non-Standard PAF:** CPT® code **96160**



Reimbursement for completion of a PAF is based on the PAF submission options outlined above.

- **Electronic PAF Completed In/Exported From the QCR: $225** Jan. 1 through Dec. 31
- **Non-Standard PAF: $100** Jan. 1 through Dec. 31

Please contact your Provider Quality Outreach Consultant for assistance with Provider Assessment Forms.

Virtual Mental Health Programs with AbleTo

BlueAdvantage is working with AbleTo, a Behavioral Health vendor offering virtual mental health programs. It focuses on cognitive behavioral therapy techniques and is designed to help patients manage emotions, reduce feelings of stress and worry, and change unhelpful thought patterns.

A provider portal is available for direct referrals at **ableto.com/refer/provider**.

Medicare Advantage 2024 Quality Program Measures

Beginning Jan. 1, 2024, Medicare Advantage will implement one change to the quality measures included in the Quality+ Partnerships program.

- The **Kidney Health Evaluation for Patients with Diabetes (KED)** measure will move from the monitoring section of the program back into the scored section of the program as a single-weighted measure.

The 2024 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Member Experience – Consumer Assessment of Healthcare Providers and Systems (CAHPS)	CMS Member Survey	4
Controlling High Blood Pressure (CBP)	HEDIS®	3
Hemoglobin A1c Control for Patients With Diabetes (HBP)	HEDIS®	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	PDE Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	PDE Files	3
Plan All-Cause Readmissions (PCR)	HEDIS®	3
Member Experience – Health Outcomes Survey (HOS)	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS®	1
Colorectal Cancer Screening (COL)	HEDIS®	1
Eye Exam for Patients With Diabetes (EED)	HEDIS®	1
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	HEDIS®	1
Kidney Health Evaluation for Patients With Diabetes (KED)	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)	PDE Files	1
Transitions of Care (TRC)	HEDIS®	1

Please contact your Provider Quality Outreach Consultant for more information or questions about the measures included in the 2024 quality program.

Nonstandard Provider Assessment Forms Discontinued in 2024

Beginning in 2024, we'll only accept Electronic Provider Assessment Forms (ePAFs). These forms can be billed with the same CPT® code 96161 and will be reimbursed at $225. You can complete the ePAFs electronically in the Quality Care Rewards tool (QCR) or by hand and upload them to the QCR. You can also fax them to **1-877-922-2963.**

If you have questions, please contact your Provider Outreach Consultant.

Over-the-Counter (OTC) Program

Medicare Advantage members have access to an over-the-counter (OTC) program, which was new for 2023. This program provides members 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. It 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.

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.

Reminder About Billing for Molecular Diagnostic Tests with Unlisted Codes

When billing for molecular diagnostic tests with unlisted codes:

- Components of the tests with specific codes should be billed with the most appropriate code.
- All components of a test with no specific code should be included on a single line and billed with the most appropriate unlisted code. Information should be submitted to identify these remaining components.
- When billing a registered DEX™ Diagnostics Exchange test with an unlisted code, both the full name of the text and the **LAB/MFR TEST ID** number must be submitted for review.

If you have questions, please reach out to 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)**.

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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.**

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

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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
Seven days/week, 8 a.m. to 9 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**.