MARCH 2023

BlueAlert℠

Mission driven FOR 75 Years

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

BlueCross BlueShield of Tennessee, Inc.

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

COVID-19 Updates

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

INSIDE THIS ISSUE

News About Digital Member ID Cards

This year, you may notice more members using a digital Member ID. While we've offered the option for some time, we're now encouraging increased use of digital IDs for many of our Commercial members.

You'll be able to find the same information as that listed on the plastic Member ID card. Simply ask your patients to share their digital ID through our BCBSTNTN 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. 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.

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.

Update Your Contact Preferences in Availity for Added Efficiency

Considering increases in telehealth visits, changes in office staff and office locations, we've noticed more providers are asking to receive important communications by email. If you'd like to switch to email, it couldn't be easier. Simply update your **Contact Preferences** through our Payer Spaces in **Availity**. There, you can make email your preferred communication method for each of these communication types and learn more about the roles required for each contact type:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in our Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications about available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure **Quality Care Rewards** application **Note:** You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, electronic funds transfers and tax-related items	Financial Reports

* Individuals assigned these roles in Availity can update contact information and download the messages and attachments at their convenience.

** For the Quality & Clinical contact type, you only need one of the roles listed.

You Can Update Your Contact Preferences By:

1. Logging in to **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verifying your **Provider Name** and **National Provider Identifier (NPI)** and clicking **Submit**.

   Tip: If you don't see your name in the drop-down list, you can add it through **Express Entry** or enter your NPI. For contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.
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 **Contact Type** boxes – or the **Select All** box, which automatically checks all your possible contact types.

In some cases, it may take time to receive these messages via email, and you may temporarily receive them as you did before. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. Please visit our **Provider Service page** where you can find links to our Enrollment and Technical Support teams. If you have questions, please log in to **Availity** or contact eBusiness Technical Support at **(423) 535-5717** (option 2).

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 receiving electronic payments and remittance advice as intended today, 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 reach out to your Provider Network Manager.

Simple Tips to Improve Quality Care for Patients

When patients are trying to understand medical conditions and recommended treatments, they sometimes feel overwhelmed by the information, which can affect treatment success. Here are some easy tips that can help you make sure your patients get the information they need.

1. **Explain things in ways that are easy to understand.** When talking with patients about a medical condition or treatment plan, try to avoid medical jargon. Consider using shared decision-making tools to help patients learn more about their conditions and options for treatment.
2. **Make eye contact with your patients and spend time listening carefully to them.** Ask your patients or their caregivers if they have concerns, as well as questions. The National Institutes of Health (NIH) recommends asking open-ended questions that require patients to answer more than a simple yes or no.
3. **Be as respectful as possible about patients' thoughts and beliefs and try to continue conversations at the next visit if they refuse care.** For example, if patients don't want their child to receive a needed vaccination, work with them to find one action that you can agree on, like scheduling a follow-up appointment.
4. **Use the teach-back method, which involves asking patients to explain what they need to do in their own words.** According to the NIH, this technique lets you see if patients need additional information or if they understand the information you presented.
5. **Coordinate care by talking with patients about services they get from other providers.** When you see your patients, ask if they've recently been to the ER or a specialist. Also, discuss any services or medications they've received elsewhere and contact their other providers to request information about test results and treatment plans.

Commercial

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

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 Radiation Therapy Prior Authorizations

Beginning **April 1, 2023**, these codes will require prior authorization through the eviCore Radiation Oncology Therapy Program for certain Commercial Administrative Service Only Plans:

0745T, 0746T, 0747T

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

Prior authorization requests can be submitted through Availity, by fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

Quest*Select*™ Program Coming Soon

Beginning early 2023, we're adding the Quest*Select* program for our Marketplace members and members who are part of our AmplifyHealth advocacy program. It'll also be optional for self-funded employer groups.

With this program, members can show their Quest*Select* card at their appointment and request their provider sends 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 will apply.

The testing must be covered and approved by the member's benefit plan, and the provider or lab technician must indicate Quest*Select* coverage on a Quest Diagnostics requisition that accompanies the specimens to Quest Diagnostics. Although there is not a unique benefit tied to the Quest*Select* 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. Quest Diagnostics will bill us directly for lab testing services.

Call Quest*Select* 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.

BlueCare Tennessee

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

Optum® Provider Claim Review

We're required to submit diagnostic data for our members enrolled in certain Medicaid health plans. You may be contacted within the next few weeks by Optum with a request to review and confirm information if a difference is found between medical records and claims you've submitted.

Optum will coordinate this provider claim review (PCR) by:

- Coordinating the review and confirmation of adjusted claims when coding results indicate a discrepancy in risk-adjusted diagnosis codes
- Identifying diagnosis codes from patient visits during chart review and creating an adjusted CMS-1500 claim form for you
- Having an Optum representative work with you to determine the appropriate person to receive these claims and explain the PCR process

If you're contacted by Optum, we'll need you to review and confirm the information on the adjusted claim and submit it through the PCR process by the date requested.

If you have questions, you can view the **Optum Reference Sheet**. Or, contact your Optum business operations specialist at **1-866-985-8462**.

Division of TennCare Schedules Annual Feedback Session for Episodes of Care

The Division of TennCare's annual feedback session for providers participating in the Episodes of Care program will take place on Thursday, March 23, at 12:30 p.m. ET (11:30 a.m. CT). The goal of the meeting is for Episodes of Care program participants to share success moments, ask questions and recommend changes to improve episode design.

This year's event will be virtual and is free, and registration is required. Please **click here** and fill out the registration form to save your spot. TennCare will send you a link to join the meeting before the event. If you have questions, please email **Payment.Reform@tn.gov**.

Please note: The information in this article only applies to BlueCare network providers participating in the Episodes of Care program.

Explore the Differences Between EPSDT- and HEDIS®-Compliant Well-Child Exams

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have reporting criteria and eligibility requirements that differ from the well-child visit performance measures included in the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS). Here's some information to help you brush up on the basics for each.

EPSDT Visits

Children and adolescents enrolled in BlueCare or TennCareSelect are eligible for TennCare Kids exams from birth until their 21st birthday. The schedule for EPSDT exams follows the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**.

The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year. Patients are eligible if they've had BlueCare Tennessee coverage for 90 continuous days at some point during the fiscal year.

HEDIS Quality Measures

Two performance measures apply to well-child checkups: Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV). These measures determine if children and adolescents receive the appropriate number of well-child visits during the measurement year for their age.

- W30 has two reported rates, which evaluate whether children get the correct number of well-child visits with a primary care provider (PCP) on or before age 15 months and between ages 15-30 months.
- WCV evaluates the rate of children and adolescents between ages 3 and 21 who receive an annual wellness visit with a PCP or OB/GYN during the measurement year.

The measurement year for HEDIS begins Jan. 1 and ends Dec. 31.

For more information about the HEDIS measures for well-child care, please see our **BlueCare Tennessee Quality Measures Booklet**. To learn more about EPSDT exams and coding EPSDT visits, please see our **TennCare Kids Tool Kit**.

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

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

All BlueCare Providers Must Register for a Tennessee Medicaid ID

All providers requesting and providing services for BlueCare Tennessee members are required to register for a Tennessee Medicaid ID on the **Division of TennCare's Provider Registration website**. Providers should allow 7-10 business day for the Medicaid ID to be provided to BlueCare Tennessee.

These provider types must be registered if submitted on BlueCare Tennessee claims:

Institutional Claims

- Billing Provider
- Attending Provider
- Operating Provider
- Other Operating Provider
- Rendering Provider
- Service Facility Location

Professional Claims

- Billing Provider
- Rendering Provider
- Service Facility Location — additional practice locations that have a different NPI must be registered in addition to the primary practice
- Purchased Service Provider
- Ordering Provider
- Referring Provider

For assistance with the online registration or revalidation process, providers should contact TennCare Provider Services at **1-800-852-2683** (option 5) or email: **Provider.Registration@tn.gov**.

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 TennCareSelect coverage have dental benefits. Previously, benefits were only available to those under age 21, during pregnancy and for 12 months after giving birth, and to those 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, please 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.

Cultural Competency Training Reminder

If you're a provider who participates in BlueCare, TennCareSelect, CoverKids, CHOICES or ECF CHOICES, you can submit a Cultural Competency Attestation Form to let us know you've completed your cultural competency training. We help members identify providers who've completed this training in our Provider Directory.

Our network providers can complete **Quality Interactions training**, which provides one continuing education unit offered at no cost to you, or complete **brief online training created by BlueCare Tennessee**. You can take training from sources other than BlueCare Tennessee if it emphasizes the delivery of services in a culturally competent manner. To be eligible for this classification, the training should include information about caring for people with disabilities, diverse cultural and ethnic backgrounds, or limited English proficiency, regardless of their sex.

Once you finish training, please email your completed **Cultural Competency Training Attestation Form** to **PNS_GM@bcbst.com** so we can update our Provider Directory.

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

Help Your Patients Prepare for Medicaid Reverification

Starting April 1, 2023, the Division of TennCare will begin the reverification process for Tennesseans with BlueCare, TennCareSelect and CoverKids coverage. As part of this process, TennCare will review each member's eligibility to continue receiving benefits.

To help ensure 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.

If you have questions, please visit the Division of TennCare's **Preparing for Renewals web page**.

BlueCare Plus (HMO D-SNP)SM

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

Special Supplemental Benefits for the Chronically Ill

BlueCare Plus members are offered special supplemental benefits as described under the Special Supplemental Benefits for the Chronically Ill (SSBCI) section of the Bipartisan Budget Act of 2018. Our Model of Care (MOC) describes our members as the most vulnerable population, and they're most often critically and chronically ill, lacking access to benefits and daily needs such as food and general supports for daily living. These supplemental benefits provide members with a monthly allowance for needed food, housing and/or utility payments.

Qualifying members must:

- Have one or more comorbid and medically complex chronic conditions;
- Have a high risk for hospitalization or other adverse outcomes; and
- Require care coordination

We'll need to receive a claim or the appropriate qualifying information to support SSBCI requirements. Documentation of comorbid and medically complex chronic conditions is required to maintain this benefit. Not all members will qualify. Primary care physicians can help their eligible patients get the benefit by including diagnosed chronic conditions on claims or completing the **Provider Attestation of Patient Diagnosis** form on behalf of the member. If you have questions, please contact our Case Management Department at **(877) 715-9503**.

2023 Special Needs Plan MOC Training Now Available

Providers participating in BlueCare Plus and BlueCare Plus Choice (HMO SNP)[SM] 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**.

Centers for Medicare & Medicaid Services (CMS) Changes to Billing Codes

For dates on or after Jan. 1, 2023, codes for continuous glucose monitor authorizations have been updated to help enrollees fill their prescription:

- K0553/K0553 KF should change to A4239/A4239 KF
- K0554/K0554 KF should change to E2103/E2103 KF

Please begin using the new A and E codes in place of the discontinued K codes moving forward. If we get requests with discontinued codes, our Utilization Management team will contact you. If you receive a denial because of a discontinued K code, call us at **1-800-924-7141**, option 2.

Physician Incentives to Benefit Your Patients and Increase Your Stars Score

Annual Wellness Exams and Member Incentives

Your patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. They may also be eligible to earn a reward they can spend on certain wellness items for completing the exam. You can help your patients earn additional rewards for their healthy living by scheduling a check-up. Your patients are eligible for rewards after completing an annual wellness exam, which should be filed with 99387, 99397, 99385, 99395, 99386, 99396, 96160, 96161, G0402, G0438 or G0439 and appropriate evaluation and management (E/M) codes.

Note: An annual wellness exam is a calendar year benefit, which means each member is entitled to one wellness exam annually, regardless of the number of days between each exam. It's not necessary to wait 365 days between exams.

Patient Assessment and Care Planning Form (PACF) Reimbursement

Providers are eligible to receive payments for completing and submitting a PACF for their patients with BlueCare Plus benefits. Please use CPT® code 96160 or 96161 to file a PACF. We'll continue to reimburse the service as E/M code 96160 or 96161, with a maximum allowable charge of $155. CMS requires all Dual Special Needs Plans (DSNPs) to provide an interdisciplinary care team (ICT) to coordinate services and benefits delivery. The ICT brings payers and providers together to promote better health and care for this vulnerable population.

The ICT is comprised of the:

- Member's primary care and/or specialist provider
- Care Coordination Team
- Member and/or member's family or representative
- Others requested by the member

Completing the PACF or providing your equivalent medical record any time you complete the Annual Wellness Exam, or when we request it, allows you to bill for the ICT code and get the $54 reimbursement. Providers who return post-discharge records for medication reconciliation are also able to bill for the ICT and receive reimbursement.

To get reimbursed for completing the PACF, you must submit the completed form through Availity or fax the completed written form to **(423) 591-9504**. The form should also be included in your patient's chart as part of their permanent record. If you have questions about the PACF, please call us at **1-877-715-9503**.

Updates to Dental Benefits

As of Jan. 1, 2023, your patients enrolled in BlueCare Plus Choice or BlueCare Plus Select now have dental coverage through the Division of TennCare Dental Benefits Manager (DBM).

We still cover routine dental services and you can file claims for routine services as you normally would. However, the comprehensive services benefits will now be on a pre-loaded flex card and issued to the member at the start of the plan year (you won't need to file a claim for this charge). Benefit limits and exclusions still apply, and details can be found in the member's evidence of coverage.

If you have questions, please see the **Adult Dental Comprehensive Notice** or reach out to your Provider Network Manager.

Medicare Advantage

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

Provider Assessment Forms

The Provider Assessment Form (PAF) is an important tool for collecting comprehensive information on each patient's current health status annually. It shows how active chronic and acute conditions are documented and managed. There are two options for PAF submission:

- **Electronic PAF:** A brief, hierarchical chronic condition-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/groups that currently have an approved non-standard PAF with BlueCross may continue to submit these assessments for 2023 either by uploading it to the QCR or faxing it.

Note: The blank PAF form has been retired and is no longer accepted.

Providers should submit the appropriate CPT® and E/M codes once per calendar year when the PAF is complete.

- **Electronic PAF:** CPT® code **96161**
- **Approved Non-Standard PAF:** CPT® code **96160**

Reimbursement for completing a PAF is based on the PAF submission option:

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

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

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement to providers who achieved quality scores of 4 Stars and above with coding accuracy during the 2022 measurement period (Jan. 1 through Dec. 31, 2022).

Stars ratings, based on last year's performance, will affect each provider's reimbursement rates starting April 1, 2023. Participating providers will receive a rate adjustment notification letter and a rate attachment with the new fee schedule by April 1. Your contract amendment will include information about your base rate, the quality escalator and total earning potential.

Begin Medication Adherence Strategies Early

Medication adherence measures are triple weighted for 2023 in the Medicare Advantage and BlueCare Plus Quality+ Partnerships programs, making these measures critically important to your overall Stars score. To maintain or reach a high adherence rate for each one, it's necessary to actively work on adherence all year.

These measures (**Medication Adherence for Cholesterol, Hypertension and Diabetes Medications**) require the patient to fill their medication at least 80% of the time they're prescribed to. These measures start off strong with high adherence rates and decrease as the year progresses. Our pharmacy reports offer timely data that's useful for actionable interventions and begin displaying patients after their first fill of an adherence medication. While CMS requires two fills to be officially included in an adherence measure, consider monitoring patients as soon as they fill a prescription for an adherence medication. Only monitoring patients with two fills will negatively impact adherence scores if the second fill occurs late in the calendar year. At that point in ime, the patient won't be able to reach the 80% proportion of days covered threshold.

Use the **MA Pharmacy Reports** located under the **Quality Reports** tile in the **Quality Care Rewards** application in **Availity** to identify members late to fill their medication after one fill and provide intervention, when possible, to help maintain adherence and improve clinical outcomes.

Opportunity for Frailty Exclusions

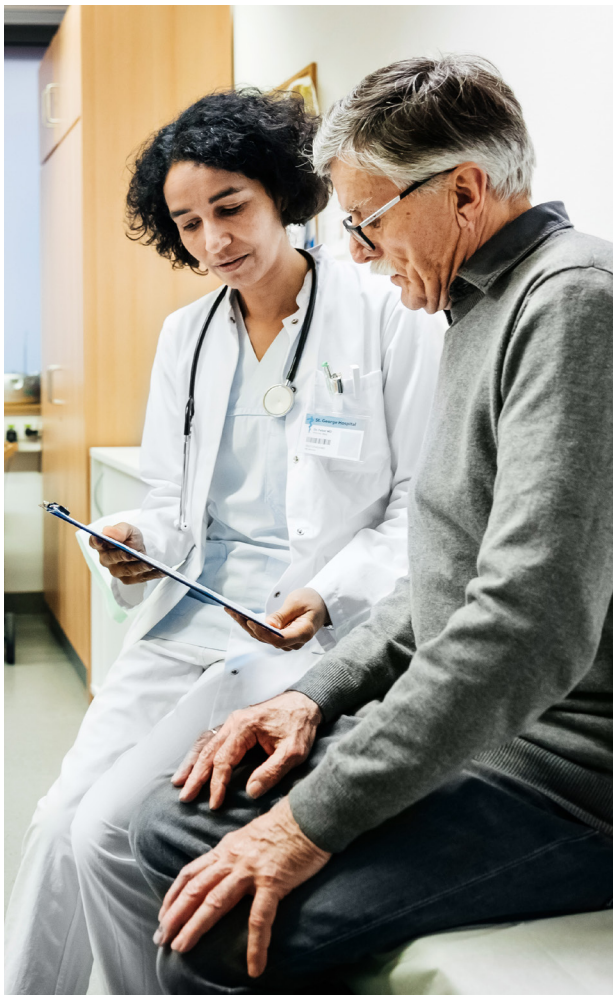
CMS allows patients to be excluded from certain quality measures when they have specific advanced illness and/or frailty diagnoses. Exclusions are made because the services recommended in the HEDIS definition may not benefit older adults with advanced illness, thus limiting their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes are often not captured during routine office visits. Annual wellness exams offer a yearly opportunity to address gaps in care as well as possible exclusions. Coding eligible frailty conditions during the current year will make the patient eligible for exclusions related to frailty and/or advanced illness.

Common frailty conditions in the senior population include:

- History of falling (Z91.81)
- Weakness (R53.1)
- Muscle weakness (M62.81)
- Other malaise (R53.81)
- Other fatigue (R53.83)
- Difficulty in walking (R26.2)

If you have questions about exclusions or codes for advanced illness and frailty, refer to our **Guide to Advanced Illness and Frailty Exclusions**.



Pharmacy

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

Coming Soon: Updated Prior Authorization Requirement for Hemophilia Gene Therapy

Effective April 1, 2023, all physician-administered hemophilia gene therapy drugs, including HEMGENIX®, etranacogene dezaparvovec-drlb, will require prior authorization. This group of medications won't be reviewed by Magellan Rx and should be submitted through the normal BlueCare Tennessee prior authorization process. Please submit requests in one of these two ways:

- Fax: **1-800-292-5311**
- Phone: **1-888-423-0131** (Select option 9 to be transferred to our Utilization Management team)

Please **don't** submit these requests through Availity at this time.

For a full listing of Provider-Administered Specialty Pharmacy Products, please click **here**.

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).

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**.