of Tennessee

OCTOBER 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.

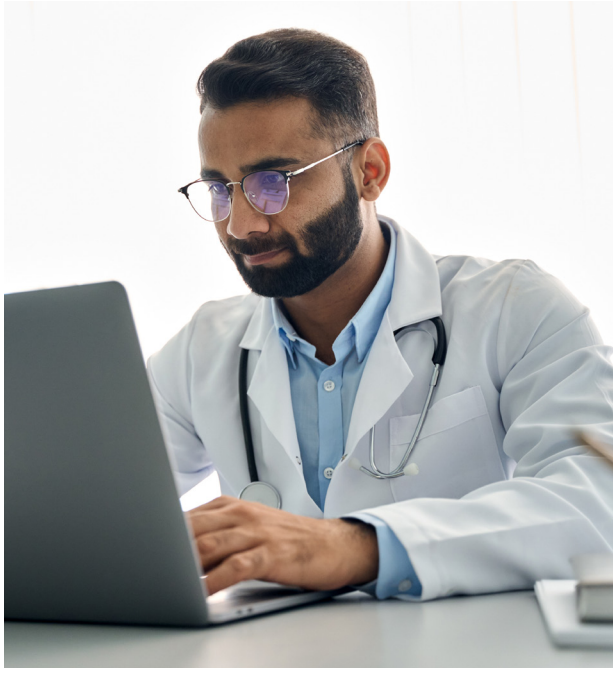
INSIDE THIS ISSUE

Ensure Your Practice Information is Correct

It's important that you have the most up-to-date information listed for your practice so members can find and access your services. Providers should verify or update their name, location, phone number and specialty on a regular basis using the following information.

First, update your CAQH profile and attest that the information is correct. Then go to the BlueCross payer space in **Availity®**, make sure your BlueCross network-related information is correct and attest on the network verification form.

Also remember to keep your Centers for Medicare and Medicaid Services (CMS) information current by going to the CMS **National Plan and Provider Enumeration System** (NPPES) and making any necessary updates to align with your **CAQH** profile information.



Help Prepare Your Patients for Flu Season

Fall signals the beginning of flu season in our state. Consider these tips to help prepare your patients – and your practice – for the **2023-2024 flu season**.

- Talk with families about the importance of the flu vaccine and how they can lower their risk of getting sick.
- Schedule patients' flu vaccines in advance and send appointment reminders. The Centers for Disease Control and Prevention (CDC) recommends that everyone age 6 months and older get a flu shot, preferably by the end of October.
- It's especially important that people 65 years and older get the flu shot because they're at higher risk of serious complications from the flu. The CDC recommends they get a higher dose or an adjuvanted flu shot.
- Changes in the immune system, heart and lungs make pregnant people more prone to serious illness from the flu. Getting vaccinated during pregnancy can protect pregnant people and help protect their babies from the flu during the first six months of life.
- Review patient medical records before visits, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams, to see if patients have already gotten their flu shot. If not, consider administering the shots during the visits as appropriate. While the CDC recommends vaccination in September or October, the agency notes that vaccination in July and August may be considered for children who have health care visits during these months. These children may not return to see a provider in September or October, so their well-care visit may be the only opportunity to give the vaccine.
- If you have patients who turn 6 months old toward the end of flu season, don't forget to order extra doses of the vaccine. Infants need two doses of the flu vaccine at least four weeks apart during their first flu season, and it's often in short supply in February, March and April. For more information about the CDC's recommendations about the flu season and young children, please click **here**.

Complex Rehabilitation Technology Authorization Requirement

In 2022, a law passed that requires health insurance companies to review billable codes for complex rehabilitation technology (CRT) and provide a coverage determination as part of the prior authorization process. To help us comply with the law and ensure CRT authorizations are processed correctly, we're asking providers to use our CRT Durable Medical Equipment (DME) Authorization forms when submitting these requests.

We've developed separate forms for each line of business:

- Providers prescribing CRT services for our Commercial members should use the **CRT DME Authorization Request Form** in the **Commercial Documents & Forms** section of **provider.bcbst.com** under the **Authorizations & Appeals** accordion. (**Note:** This doesn't apply to members covered by the Federal Employee Program [FEP].)
- Those requesting authorization for a BlueCare, TennCare*Select* or CoverKids member should use the **CRT DME Authorization Request Form** on the Forms page of **bluecare.bcbst.com/providers**.

If you have questions about the process for CRT benefits or authorization, please contact your Provider Network Manager.

Submit High Tech Imaging (HTI) Authorizations through Availity

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**.

Coding, Billing and Claims Reimbursement Hierarchy

As a reminder, we use the following hierarchy for coding, billing and claims reimbursement.

1. Provider's contract
2. BlueCross policies and procedures
3. CMS guidelines
4. Coding guidelines from CPT®
5. Coding guidelines from coding organizations

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 now process these authorizations internally.

While we'll now review authorization requests, the authorization decision process and appeal process will stay the same. 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** application for a more streamlined process and to avoid phone wait times and receive faster response times for the member's authorization. Often times, online authorization submission will be instantly reviewed.

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

Claims Being Filed Under the Wrong Members

We're noticing more claims being filed under the wrong member's name and/or Member ID. When researching member eligibility, it's important to verify each data element closely to make sure you're selecting the appropriate Member ID. You should always verify the member's full name, date of birth (DOB) and address.

Here's an example:

A member comes into the provider's office without their Member ID card. The office staff looks up the member by name and DOB and finds what they believe is a correct match. This Member ID is added to the patient's chart and now linked with the member receiving service. The issue is the staff found the wrong member.

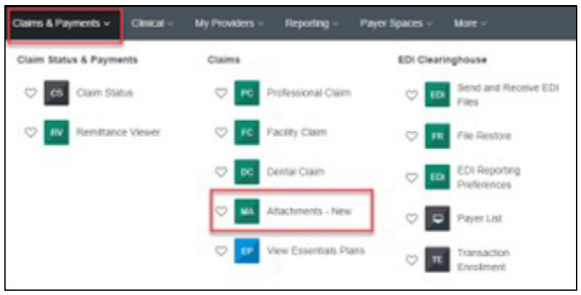
Chris Hall and Chris B. Hall have the same date of birth but different middle initials and addresses. As a result, claims were filed and processed for the wrong member.

Chris Hall	**Chris B. Hall**
DOB: 01/01/1999	DOB: 01/01/1999
Member ID: XXX123456789	Member ID: ZZZ987654321
Address: 123 Member Ln.	Address: 456 Healthy Dr.
Any Town, TN 12345	Big City, TN 54321

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 assistance, contact our eBusiness Technical Support team Monday-Thursday, 8 a.m. to 6 p.m. ET and Friday, 9 a.m. to 6 p.m. ET at **(423) 535-5717, option 2**.

Toll free: **1-800-924-7141**, follow prompts then **option 4** 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 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. Providers can find the PEF and GEF in **Availity** under the **Provider Enrollment, Updates and Changes** tile.

As of mid-March, we're rejecting PEFs for individual providers if they belong to or join 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.

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 uswill 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**.

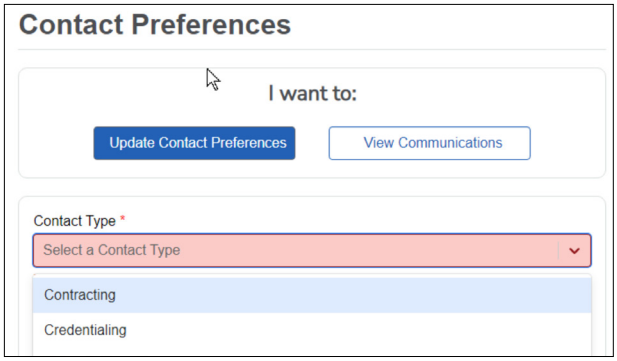
If you're already an in-network provider and currently receive electronic payments and remittance advice as intended, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to **eBusiness Technical Support**. You can also contact your Provider Network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

Get Contracts and Fee Schedule Updates Quicker

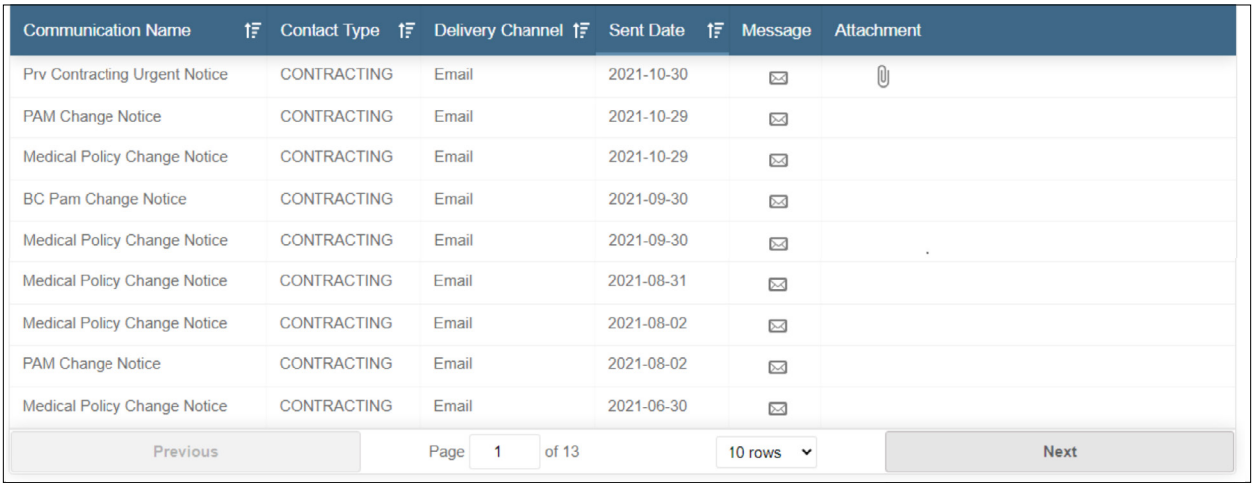
You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. Simply update your **Contact Preferences** through our Payer Spaces in Availity and make email your preferred **contracting** communication type. Here's how:

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.

Checking the Details of Your Authorization Approval

It's easy to check the details of an existing authorization, like dates and CPT® codes, in Availity. Start by going to the **Payer Spaces** tile and then select **Authorization Submission/Review Application**. Next, select **Auth Inquiry/Clinical Update** and then **BCBST**. You can search by authorization case number or by member. If you need to update an existing authorization, you can do it at the bottom of the Authorization Details page.

If you need help or want to set up training, please contact your eBusiness Marketing Consultant, which can be found **here**.

Changes to Some Physical Member ID Cards

Beginning **Nov. 1, 2023**, some commercial group members will receive paper Member ID cards instead of plastic ones. This change lets us send physical cards to members more quickly. While they may feel different than our other Member ID cards, the paper ones are authentic. Digital Member ID cards are still available, and some of our members will continue to have plastic ID cards.

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 will be required to attest an abortion was performed in accordance with 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 Provider Service line at **1-800-924-7141**, Monday- Friday, 8 a.m. to 6 p.m. ET.

Changes to Genetic Testing Prior Authorization for Commercial Plans

Beginning **Nov. 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.

0403U	0409U	0411U	0414U	0418U
0405U	0410U	0413U	0417U	0419U

The following codes will be removed from the EviCore Genetic Testing Prior Authorization List, effective **Nov. 1, 2023**.

0386U 0397U

Applied Behavioral Analysis (ABA) Updates

You spoke, we listened! You no longer need to fax your ABA Authorization requests for Commercial members. We've streamlined the ABA Authorization submission process so Commercial and BlueCare/TennCare*Select* authorizations can be submitted online through Availity.

To request prior authorization:

1. Log in to **Availity**.
2. Go to BlueCross **Payer Spaces** and select **Authorization Submission/Review**.
3. Select the **Outpatient Behavioral Health form** and complete the authorization online.

To update existing authorizations, select **Auth Inquiry/Clinical Update**.

Please contact your **eBusiness Marketing Consultant** for Availity training requests.

BlueCare Tennessee

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

BlueCare Tennessee Laboratory Services Update

In the **July 2023 BlueAlert**, we shared some laboratory services updates. These updates included that effective July 1, 2023, providers no longer have to use Quest Diagnostics for laboratory testing services. With the passage of the Any Willing Medical Lab Provider legislation, providers may use any participating laboratory for services beginning July 1.

Beginning Aug. 1, 2023, we're requiring prior authorization for select high-cost lab testing codes. These requests can now be submitted in Availity.

The full list of laboratory testing codes requiring prior authorization is available **online**. We also updated the Provider Administration Manual with these changes. As a reminder, prior authorization requests can be submitted:

- Online in Availity
- By fax: **1-800-292-5311**
- By phone: **1-888-423-0131**

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.

Mileage Reimbursement for BlueCare Tennessee Members

We're working with Verida to provide non-emergency medical transportation to and from covered TennCare services. Depending on a member's location, transportation options may include a shared ride service, such as Lyft, multiple passengers in the vehicle, a bus pass or mileage reimbursement.

Mileage reimbursement is a convenient option for members with access to a vehicle or a friend/relative willing to drive them to their appointment. Members who choose mileage reimbursement will receive a form that providers need to sign confirming they visited the office. They'll then send the form to Verida, which will refund them for the miles traveled.

Note: This doesn't apply to CoverKids.

Promote Access to Timely Prenatal Care

Prenatal care is an essential part of improving the health of pregnant members and babies in our state. By serving in our BlueCare, TennCare*Select* and CoverKids networks, providers agree to make regular and urgent prenatal appointments within these timelines:

Members in their first trimester of pregnancy

- **Regular appointments:** Within three weeks of the member's request
- **Urgent appointments:** Less than 48 hours from the date of the member's request

Members in their second and third trimesters of pregnancy

- The first prenatal appointment should occur within 15 days of Medicaid eligibility.

Seeing patients within these timeframes can also help improve performance on Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures.

HEDIS Measures Related to Prenatal and Postpartum Care

The quality measure related to timely care during and after pregnancy has two components:

- The **Timeliness of Prenatal Care** component assesses the percentage of deliveries that received a prenatal care visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.
- The **Postpartum Care** component assesses the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

For more information about these measures, please see our **Quality Care Measures** provider guide. To learn more about our BlueCare Tennessee and CoverKids Maternity Care Program and how we support our members and network providers, click **here**.

Review Recommendations for Pediatric Behavioral Health Screening

Assessing development and psychosocial/behavioral health is an essential part of well-child care and should be included in each Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exam. At certain ages, specific screenings, including screening for depression, are also needed. Early detection and treatment of behavioral health conditions helps improve outcomes for children and teens.

Our BlueCare and TennCare*Select* members, including *Select*Kids, are eligible for preventive care on the same schedule put forward by the American Academy of Pediatrics (AAP). In addition to developmental and autism screenings in young children, the **AAP/Bright Futures Periodicity Schedule** recommends:

- Depression screening at 12-21 years of age
- Alcohol and drug use assessment at 11-21 years of age

For more information about the screenings needed at each stage of development, please see our **EPSDT Provider Tool Kit**. If you're concerned about substance use or your patient's behavioral health, call us at **1-888-423-0131**.

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.

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, TennCare*Select* 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**.

BlueCare Plus (HMO D-SNP)SM

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

Vision Services Billed to Medical Coverage

Vision services considered medical, such as diabetic eye exams and eye care related to cataracts, should be billed to your patients' medical benefit instead of using their BlueCare Plus myFlexCard. This helps ensure the care you give counts toward your quality performance for the Eye Exam for Patients with Diabetes star measure and your patients get the maximum benefit from their myFlexCard.

The myFlexCard has a limited amount, and using the myFlexCard for medical claims reduces the amount members can use for other supplemental benefits.

If you have questions, call the Provider Service line at **1-800-299-1407**, Monday - Friday from 8 a.m. to 6 p.m. ET.

Increasing Access to Healthy Food, Over-the-Counter and Housing Utilities Benefits

Effective Jan. 1, 2024, all BlueCare Plus Tennessee members will have access to healthy food, over-the-counter and housing utilities benefits. We'll no longer limit these benefits to those who meet Special Supplemental Benefits for the Chronically Ill requirements.

If you have questions, call the Provider Service line at **1-800-299-1407**, Monday - Friday from 8 a.m. to 6 p.m. ET.

Introducing Spiras Health

We're working with Spiras Health to offer at-home care at no cost to our members.

With Spiras, your patients can:

- Receive ongoing, specialized care while getting help managing conditions more closely at home.
- Get help staying on track with their medication.
- Call their Spiras Care Team 24/7 to answer their health questions.

As a provider, Spiras can work with you to create a care plan tailored to each patient's health goals. A nurse will meet with patients in the comfort of their home to get to know them and their health needs. The program won't replace any existing care but will provide an additional layer of support.

Your patients with BlueCare Plus Tennessee coverage can call Spiras at **(615) 819-1471, TTY 711**. They're available Monday - Friday, from 8:30 a.m. to 5:30 p.m. ET. For more information, visit **spirashealth.com**.

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.

Connect Eligible Patients to Palliative Care

We're working with palliative care providers to serve our members. The focus of palliative care is to reduce suffering and create a better understanding of a patient's disease course and progression. This helps patients and their caregivers make informed decisions about treatment goals.

Our goal is to help provide empathy, education and partnership with patients. Palliative care providers help set expectations for advanced health care planning. They can also help patients, their caregivers and providers focus on physical, mental and spiritual needs in all stages of disease progression.

Our members can take advantage of palliative care services as part of their health care benefits. Please let your patients with BlueCross Medicare Advantage coverage know they can find a palliative care provider in our network by visiting our **online directory**. If you have questions, call the Provider Service line at **1-800-924-7141**, Monday - Friday from 8 a.m. to 6 p.m. ET.

Nonstandard Provider Assessment Forms Discontinued in 2024

Beginning in 2024, only Electronic Provider Assessment Forms (ePAFs) will be accepted. 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 complete them by hand and upload them to the QCR. You can also fax them to **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 OTC program, which is 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.

2024 Drug List Changes

Each year, we review our drug lists and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they may occur at any time because of market changes, such as:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links on the Pharmacy Resources & Forms page to view the 2024 drug list changes:

- **2024 Preferred Formulary Changes**
- **2024 Essential Formulary Changes**
- **2024 BlueAdvantage Formulary**
- **2024 BlueCare Plus Formulary**

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**.