of Tennessee

NOVEMBER 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

New Behavioral Health Clinical Practice Guidelines for Providers

We maintain Clinical Practice Guidelines (CPG) on the **Manuals, Policies & Guidelines** page of **provider.bcbst.com** for our network providers. This section of our website provides a list of CPGs from respected professional organizations on a variety of health topics.

We recently added several guidelines to the **Behavioral Health CPG** section. These guidelines are intended to support you by giving you quick and easy access to clinically sound, evidence-based practice guidelines for behavioral health conditions your patients may be experiencing. The newly added CPGs include:

- American Academy of Child and Adolescent Psychiatry: **Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders - Journal of the American Academy of Child & Adolescent Psychiatry (jaacap.org)**
- American Academy of Child and Adolescent Psychiatry: **Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Major and Persistent Depressive Disorders - Journal of the American Academy of Child & Adolescent Psychiatry (jaacap.org)**
- American Academy of Pediatrics: **Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents | Pediatrics | American Academy of Pediatrics (aap.org)**
- American Psychiatric Association: **Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (apa.org)**
- American Psychiatric Association: **The American Psychiatric Association Practice Guideline for the Treatment of Patients With Eating Disorders | American Journal of Psychiatry (psychiatryonline.org)**
- Veterans Affairs/Department of Defense: **Management of Substance Use Disorder (SUD) (2021) - VA/DoD Clinical Practice Guidelines**

Moving forward, we'll add new or updated CPGs as they're available and let you know when changes occur.

Help Prevent Coordination of Benefits (COB) Denials

You can help prevent COB denials on claims by reviewing Availity® to determine if the COB hasn't 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 then fax to the number at the top of the Questionnaire. This will allow the COB information to be updated and the claims to be processed.

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

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

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

Reminder: Counting Minutes for Timed Therapy Codes

Claims submitted for timed codes should be submitted according to the Centers for Medicare and Medicaid Services (CMS) coding standards, known as the "8-minute rule," for all lines of business.

For any single timed CPT® code in the same day, providers bill a single, 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes, and so on (and no units if service is for less than 8 minutes).

- 1 unit: ≥ 8 minutes to 22 minutes
- 2 units: ≥ 23 minutes to 37 minutes
- 3 units: ≥ 38 minutes to 52 minutes
- 4 units: ≥ 53 minutes to 67 minutes, and so on.

When **more than one** service represented by a 15-minute time code is performed in a single day, the total number of minutes of service determines the number of timed units billed.

The expectation (based on the work values for these codes) is a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If two different services are performed for 8 minutes (for a total of 16 minutes) that may only be billed as a single unit. The total number of units is constrained by the total treatment time.

Example:

- 24 minutes of neuromuscular reeducation, CPT® code 97112
- 23 minutes of therapeutic exercise, CPT® code 97110

Total timed code treatment time was 47 minutes— The total units billed should be three. Each of the codes is performed for more than 15 minutes, so is billed for at least one unit. The correct coding is two units of CPT® code 97112 and one unit of CPT® code 97110, assigning more timed units to the service that took the most time.

Note: Our professional reimbursement is based on the CMS resource-based relative value scale (RBRVS) methodology, as defined in our **Provider Administration Manuals**. See Chapter VI Billing and Reimbursement, Section C: Professional Claim Billing and Reimbursement Guidelines, 3. Reimbursement Hierarchy for Professional and Home Health Services.

For a full explanation of the "8-minute rule" standard, please review Chapter 5, 20.2(C), "Counting Minutes for Timed Codes in 15 Minute Units," in the **CMS Claims Processing Manual**.

Behavior Analyst Credential Requirements

As a reminder, we require that Behavior Analysts have a license with the state of Tennessee. Please note, this may not have been a requirement when the provider was originally credentialed. However, during the next recredentialing process, the license will need to be verified. If a provider doesn't have a license at the time of recredentialing, they won't meet our credentialing requirements and will be denied. A provider can't have contracts if they're not credentialed.

Please see page 239 of the current **Provider Administration Manual** for additional credentialing requirements of Behavior Analysts.

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** application for a more streamlined process and to avoid phone wait times and receive faster response times for the member's authorization. Often, online authorization submission will be instantly reviewed.

Please reach out to your **eBusiness Marketing Consultant** for 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

Provider Exclusion Screening Process

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

You also need to conduct criminal background checks and registry checks in accordance with state law to determine if anyone is an "ineligible person," and therefore, excluded from participation in the Medicare or Medicaid programs. At minimum, registry checks should include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, Office of Inspector General, U.S. Department of Health and Human Services (HHS-OIG) List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and the Tennessee Terminated Providers List.

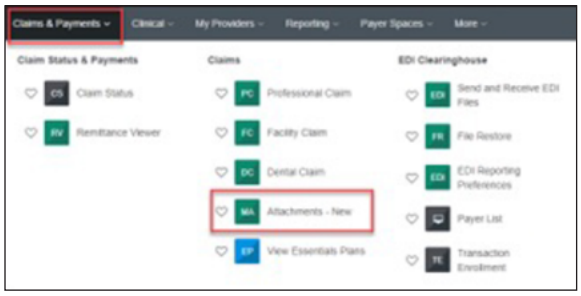
The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

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

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 us will be rejected.
- Once you receive your approval confirmation, please go to our Availity **Provider Enrollments and Changes** section.
- For questions about the progress of your Change Healthcare application, please visit **payerenrollservices.com**.

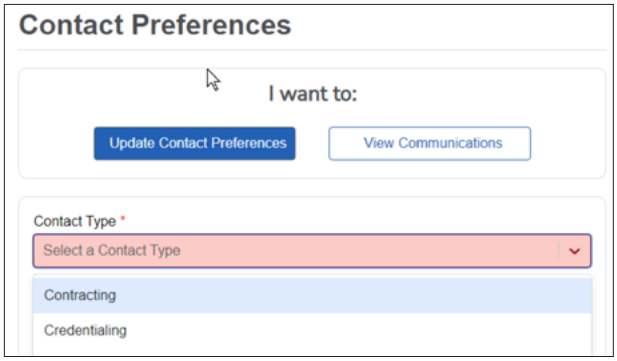
If you're already an in-network provider and currently receive electronic payments and remittance advice as intended, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to **eBusiness Technical Support**. You can also contact your Provider Network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

Get Contracts and Fee Schedule Updates Quicker

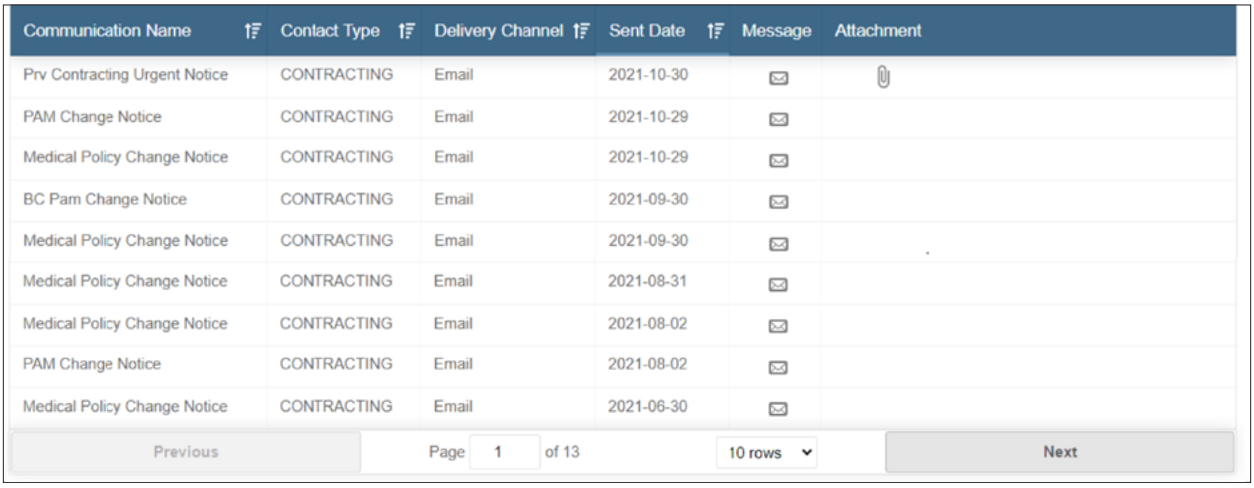
You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. Simply update your **Contact Preferences** through our Payer Spaces in Availity and make email your preferred **contracting** communication type. Here's how:

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.

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.

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.

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 & CoverKids1 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.

Prioritize Health Education During Well-Child Exams

The number of people under age 20 living with type 1 diabetes rose 45% between 2001 and 2017, according to the Centers for Disease Control and Prevention (CDC). The incidence of type 2 diabetes in this population rose 95% during the same time. And the CDC estimates that rates of diabetes in young people will continue to rise over the next 40 years.

While research into the causes of these increases is ongoing, growing rates of childhood obesity likely contribute to the rise in type 2 diabetes levels. Healthy habits, like eating a healthy diet and making time for physical activity, start early. You can help address these rising rates by discussing healthy habits during checkups.

Health education is an essential part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. This important step allows you to address age-appropriate topics, including nutrition, physical activity, media use, sleep position counseling, and violence, injury and illness prevention. Additionally, consider using this time to talk with patients about any specialists they're seeing or other medications they're taking. Some prescriptions and over-the-counter medications can raise blood sugar levels. For example, children and adolescents who take antipsychotic medication need yearly metabolic screening tests to check their blood sugar and cholesterol levels.

For more information about the components of EPSDT visits, please see our **TennCare Kids Tool Kit** in the **Provider Tools and Resources** section of **bluecare.bcbst.com/providers**.

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

Help Connect Your Patients to Breastfeeding Support

Effective June 1, 2023, BlueCare, TennCareSelect and CoverKids benefits include outpatient lactation consultant services. Please see below for important updates and reminders as you work to ensure your patients get breastfeeding support:

- Benefits include medically appropriate lactation consultation services from in-network providers during pregnancy and after birth.
- Parents can get services through telehealth or in person in a one-on-one or small group setting, and there's no limit on the number of visits allowed during pregnancy and through the extended postpartum period or for as long as medically necessary.*
- In-network International Board-Certified Lactation Consultants (IBCLC) and contracted providers with lactation counseling, education or consultation within their scope of practice can bill for lactation services.
- Certified Lactation Counselors (CLCs), Certified Lactation Educators (CLEs), Certified Lactation Specialists (CLSs) and Certified Breastfeeding Specialists (CBSs) may also provide lactation support when services are supervised and billed by a registered, in-network provider.** In this case, the supervising provider would be the rendering provider on the associated claim.

For more information about your patients' lactation benefits, including coding guidance, please see our **BlueCare Tennessee and CoverKids Maternity Care Program** webpage.

* We may ask for additional documentation after 15 units are billed.

**These are new covered specialties. Previously, only CLCs and CLEs were allowed to provide supervised lactation support.

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**.

Review the Health Care for Adults with Intellectual and Developmental Disabilities (IDD) Tool Kit

Developed for primary care providers by Vanderbilt University Medical Center and the Vanderbilt Kennedy Center, the **Health Care for Adults with IDD Tool Kit** contains general information about caring for those with IDD, diagnosis-specific health watch tables, resources for meeting behavioral and mental health issues, and preventive care checklists.

While the tool kit is geared toward adult patients, it contains useful information for all primary care providers, including those caring for children and young adults. To view the tool kit and related resources, please click **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, TennCareSelect 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.

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

In late 2023, we'll review BlueCare, TennCareSelect 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.

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 – An appeal must be received in writing with all supporting medical records within 60 days after receiving the other party's response to its inquiry/reconsideration. Please use the **Provider Appeal Form** to submit appeal requests. Like the 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**.

BlueCare Plus (HMO D-SNP)SM

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

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

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

Medicare Advantage

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

Prior Authorization Code List Updates

Providers currently review several code lists to determine if a code requires prior authorization. To simplify this process, we're combining the lists into one master prior authorization code list. We'll still have the Specialty Pharmacy (Part B) code list as a separate document, but we hope this simplifies the way providers search for prior authorization codes.

Check back for updates at **provider.bcbst.com/tools-resources/documents-forms** under **Medicare Advantage**.

Continuous Glucose Monitors

We review several brands of non-adjunctive continuous glucose monitors, including Freestyle Libre 2, Freestyle Libre 3, Freestyle Libre 14, Dexcom G6 and Dexcom G7.

When requesting prior authorization for these brands, please include a signed physician's order with the following details:

- Brand name
- Face-to-face encounter(s) from the last six months
- Documentation of insulin use or problematic hypoglycemia

After utilization management approval, these are available through pharmacy benefits and are available for your patient to pick up at their pharmacy.

Note: The reader/receiver for the **Freestyle Libre 3** must be dispensed by a durable medical equipment (DME) provider. Sensors are available through pharmacy benefits. Please specify the DME supplier and national provider identifier (NPI) when requesting this brand.

Acute Hospital Diagnosis-Related Group Extension Requests

Effective Oct. 1, 2023, acute hospital diagnosis-related group extension (concurrent) requests only need to be submitted every seven days after the initial six days during the hospital stay. This will help reduce the administrative burden for our providers. A full medical necessity review and collaborative discharge planning activities will be conducted to best support our members.

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

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)**.

Quality Care Rewards

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

When Type 2 Diabetics are Intolerant to Statin Therapy

Numerous clinical trials and studies have demonstrated the benefits of statin therapy for type 2 diabetes. These studies have solidified the role of statin therapy in diabetes management guidelines. For patients with reported side effects to the use of statin therapy, a 2007 randomized control study published in **The American Journal of Cardiology** suggests that using CoQ10 supplements seemed to decrease the muscle breakdown, pain and discomfort associated with statin use.

Consider offering CoQ10 supplements as an alternative to stopping treatment when patients complain of side effects. If muscle pain is severe or persistent, alternative statin medications or dosages might be considered (before stopping medication completely).

If you have patients who are intolerable to statin therapy and need to change to a lower dose or alternative therapy, be sure to indicate it in their medical records with the following billable codes:

- **G72.0** – Drug induced myopathy
- **Z79.899** – Other long-term drug therapy, including statin intolerance, is eligible for reimbursement when accurately coded
- **Z91.130** – Patient's intentional underdosing of medication regimen due to adverse effects, can be billed when documented accurately

For more information about the Statin Therapy for Patients with Diabetes (SPD) HEDIS measure, go to **ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/**.

Tennessee Healthcare Innovation Initiative (THCII) Episodes of Care Program News and Updates

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available Nov. 16, 2023. If you're a quarterback who's having trouble accessing your Quarterly Report, please call **(423) 535-5717** and press option 2 or email **eBusiness_Service@bcbst.com**.

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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.

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