APRIL 2024

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 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

Office and Outpatient Evaluation and Management Visit Complexity Add-on Payment Code G2211

The Centers for Medicare & Medicaid Services (CMS) recently announced changes to the status of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Payment Code G2211. They changed the status of the code to make it separately payable by assigning it an "active" status indicator, effective Jan. 1, 2024.

We've implemented this change for our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans and will follow CMS guidelines. Please refer to CMS guidance on when and how to bill this code correctly and what supporting documentation is required. Our Commercial and BlueCare Tennessee networks will not implement this change.

You can find more information about our Quarterly Reimbursement Policy in our Provider Administration Manuals. We've also posted this information in the Code Updates section of our **provider.bcbst.com** site. Please navigate to **Tools & Resources > Coverage & Claims > Codes for Submitting Claims > Coding Updates**.

Updated Lab Testing Policies

As of Sept. 1, 2023, we implemented the Avalon Healthcare Solution Laboratory Procedures Reimbursement Policy. These edits are based on industry standards and are centered on input from a dedicated staff of full-time clinical professionals. All policies have been extensively researched and are reviewed and updated as necessary.

Screening for cervical cancer

Some recent policy changes apply to how often providers should screen for cervical cancer. Here's our current policy for these types of screenings:

For women ages 21-29

- Every three years with cytology alone

For women ages 30-65

- Every three years with cytology alone
- Every five years with high-risk human papillomavirus (hrHPV) testing alone or every five years with co-testing

You can find more information by referring to the **Laboratory Testing Code Reimbursement Policies** document under the **Coding Updates** section at **provider.bcbst.com**.

Prior Authorization Letters Now Available in Availity®

We're happy to announce that you can now view prior authorization letters in Availity. To view:

1. Log in to **Availity**.
2. Click on **Payer Spaces** and select the **BlueCross BlueShield of Tennessee logo**.
3. Select the **Authorization Submission/ Review** application.
4. Go to the **Auth Inquiry/Clinical Update** drop-down arrow then click **BCBST** to search for the existing authorization.
5. Next, choose the **case ID number** to view the authorization details.
6. Look for the letter section in the upper right to **view and print** the authorization letters.

Please contact your **eBusiness Marketing Consultant** for your Availity questions or training needs.

Sign Up to Receive Important Communications by Email

With increases in telehealth visits, changes in office staff and updated office locations, we've noticed more providers are asking to receive important communications by email. You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email.

If you'd like to switch to email, simply update your **Contact Preferences** through our **Payer Spaces** in **Availity**. There, you can select email instead of mail for five different types of communications. You can add a contact name and email address for contracting, credentialing, network operations, network updates, quality and clinical information and financial updates.

To receive communications by email, 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**.
4. Selecting your **Organization** and **Tax ID**. (Tax ID is a newly added feature that lets you select a specific provider based on Tax ID allowing updates to contact information for all Tax IDs in addition to the primary Tax ID associated with the corresponding NPI.)
5. Picking a **Provider** from the drop-down list or directly entering the provider's **NPI** and clicking **Submit**.

   Tip: If you don't see your name in the drop-down list, you can add it through the **Manage My Organization** dashboard. For contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.
6. Following 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. When finished, 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 contact types you have access to. In some cases, you may find it takes time to receive these messages through your newly specified 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. If you have questions, please log in to Availity or contact eBusiness Technical Support at **(423) 535-5717, option 2**.

Taxonomy Code Reminder

As a reminder, professional claims need a taxonomy code (unique 10-character code that designates your classification and specialization) to be submitted for billing and rendering providers. The **National Plan and Provider Enumeration System (NPPES)** directory shouldn't be the single source of determining the correct taxonomy.

It's important that both the billing and rendering provider taxonomy codes match how you're credentialed and contracted with us. For example, if you have a pharmacy, specialty pharmacy and DME provider contract, you'll need to file with the specific taxonomy indicated for each contracted service. If you don't submit the appropriate taxonomy codes, your claims may be rejected, denied or result in reduced reimbursement.

Please be sure to file the two-digit qualifier with taxonomy.

2024 Health Equity Report Now Available

We're building on our commitment to understand and address health disparities with the release of our second annual **Health Equity Report**. In the 2024 version, we've added a section on social drivers of health featuring our proprietary Social Risk Index and highlighted efforts to help improve health outcomes.

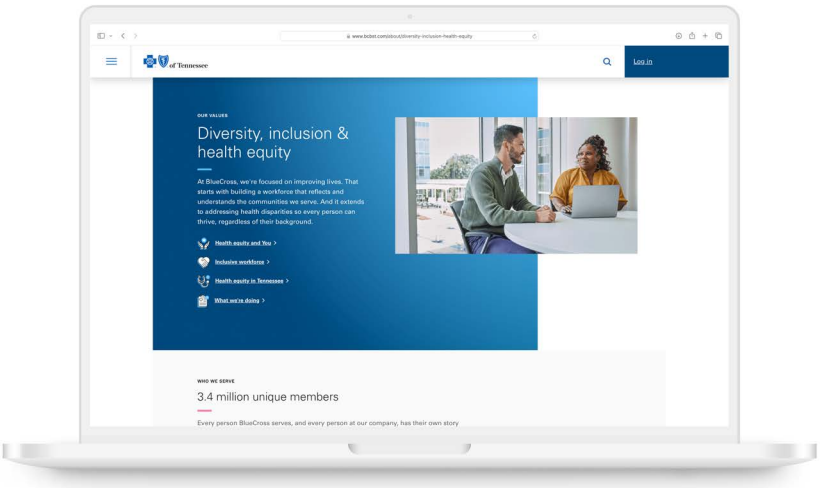
Using data from several publicly available sources, we published the report for the first time in 2023 with a focus on how social factors impact physical and mental wellbeing. This year's edition highlights the impact of 20 key **social risk factors** and provides updated data on key health categories, including:

- **Behavioral health**
- **Cancer**
- **Child and adolescent well-care**
- **Chronic condition management (high blood pressure, diabetes, asthma)**
- **Maternal health**

Our new 2024 report reveals:

- Maternal health disparities persist, and they play a role in maternal mortality – substance use disorders contributed to 39% of all pregnancy-related deaths.
- In Tennessee, Hispanic individuals are the least likely of all racial groups to be screened for colorectal cancer at the recommended age.
- One in four Tennesseans had a mental illness in 2021, and Black individuals were less likely to receive follow-up care within seven days of a hospitalization.

Providers play a key part in helping to address health disparities, so we appreciate the work you do to reach our members and make sure they get the care they need. To review the Health Equity Report and more of its key findings, please visit **https://www.bcbst.com/healthequity**.



Save Time with Digital Drug Prior Authorization Requests

Did you know you can avoid on-hold wait times by submitting provider-administered drug prior authorization requests in Availity? You can speed up submission and have access to a dashboard of all your open and completed coverage reviews.

You can find instructions in the **Provider-Administered Drug Prior Authorization Quick Reference Guide** in Availity's **Payer Spaces** under **Resources**. If you need access to Availity, check with your office Availity Administrator. If your office doesn't have access to Availity, you can register your organization at: **availity.com/Essentials-Portal-Registration**.

For help getting started, contact your eBusiness Marketing Consultant for training and education. Please note, self-administered drugs can still be requested through **CoverMyMeds** or **Surescripts**.

Providers New to Our Medicaid Networks Need a Medicaid ID to Enroll

As a reminder, individual practitioners joining a group practice that participates in our BlueCare℠ and TennCare*Select* networks need a Medicaid ID from the Division of TennCare before applying with us.

Group practice managers should start the Medicaid ID process immediately after learning a new practitioner is joining their group. You can find more information on the **TennCare site**.

In addition, individual practitioners joining a new group must be eligible to participate in all networks the group is contracted for. They'll also need a valid and current CAQH profile, which can be managed through the **CAQH Provider Data Portal**.

For more information, providers should reach out to their Provider Network Manager.

Digital Member ID Cards Coming Soon in Availity

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

Commercial

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

Changes to Prior Authorization Requirements for Commercial Plans

Beginning **May 1, 2024**, the following services will be removed from the Commercial prior authorization list.

- 23-Hour Observation (when elective, direct admission from MD office and transfers from another facility)
- Varicose Veins procedures
- Hysterectomy in the outpatient setting including OBS setting

Beginning **May 1, 2024**, the following services will be removed from the Commercial Behavioral Health prior authorization list.

- Electroconvulsive Therapy (ECT)

Beginning **May 1, 2024**, the following services will be updated on the Commercial prior authorization list.

- DME will be changed from >$500 to >$1000.
- Inpatient Hospice will remain on the prior authorization list. Home Hospice services will no longer require prior authorization.

Note: These changes do not apply to the Federal Employee Program (FEP).

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning **June 1, 2024**, the following codes will be added to the Genetic Testing prior authorization list in the EviCore Genetic Testing Program.

0439U, 0440U, 0444U, 0448U, 0449U

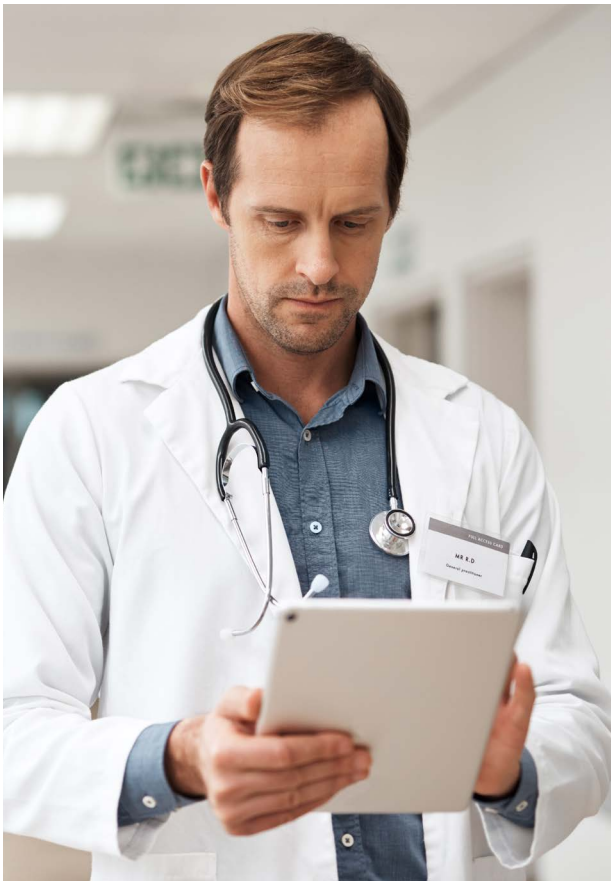
Changes to Musculoskeletal Program Prior Authorization for Commercial Plans

Beginning **May 1, 2024**, the following codes will be added to the MSK Prior Authorization List and will require prior authorization for those members with the Musculoskeletal Program Benefit:

0784T, 0785T, 0790T, 22836, 22837, 22838, 27278

The following codes will be removed from the MSK Prior Authorization List effective **May 1, 2024**, for those members with the Musculoskeletal Program Benefit:

0775T, 0809T



BlueCare Tennessee

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

Stay Up to Date on the Provider Appeals Process

If you disagree with the amount paid for a particular claim, you can 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 the below process differs from the process used for utilization management and clinical authorization appeals.

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

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

Step 2: Appeal – We must receive your appeal in writing with all supporting medical records **within 60 days** after receiving the other party's response to its inquiry/reconsideration. **If we don't receive it within 60 days, your appeal could be rejected as a timely filing denial.** Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each document should only include one patient, one claim and one date of service.

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

Non-Discrimination Compliance Training Reminder

We encourage all providers who participate in BlueCare, TennCare*Select*, CoverKids, CHOICES or ECF CHOICES to complete your annual non-discrimination compliance training. You can find the Non-Discrimination Compliance Information for Providers presentation at **Tools and Resources** on the BlueCare website.

Discuss Naloxone with Your Patients

Opioid overdose continues to be a serious health concern in our state and around the country. Naloxone, a medication that reverses opioid overdose, is designed for use in emergency situations where there's a suspected or confirmed overdose. The Centers for Disease Control and Prevention (CDC) recommends providers prescribe naloxone to all patients using opioids – especially those at a higher risk of overdose.

Consider talking with patients who use opioids and their families about naloxone, its benefits and how to use it. As a health care provider, you play an essential part in making sure this potentially life-saving medication is available.

For more information about naloxone and facilitating conversations with your patients, visit **www.cdc.gov/opioids/naloxone/**.

Assess Your Patients' Development at Key Ages and Stages

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits consist of seven components, including:

- Comprehensive physical and developmental health history
- Complete physical exam
- Lab tests (as needed)
- Immunizations (as needed)
- Vision and hearing screening
- Developmental/behavioral screening
- Health education/anticipatory guidance

You can learn more about the components of these visits and best practices for completing them in our **EPSDT Provider Booklet**.

Evaluating children's development is particularly important during early childhood and allows you to identify concerns and start intervention services early. Your patients enrolled in BlueCare and TennCare*Select* are eligible for preventive services according to the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**.

In addition to regular hearing and vision assessment, screening recommendations related to healthy development include:

- **Developmental screening** at ages 9, 18 and 30 months
- **Autism spectrum disorder screening** at ages 18 and 24 months
- **Behavioral/social and emotional screening** at each wellness exam, from the newborn visit to age 21 years

When scheduling EPSDT visits, let parents and guardians know if their child will be getting a developmental screening at their upcoming visit and discuss the importance of these services.

If a child has a developmental delay or disability, consider referring families to the Tennessee Early Intervention System (TEIS). This program offers therapy and other services to families of infants and young children. You can find **more information about TEIS** online through the Tennessee Department of Intellectual and Developmental Disabilities. To refer a patient younger than age 3, complete the **online referral form**. To refer older patients, contact their local school district. If you have questions or would like to make a referral over the phone, please call **1-800-852-7157**.

Dedicated Staff to Support Children in Foster Care

We have a specialized team to assist foster families and our members in state custody. Our *Select*Kids team can help with scheduling appointments and locating providers, out-of-state pharmacy needs, and addressing social determinants of health. They can also connect families to our Integrated Care Team as needed for help with healthy living, managing short- or long-term illness or injury, or more complex health needs.

Additionally, our *Select*Kids team works closely with the Department of Children's Services (DCS) and can serve as a liaison with DCS if you need help coordinating patient care.

Please let foster families know we're here to help. You and your patients' guardians can reach our care team by emailing **SelectKids_GM@bcbst.com** or calling **1-800-451-9147**. Calls are answered Monday through Friday from 8 a.m. to 6 p.m. ET. After hours, calls are automatically routed to our Nurseline.

Use Availity to Change Members' Primary Care Provider

Effective **April 1, 2024**, providers must use the **BlueCare Primary Care Provider (PCP) Change Maintenance** application in Availity to change a BlueCare, TennCare*Select* or CoverKids member's assigned PCP. We're no longer accepting PCP changes by fax or email.

As a reminder, when you use the application, changes are made in real time. New ID cards are mailed to members automatically when the change is made, and digital ID cards are available immediately in their online account.

For step-by-step instructions for using the Availity application, review our quick reference guide in the **Resources** section of our **Payer Space**. If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your eBusiness Regional Marketing Consultant.

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 their online account.

Addressing Disparities in Maternal Health Care

People of color are less likely to get the right prenatal care. According to the Tennessee Department of Health's **2023 Maternal Mortality in Tennessee** report, Black patients were 2.3 times as likely to die during pregnancy than white patients. And our **2024 Health Equity Report** shows our Black BlueCare members are less likely to get three types of prenatal care than Asian, Hispanic and White members.

- 8.4% of Black patients got recommended prenatal immunizations
- 65.2% of Black patients had a prenatal visit during their first trimester
- 61.7% of Black patients received postpartum care within 90 days of giving birth

To help bring awareness to maternal health disparities, the CDC designates April 11-17 as Black Maternal Health Week each year.

As a provider, you play a key role in ensuring your patients get needed care, and we're here to help. We offer a variety of resources to our members and network providers:

- **Member Maternity Program** – Your patients' BlueCare Tennessee and CoverKids benefits include one-on-one support from the beginning of pregnancy through the postpartum period. Your patients can get started in our Maternity Program and connect with a dedicated care team by downloading the **CareTN app**.
- **Breastfeeding support** – BlueCare Tennessee and CoverKids benefits also include lactation consultant services.
- **Extra maternity care payments for providers** – Our network providers can earn payments on top of regular reimbursement for maternity care. Visit our **Provider BlueCare Tennessee and CoverKids Maternity Care Program web page** for more information.
- **Non-Discrimination Compliance and Cultural Competency training** – The CDC suggests that recognizing and working to eliminate unconscious bias in provider offices as a way to help reduce Black maternal mortality. We offer several training materials that address various facets of non-discrimination and culturally competent care. They include:
  - **Non-Discrimination Compliance Training for Providers**
  - **Cultural Competency in Health Care**
  - **Quality Interactions Cultural Competency Training**

If you have questions about these maternity care resources, please contact Ashley Henderson, Performance Improvement Consultant, at **Ashley_Henderson@bcbst.com**.

BlueCare Plus (HMO D-SNP)SM

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

2024 Special Needs Plan Model of Care (MOC) Training is Now Available

Providers participating in BlueCare Plus Tennessee (HMO D-SNP)SM special needs plans are contractually required to complete our Model of Care Training after initial contracting, then every year afterwards. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation at **bcbst.com/model-of-care-training**.

Provider Authorization Tool

BlueCare Plus is taking steps to help improve member access to care by removing multiple prior authorization requirements for your patients. To view these updates, refer to the **Prior Authorization Tool** in **Availity**.

Preadmission Screening and Annual Resident Review (PASRR)

Providers admitting patients with BlueCare Plus coverage to a certified nursing facility are required to complete a PASRR prior to admission. A practitioner certification stating the patient isn't expected to remain in the nursing facility beyond 30 days is also accepted. Failure to provide a PASRR or Practitioner Certification Form with a skilled nursing facility request may result in a delay in determination processing.

You may download the Practitioner Certification Form **here**.

Medicare Advantage

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

Hospital Services Review Process

We follow the two-midnight benchmark as a part of the inpatient admission criteria for coverage decisions of inpatient stays. When a provider makes the determination to admit a member with Medicare Advantage coverage to the hospital, our plans provide coverage for such admissions. Our Medicare Advantage plans are not required to and do not follow the two-midnight presumption, which presumes any inpatient admission that crosses two midnights is presumed appropriate for payment.

To learn more, view the **Hospital Services Review Process and FAQs** document online at **provider.bcbst.com/tools-resources/documents-forms** under **Medicare Advantage Authorizations & Appeals**.

Kidney Health Evaluation for Patients with Diabetes

The **Kidney Health Evaluation for Patients with Diabetes (KED)** measure has been added as a single-weighted measure for the 2024 Medicare Advantage quality program as of Jan. 1, 2024.

The KED measure evaluates the percentage of patients 18-85 years old with diabetes (type 1 or type 2) who received a kidney health evaluation, which is defined by an **estimated glomerular filtration rate (eGFR)** and a **urine albumin-creatinine ratio (uACR)**, during the measurement year. Patients need to have **both** an eGFR and a uACR on the same or different dates of service during the measurement year. To satisfy the uACR component, the patient must have either a urine albumin-creatinine ratio test or both a quantitative urine albumin test and a urine creatinine test with service dates four or fewer days apart.

This measure can be closed through administrative claims or by attestation in the Quality Care Rewards (QCR) application in Availity. If you're attesting to this measure in the QCR application, an attestation must be submitted for each test completed.

Please contact your Provider Quality Outreach Consultant for questions or assistance with the KED measure.

Complete 2024 Provider Assessment Forms

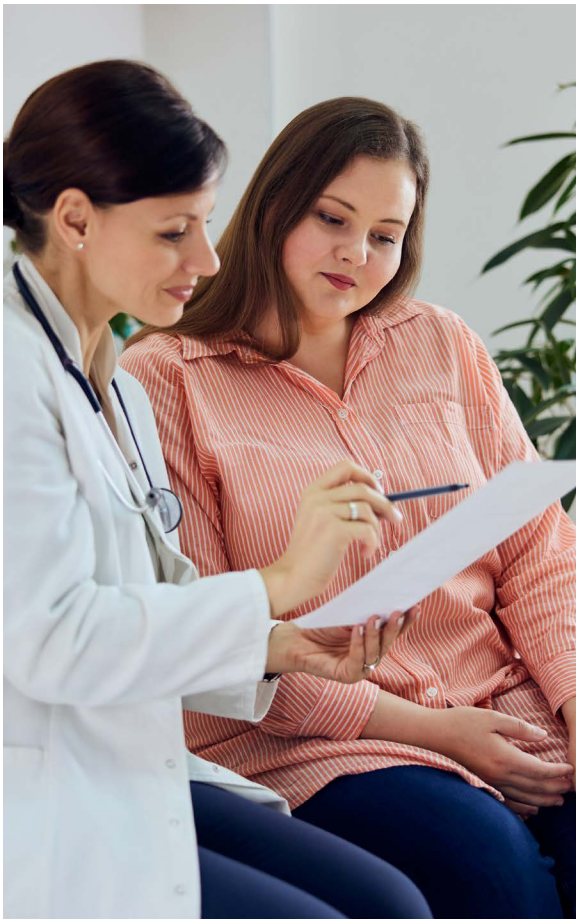
Remember to complete Provider Assessment Forms (PAF) on your patients this year. A PAF must be completed during a face-to-face or telehealth visit (using both video and audio components). A PAF may be completed once per year in conjunction with a Medicare Annual Wellness Visit (AWV) or any other office visit type.

To complete a PAF, locate the brief, hierarchical chronic condition (HCC)-focused PAF in the QCR application in Availity. You can complete it in the QCR application, export it for manual completion and upload it to the QCR, or fax it to the number at the top of the form.

Please note: The non-standard PAF is no longer accepted for 2024 dates of service and won't be reimbursed.

Submit CPT® code **96161** on your claim once the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code. No modifier is needed. Reimbursement for completion of a PAF completed in/exported from the QCR application is $225.

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



Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions

Attestations for patients in the Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) measure are only permitted for telephone visits completed on the day of or within seven days after the ED discharge that aren't billed.

- Attestations for office visits or telephone visits that are billed aren't needed because the claim will satisfy the requirement of the measure if it was completed in the appropriate time frame.
- Please allow a minimum of four to six weeks for the claim data to process and close the gap.
- Attestations for telephone visits **require** documentation of the telephone visit from the medical record to be submitted.

FMC measure attestations without proper supporting documentation and/or unnecessary attestations are subject to removal from the QCR application.

Please contact your Provider Quality Outreach Consultant for questions or help with the FMC measure.

Statin Therapy for Patients with Cardiovascular Disease

Attestations for patients in the Statin Therapy for Patients with Cardiovascular Disease (SPC) measure are available in the QCR application in Availity.

Please note: Attestations are only allowed for measure exclusions and statins filled through cash pay, the Veteran's Administration (VA) and Patient Assistance Programs (PAPs).

- Attestations for statins filled at the pharmacy using the patient's Part D benefit aren't needed because the pharmacy claim data will satisfy the requirement if the medication fill meets all other requirements (minimum dosage of a specific statin filled during the measurement year).
- Please allow a minimum of four to six weeks for the pharmacy claim data to process and close the gap.
- Attestations for statins filled through cash pay, VA and PAPs **require** a photocopy of the prescription bottle or pharmacy receipt that includes the full label with patient identification, medication name, dose, route and dispensed date to be submitted with the attestation.
- Attestations for SPC exclusions **require** documentation from the medical record to support the exclusion to be submitted with the attestation.

SPC measure attestations without proper supporting documentation and/or unnecessary attestations are subject to removal from the QCR application.

Please contact your Provider Quality Outreach Consultant for questions or help with the SPC measure.

Provider Star Ratings Now Available in Availity

The Medicare Advantage Quality+ Partnerships Program offered providers enhanced reimbursement for 4-STAR and above quality scores and coding accuracy completed during the 2023 measurement period of Jan. 1 – Dec. 31, 2023. Participating providers may view their 2023 Star rating in Availity by accessing the QCR application, clicking on the **Scorecards** tile, then the **Prior Year Scorecards** link under the **More Information** tile. The rating is located at the top of the scorecard.

Star ratings, as calculated by the previous year's performance, impacted each provider's current reimbursement rates which are effective April 1, 2024. Providers should refer to the rate attachment provided with their rate adjustment notification letters mailed at the end of March to see their new fee schedules.

Contract amendments contain information about their base rate, the quality escalator and total earning potential.

Pharmacy

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

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Billing Guidelines for Bilateral Codes

Based on Centers for Medicare & Medicaid Services (CMS) guidelines in association with the National Physician Fee Schedule Relative Value File, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One unit should be reported.

In certain situations, modifier 50 shouldn't be added to a procedure code. Some examples include, but aren't limited to:

- A bilateral procedure performed on different areas of the right and left sides of the body (e.g., reduction of fracture, left and right arm).
- The procedure code description specifically includes the word **bilateral**.
- The procedure code description specifically indicates the words **one or both**.

Sometimes it's appropriate to bill a bilateral procedure with:

- A single line with no modifier and one unit;
- A single line with modifier 50 and one unit; and/or
- Two lines with modifier LT and one unit on one line and modifier RT and one unit on another line.

These guidelines apply to both Professional CMS-1500 and Facility CMS-1450 claims.

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
Seven days/week, 8 a.m. to 9 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice or facility:

Please visit our payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Provider Portal** website

Questions? Call **1-800-924-7141**.