of Tennessee

MAY 2024

BlueAlert℠

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.

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It's Almost Time for the 2024 All Blue Workshop℠

Be sure to mark your calendars for the 2024 All Blue Workshop, which will be held Thursday, **Aug. 1, 2024**. The annual event will once again be hosted virtually and will last the entire day. The morning will be dedicated to general sessions and breakout sessions are scheduled after lunch. Please be sure to check upcoming issues of BlueAlert for registration information and more details.

Updated Health Reimbursement Account (HRA) Information in Availity®

The Eligibility & Benefits application has been enhanced to show the individual and family HRA balance including the remaining balance details in Availity. If you have additional questions about the member's benefits, you can click the Coverage Questions button to get to the Fast Path phone number and member transaction ID number.

If you need Availity training, please contact your **eBusiness Marketing Consultant**.

Evaluation and Management CPT® Codes Shouldn't be Applied for Admission through Availity

When submitting prior authorizations for inpatient or observation care, please don't apply CPT® Codes such as 99221, 99222 and 99223. The Milliman Care Guidelines (MCG) will display correctly based on the diagnosis code on the authorization. If the member meets the MCG guideline criteria, authorizations may receive immediate approval without these procedure codes. The authorization is more likely to unnecessarily pend for review when using these CPT® Codes.

Enter Individual NPI's When Requesting Prior Authorizations

When requesting a prior authorization, always enter the Individual NPI into the **Requesting/Servicing** provider field for BlueCard® and BlueCross BlueShield of Tennessee members. If the Group NPI is submitted, the authorization will appear to be out of network, which may delay the authorization.

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**.

The Importance of Care Coordination Between Medical and Behavioral Health Providers

Collaboration between medical and behavioral health providers helps ensure comprehensive patient care, improved outcomes and cost-effectiveness.

When providers collaborate through care coordination, the results are invaluable:

- The whole person is addressed through **holistic patient care** – considering both physical and mental well-being which leads to better outcomes.
- Studies consistently show coordinated care leads to **enhanced outcomes** through tailoring treatment plans, identifying potential interactions between physical and behavioral health conditions and optimizing interventions.
- Effective coordination **reduces health care costs** by reducing service duplications, streamlining referrals and minimizing fragmented care. Additionally, screening and early intervention in behavioral health issues can prevent more severe conditions which saves resources.
- Seamless transitions between medical and behavioral health services **enhance patient satisfaction**. Communication and shared information create a cohesive health care journey.

Increased collaboration can create a health care ecosystem that prioritizes patients' well-being, fosters positive outcomes and optimizes resource use. When medical and behavioral health providers synchronize their efforts, patients thrive, and our health care system becomes more resilient.

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 (the "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 whether any of them are **ineligible persons**, 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, 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**.

Updated Lab Testing Policies

Effective **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 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.

You can update your Contact Preferences by:

1. Logging in to **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type**.
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. You can update contact information for all Tax IDs, including 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**.

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 Radiation Oncology Program Prior Authorization

Beginning **July 1, 2024**, the following codes will be added to the Radiation Oncology prior authorization list in the EviCore Radiation Oncology Therapy Program.

32553, 49411, 49412, 55876

Behavioral Health Acute Inpatient Prior Authorizations

As a reminder, inpatient behavior health prior authorizations can be submitted online through Availity. If the member meets the clinical criteria for an authorization request, you may receive an approval. If you need to check the details or update an existing authorization, that's easily handled through Availity.

If your practice needs Availity training and education, contact your **eBusiness Marketing Consultant**.

Changes to Genetic Testing Program Prior Authorization

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

New Cultural Competency Training Available

Our network providers now have access to three cultural competency education courses through Quality Interactions training at no cost to them. Our course offerings include:

- ResCUE Model for Cross-Cultural Clinical Care
- Improving Adherence in Diverse Populations
- Recognizing and Responding to Implicit Bias in Maternal Health

These courses are interactive, engaging and fully mobile-friendly so you can learn on the go. Because they're accredited, you'll be eligible for one (1) hour of CME, CEU or CCM credits upon completion. We'll also award you a Cultural Competency designation in our online provider directory.

You can access the training at **learn.qualityinteractions.com/bcbstn/bcbstnproviders**.

Changes to Prior Authorization Requirements

Effective **May 1, 2024**, the following services are 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 the office-based surgery setting

Effective **May 1, 2024**, the following services are removed from the Commercial Behavioral Health prior authorization list.

- Electroconvulsive Therapy (ECT)

Effective **May 1, 2024**, the following services are updated on the Commercial prior authorization list.

- Durable medical equipment will be changed from >$500 to >$1,000.
- Inpatient hospice will remain on the prior authorization list. Home hospice services will no longer require prior authorization.

Note: These changes don't apply to the Federal Employee Program (FEP).

BlueCare Tennessee

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

Review Preeclampsia Warning Signs with Your Pregnant Patients

Preeclampsia affects between 5-8% of pregnancies in the United States, according to the March of Dimes. May is Preeclampsia Awareness Month, so this is a good time to talk with your patients and their families about preeclampsia.

We've included some talking points to consider for these discussions below:

- Let your patients know preeclampsia can occur during pregnancy – typically in the first pregnancy and after week 20 – or shortly after birth. It can cause serious complications for pregnant patients and their babies.
- Reminding your patients about the importance of attending scheduled prenatal visits and performing a blood pressure reading at each visit can help identify changes in blood pressure early.
- Review risk factors with patients:
  - Personal or family history of preeclampsia
  - Multiple gestation
  - Certain medical conditions, including chronic high blood pressure, kidney disease, diabetes, and lupus or other autoimmune conditions
  - A body mass index (BMI) over 30
  - Getting pregnant through in vitro fertilization
  - Maternal age 35 or older
  - Black race
  - Low income (due to health disparities)
- Educate patients about preeclampsia warning signs, such as:
  - Swelling in the face, legs or hands
  - Severe or persistent headache
  - Changes in vision
  - Sudden weight gain (at least two to five pounds in a week)
  - Difficulty breathing
  - Nausea and vomiting during the second half of pregnancy
  - Pain in the upper abdomen or shoulder
  - Dizziness

To learn more about how we support our members during and after pregnancy and review resources you may find helpful, please see our **BlueCare Tennessee and CoverKids Maternity Care Program webpage**.

Providers Must Use Availity to Change a 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, TennCareSelect or CoverKids member's assigned PCP. We'll no longer accept 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 provider's use. Our members can still change their PCP by calling the Member Service line or through their member online account.

New Requirement for Incontinence Wipe Orders

Effective **May 1, 2024**, Home Care Delivered will contact providers to request supporting clinical documentation for orders of more than 800 incontinence wipes per month. If you're contacted, please work with Home Care Delivered to share the requested information.

BeHiP Program Offers Behavioral Health Care Resources for Pediatric Providers

As a reminder, we're working with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to provide the Behavioral Healthcare in Pediatrics (BeHiP) training program for pediatric health care providers. The BeHiP program is designed to equip providers with tools to screen, assess and manage patients with emotional, behavioral and substance use concerns. It also covers coding and offers strategies for delivering more effective care and improving family and physician relationships.

Program objectives include:

- Applying principles of systems-based practice to behavioral health disorders in the primary care pediatric setting
- Demonstrating ways to screen, assess and treat behavioral health concerns
- Developing office-based protocols to improve communication and collaboration with the behavioral health system of care

Pediatric providers can request virtual or in-person office-based training conducted by TNAAP BeHiP staff or complete online learning modules. Both types of training are free, and continuing education credits are available. Providers in our BlueCare, TennCareSelect (including the Best Practice Network), and CoverKids networks may also be eligible to join the BeHiP Foster Care Learning Collaborative as a Best Practice Network Provider. The learning collaborative consists of Best Practice Network Providers, psychiatrists and psychologists, Department of Children's Services nurses and staff, BeHiP staff, and community behavioral health providers. The group meets virtually every month and uses case-based learning to discuss how to address behavioral health issues in children in foster care.

For more information, visit **tnaap.org/programs/behip/behip-overview/**. If you'd like to schedule training for your practice, please email Amber Stroupe, MBA, BeHiP Training Coordinator, at **amber.stroupe@tnaap.org**.

Address All Areas of Pediatric Health

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits should include developmental and behavioral health screenings, as well as health education and anticipatory guidance for parents and guardians. This provides opportunities to discuss any concerns parents and guardians may have and identify any behavioral health needs.

To get a holistic picture of a child's emotional, physical and behavioral development, consider asking questions about these aspects of health and development:

- Emotional health
- Physical health
- Occupational health
- Intellectual health
- Spiritual health
- Physical health
- Social health

For more information, including example questions for initiating these discussions, please see our **EPSDT Provider Booklet**.

BlueCare Plus (HMO D-SNP)SM

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

Use Availity to Change Members' Primary Care Provider

The **BlueCare Primary Care Provider (PCP) Change Maintenance** application is now available in Availity. We're phasing out the existing PCP Change Request Form.

Beginning **June 1, 2024**, providers will need to use the BlueCare PCP Change Maintenance application to change the PCP for a member with **BlueCare Plus** coverage. We'll no longer accept PCP change requests from providers by fax or email.

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 member online account.

When you use the application, changes are made in real time. For step-by-step instructions for using the new 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.

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**.

Medicare Advantage

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

Pulmonary Medication Adherence is Important During Peak Allergen Months

Helping your patients manage their medication is always important, especially during peak allergen months for those with pulmonary disorders.

The **Pharmacotherapy Management of COPD Exacerbation (PCE)** HEDIS measure assesses chronic obstructive pulmonary disease (COPD) exacerbations for adults 40 years and older who had appropriate medication therapy to manage an exacerbation. A COPD exacerbation is defined as an inpatient or ED visit with a primary discharge diagnosis of COPD.

To prevent exacerbations, talk to your patients about taking their medication as prescribed. Some patients may be struggling to manage multiple medications. Consider reviewing and simplifying their medication regimen when possible. To find more resources for the PCE measure, visit the **NCQA website**.

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

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 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.

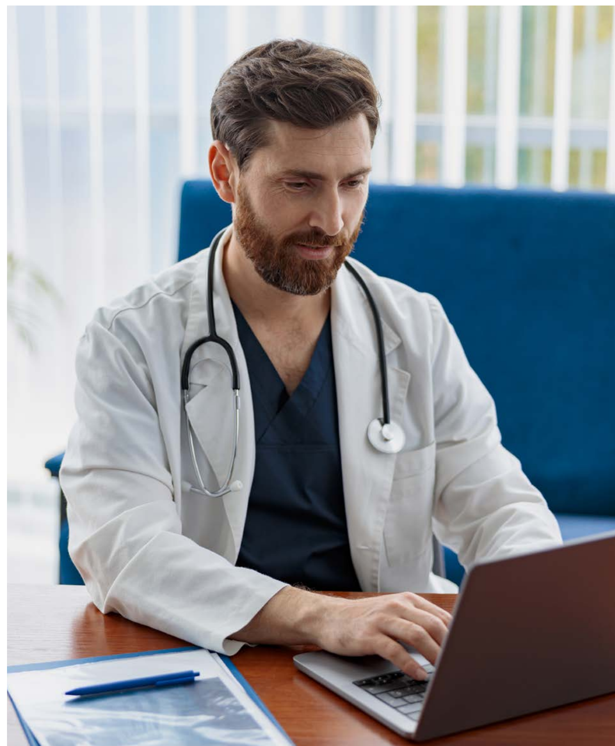
Please contact your Provider Quality Outreach Consultant for questions or help with the SPC measure.

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 included 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.

Step Therapy for Additional Medicare Part B Drug

Effective **May 1, 2024**, BlueAdvantage and BlueCare Plus will implement step therapy for an additional Part B drug, Udenyca ONBODY. This will affect members who are new to therapy. Prior authorization and step therapy will follow CMS regulations and will be required. You can find our Part B Step Therapy guide on **provider.bcbst.com** by navigating to **Documents & Forms** under Medicare Advantage and clicking the **Part B Step Therapy Provider Reference Guide**.

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

Change in Commercial Preferred Drug List

Beginning **July 1, 2024**, we're removing Levemir® vial, Levemir® FlexPen®, and Levemir® FlexTouch® from our Preferred Drug List for Commercial lines of business. We'll send letters to any members impacted by this change. Please consider prescribing a covered alternative for your patients who are currently prescribed these medications.

You can view the full list of covered drugs and preferred alternatives in the **2024 Preferred Formulary Guide**. If you have questions, please contact your Provider Network Manager.

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)**.

Quality Care Rewards

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

Tennessee Healthcare Innovation Initiative (THCII) Episodes of Care Quarterly Reports Coming Soon

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available May 16, 2024. 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**.

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**.

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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

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**.

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