DECEMBER 2025

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.

INSIDE THIS ISSUE

Enhancements Coming to Electronic Claim Acknowledgement Reports

Starting in January 2026, we'll be upgrading our electronic claim acknowledgement reports (277CA) to improve clarity and compliance. These reports notify claim submitters whether their electronic claims have been accepted or rejected.

The updated 277CA format will reflect each submitter's structure, including aggregated claims, claim counts and total charges by transaction batch number. This enhancement ensures that we communicate all relevant information accurately and remain fully compliant with the American National Standards Institute (ANSI) guidelines.

Stay Informed by Submitting Prior Authorizations in Availity®

Submitting prior authorizations through the Prior Authorization Tool in Availity gives you more options and can make the decision process faster than submitting them directly to Cohere.

When you submit a prior authorization in Availity:

- The system will send your prior authorization to the appropriate place/vendor.
- Availity verifies the Member ID is active.
- You can verify the status of authorizations.
- You can easily locate authorization letters.
- You can quickly update existing authorizations.

If you have questions about submitting a prior authorization in Availity, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Upcoming Changes to Existing Payment Policies

Please review the information below to learn more about existing payment policies and upcoming changes.

Same Day E/M and Preventive Medicine Exam Payment Policy

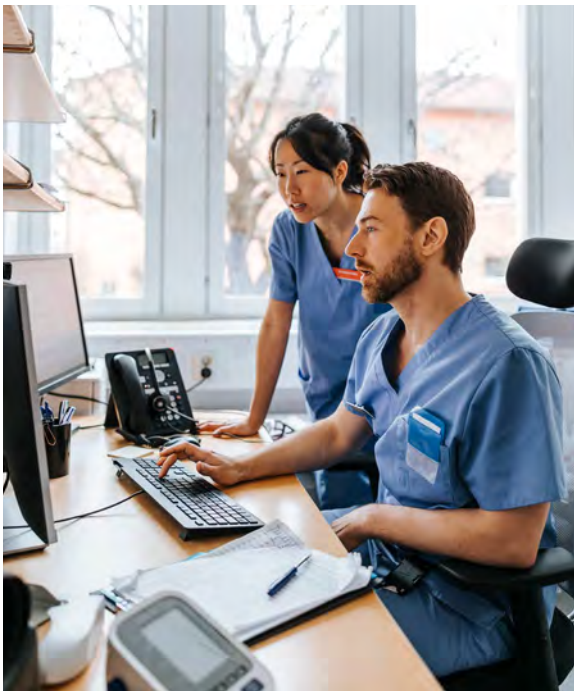
This payment policy took effect for Commercial and Medicare Advantage Oct. 1, 2025. As of Nov. 1, it also includes BlueCare Plus Tennessee. BlueCare Tennessee isn't included in this payment policy.

We allow separate reimbursement for professional providers submitting claims for routine or problem-focused evaluation and management (E/M) services with a preventive medicine service during the same patient encounter using Modifier 25. This currently includes CPT® codes 99381-99387.

If certain criteria are met, the E/M service will be reimbursed at 50% of the appropriate fee schedule. The preventive medicine service will be reimbursed at 100%. You can read more about this policy in our Provider Administration Manuals.

Beginning **Jan. 1, 2026**, we'll make these changes to this policy:

- We'll reimburse separately for these services, as indicated above, but Modifier 25 should be appended to the E/M service code line of the claim.
- Preventive medicine service codes will also include CPT® codes 99391-99397.



Coding Update to Discontinued and Reduced Services/Procedures Payment Policy

This payment policy applies to Commercial, Medicare Advantage, BlueCare Plus Tennessee and BlueCare Tennessee

For claims with dates of service on or after Jan. 1, 2026, we'll reimburse discontinued or reduced services as indicated below for all claims:

- Reduced services, identified with a modifier 52, at 50% of the appropriate fee schedule
- Discontinued services, identified with a modifier 53, at 25% of the appropriate fee schedule
- Discontinued services before planned anesthesia, identified with a modifier 73, at 25% of the appropriate fee schedule
- Discontinued services after planned anesthesia, identified with a modifier 74, at 50% of the appropriate fee schedule

Troubleshooting Availity Browser Issues

Some providers are experiencing issues loading Availity while using Google Chrome or Microsoft Edge. If you experience similar issues, follow these troubleshooting steps.

For problems with Availity while using Chrome:

1. Close all tabs within the browser.
2. Open a new tab and input **Ctrl + H** (Mac users **Command + H**).
3. Select **Delete browsing data**.
4. Select **All time**, then select **Clear Data**.
5. Open a new **Incognito tab** and go to **Availity.com** (do not use a bookmarked link).

For problems with Availity while using Edge:

1. Close all tabs within the browser.
2. Open a new tab and input **Ctrl + H** (Mac users **Command + H**).
3. Select the **trash can symbol**.
4. Select **All time**, then select **Clear Data**.
5. Open a new **InPrivate window** and go to **Availity.com** (do not use a bookmarked link).

If you still need help accessing Availity, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

A Faster Way to Receive Important Communications From Us

You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. By selecting email and adding a contact name and email address, you can also request email for credentialing, network operations, network updates, quality and clinical information, and financial updates.

You can update your contact preferences through our Payer Spaces in Availity. Simply select email instead of mail for all types of communication and add a contact name and email address for each one.

Follow these steps in Availity:

1. Log in to **BlueCross Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type**.
4. Select 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. Pick a provider from the drop-down list or by directly entering the provider's **NPI** and click **Submit**.
6. Follow the remaining cues and check the email **Opt In** box. Make 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.

Tip: If you don't see your name in the drop-down list, you can add it through the **Manage My Organization** dashboard. For the contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.

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**.

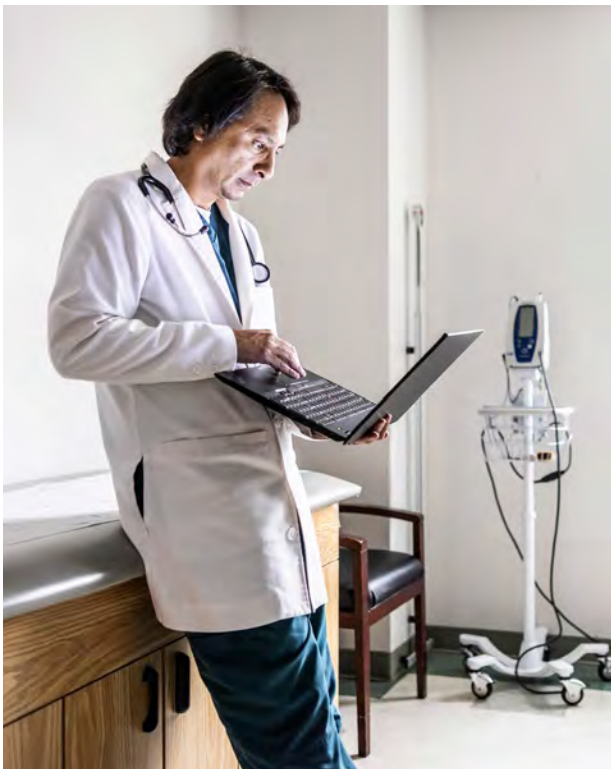
Coming Soon: New Inquiry, Reconsiderations and Appeals Tool in Availity

We're excited to announce our new online inquiry, reconsiderations and appeals tool in Availity is launching the first quarter of 2026. Providers currently submit by phone, fax, mail and email. This new tool will streamline that process.

We encourage providers to submit inquiries, reconsiderations and appeals in Availity as soon as the tool is live. During the interim, we've disabled the "Message this Payer" feature as we transition to the new process.

Please note that all in-state providers will eventually be required to submit inquiries, reconsiderations and appeals through Availity, and we'll no longer accept these submissions by fax, mail or email.

For more information, please contact your **eBusiness Regional Marketing Consultant**.



Change of Ownership Reminder

If you're acquiring or being acquired by a provider facility or group, you must give us at least 60 days advance notice of change of ownership (CHOW). You also need to submit a CHOW notification using the **Provider Change of Ownership Notification Form**.

Once the transaction has closed, send us a copy of the executed bill of sale or purchase document (minus the purchase price) within five business days of closing. If you don't provide the required notice or documents, your payments could be impacted. For more details about CHOW requirements, please consult your BlueCross provider agreement or our PAM.

You can also find additional information in the Frequently Asked Questions document **here**.

New Prior Authorization Submission Process Expands to All Lines of Business

We recently began using Cohere Health technology to manage most prior authorizations for our Commercial members. In December, we're expanding the use of this technology to all lines of business. In addition to our Commercial plans, this will also apply to:

- BlueCare Tennessee
- BlueCare Plus Tennessee
- BlueAdvantage (PPO)℠

For your convenience, you'll continue to submit requests directly to us through Availity.

To learn more about this update, join one of our webinars hosted by eBusiness. Choose from one of these two December 2025 dates:

- Thursday, Dec. 4 at 10 a.m. CT / 11 a.m. ET – **Webinar link**
- Friday, Dec. 5 at 1 p.m. CT / 2 p.m. ET – **Webinar link**

If you have questions about using Availity, please call **(423) 535-5717, option 2,** or contact your **eBusiness Regional Marketing Consultant**. You can find additional training about the Cohere process on Availity.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless specifically identified below.

Understanding the Behavioral Health (BH) Comprehensive Network

Medical providers are typically contracted for specific Commercial networks—such as Networks P, S, L and E. Depending on the region, a provider may be part of one or several of these networks.

BH providers are contracted into the BH Comprehensive Network, which automatically includes all Commercial networks (P, S, L and E). They're considered in-network for any member with a Commercial plan.

Multi-Specialty Group Practices

Some health care group practices include both medical and BH providers. While the BH provider may be in-network due to the BH Comprehensive Network, the medical provider in the same practice might not be in-network for the member's specific Commercial plan.

Examples where a multi-specialty health care group practice is contracted for Commercial Networks P, S, L and/or E along with the BH Comprehensive Network:

Scenario 1:

- The member's policy is supported by Network S.
- The health care group practice is contracted in Network P and the BH Comprehensive Network. However, the provider isn't contracted for Network S.
- In this scenario, the member would have in-network benefits with the BH provider, because the BH Comprehensive Network covers all networks.
- The medical providers in the group would be out-of-network for the member because they only participate in Network P.

Scenario 2:

- The member's policy is supported by Network S.
- The health care group practice is contracted in Network P and S and the BH Comprehensive Network.
- In this scenario, the member would have in-network benefits with the BH provider **and** medical provider, because the BH Comprehensive Network covers all networks, and the medical provider is in the member's network.

Updates with this clarification are being made to the Provider Quick Reference Guide.

Authorizations for Out-of-State Members

You can submit authorization requests for out-of-state members electronically through Availity. To do this, simply:

1. Log in to Availity.
2. Select **Patient Registration** then **Authorization and Referrals**.
3. Select **Payer** and **Request** type.
4. Enter the ordering/requesting provider information and complete all necessary fields.
5. The three-digit member prefix will single sign-on (SSO) over to the member's Home Plan to complete the authorization.

View the **InterPlan tool** for specific medical policy or prior authorization details based on the member's three-digit prefix. You can also reach out to your **eBusiness Regional Marketing Consultant**.

Future Updates: See the Latest and What Changes Are on the Way

Please review the table below to find the latest information from us and what changes are on the way. If you have questions, please contact your Provider Network Manager. If you're unsure who that is, go to **My BlueCross Contact**. For questions about medical policy updates, please send an email to **medical_policy@bcbst.com**.

Update Type	Availability	Where to Find It
Coding Updates	60 days before the effective date	Go to the **Coverage & Claims** page on **provider.bcbst.com**. Updates are located under **Coding Updates** in the **Coding Information** section.
Lab Testing Policies	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**.
Upcoming Prior Authorization Changes	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**. Updates are located under **Upcoming Prior Authorization** Changes in the **News & Updates** section.
Pharmacy Updates	Updated as needed	Download a summary of select upcoming drug prior authorization criteria changes **here**.
Medical Policy Updates	60 days before the effective date	Go to the **Manuals, Policies & Guidelines** page on **provider.bcbst.com**. Updates are located under **Coverage**.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless specifically identified below.

Eligibility Reminder for Qualified Medicare Beneficiary-Only (QMB-Only) Members

The Division of TennCare assigns Qualified Medicare Beneficiary-only (QMB-only) members to TennCare*Select* for processing of their Medicare/Dual-Eligible Special Needs Plan cost-share amounts. TennCare*Select* QMB-only eligibility applies to Medicare crossover claims only and **doesn't include** Medicaid benefits. Individuals in the QMB-only eligibility category aren't eligible for Medicaid benefits or any Medicaid service.

Please don't request prior authorization for QMB-only members, as they don't have any Medicaid medical benefits.

If you have questions, please call the TennCare*Select* Provider Service line at **1-800-276-1978**.

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

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have reporting criteria and eligibility requirements that differ from the Healthcare Effectiveness Data and Information Set (HEDIS) measures for well-child performance. Here's what you need to know.

EPSDT Visits

Children and adolescents enrolled in BlueCare or TennCareSelect are eligible for TennCare Kids exams until they turn 21. The schedule for EPSDT exams follows the Bright Futures/American Academy of Pediatrics Periodicity Schedule.

The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year.

HEDIS® Quality Measures

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

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

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

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

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

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

Supporting Foster Youth in Their Transition to Adult Care

As providers, you play a vital role in guiding young patients through one of the most significant transitions of their lives – moving from foster care or state custody into adulthood and adult health care. This journey can be complex, but with thoughtful preparation and compassionate support, you can help them build a strong foundation for lifelong well-being.

Start Early, Stay Engaged

Transition planning should begin well before a patient ages out of pediatric care. If your practice transitions patients at age 18, start the conversation by their 17th birthday. Use each EPSDT exam as an opportunity to provide guidance and health education. Talk openly about what adult care looks like, why it matters and how to maintain regular checkups, including dental and vision care.

Share the Essentials

Before a patient transitions, make sure they leave your care with a clear, accessible health summary. This should include:

- Current medications
- Diagnoses
- Recent test results
- Immunization records

Encourage them to identify a new adult care provider and offer to send their medical records directly. This helps ensure continuity of care and empowers them to take ownership of their health.

Build Bridges with Foster Families

Foster parents are key partners in this process. Help them recognize emotional, physical and behavioral health concerns, especially signs of trauma. Offer guidance on how to support their foster children through change, and connect them with resources like transportation assistance, 24/7 nurse lines and training materials available at **bluecare.bcbst.com/foster**.

Encourage Life Skills and Independence

Patients transitioning out of foster care often face adult responsibilities without the safety net many of their peers enjoy. You can help by:

- Referring them to independent living programs
- Encouraging financial and health insurance literacy
- Connecting them to mentors and community supports
- Promoting post-secondary education and career planning

Highlight Available Support Services

We offer a wide range of support services beyond medical care. Patients aging out of foster care may be eligible for help with:

- Housing and utilities
- Food and transportation
- Dental and behavioral health care
- Substance use disorder support
- Internet access and phone bill assistance

Encourage your patients to visit **bluecare.bcbst.com** and enter their ZIP code in the **"Need extra support?"** box at the bottom of the page to explore these services. They can also call us at the Customer Service number on the back of their Member ID card.

Supporting Maternal Health

We're here to help you deliver the best possible care to your pregnant patients. From quality measures to billing tips and behavioral health resources, here's what you need to know to stay informed.

HEDIS® Measures

The **2025 Quality Care Measures Guide** outlines key HEDIS® measures for maternal health:

- **Prenatal Care (PPC):** Patients should have a prenatal visit in the first trimester.
- **Postpartum Care (PPC):** A postpartum visit should happen between seven and 84 days after delivery.
- **Prenatal Immunization Status (PRS-E):** Patients should receive flu and Tdap vaccines during pregnancy.
- **Follow-Up After ED Visit for Substance Use Disorder (FUA):** Patients with substance use disorder diagnoses should have a follow-up visit within seven and 30 days of their ED visit.

Billing Made Simple

We've made it easier for you to get paid for the care you provide.

- **Maternity Incentives:** Through our Maternity Care Program, you can earn extra payments on top of regular reimbursements. Click **here** for a step-by-step billing chart and guidelines.
- **Lactation Services:** Patients with BlueCare Tennessee coverage have access to lactation benefits. Use codes 98960-98962 (modifier U8) and indicate the visit length with units (e.g., 1 unit = 16-45 minutes). There's no visit limit, but we may request documentation after 15 minutes.

Behavioral Health Support for Pregnant Patients

We know pregnancy can be a vulnerable time, especially for patients with a substance use disorder. That's why we offer robust behavioral health support:

- **One-on-One Care:** Patients can connect with behavioral health case managers, health navigators and social workers for personalized support.
- **Peer Support:** Patients can talk with others who've been through similar experiences.
- **Medications for Opioid Use Disorder (MOUD):** We cover MOUD services and offer training resources for providers.
- **BeHiP Program:** This collaborative initiative helps pediatric providers deliver behaviorally effective care. Learn more **here**.

For more information about supporting pregnant patients, visit our **Maternity Support** web page.

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

Your Source for Division of TennCare Announcements

You can view announcements from TennCare in the **News and Updates** section of **bluecare.bcbst.com/providers**. These announcements replace the TennCare Provider Experience newsletter. We'll update them quarterly, so check back frequently for news you need.

BlueCare Plus Tennessee and Medicare Advantage

This information applies to our Medicare Advantage and BlueCare Plus Tennessee plans unless specifically identified below.

Medicare Advantage 2026 Quality Program Measures

Beginning Jan. 1, 2026, the following changes will be made to the quality measures included in the Medicare Advantage Quality+ Partnerships program:

- The **Medication Adherence measures** weight will reduce from 3 to 1.
- The measures listed below will be removed from the program for the 2026 performance year.*
  - **Eye Exam for Patients with Diabetes (EED)**
  - **Osteoporosis Management in Women Who Had a Fracture (OMW)**
  - **Statin Therapy for Patients with Cardiovascular Disease (SPC)**
  - **Polypharmacy – Multiple Anticholinergic Medications (Poly-ACH)**
- The **Member Experiences** measures will be:
  - **Consumer Assessment of Healthcare Providers and Systems (CAHPS): Care Coordination**
  - **Health Outcomes Survey (HOS): Improving or Maintaining Physical Health**

The 2026 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Controlling Blood Pressure (CBP)	HEDIS®	3
Glycemic Status Assessment for Patients with Diabetes (GSD)	HEDIS®	3
Plan All-Cause Readmissions (PCR)	HEDIS®	3
Medication Adherence for Cholestoral (Statin)	Prescription Drug Event (PDE) Files	1
Medication Adherence for Hypertension (RAS Antagonist)	Prescription Drug Event (PDE) Files	1
Medication Adherence for Non-Insulin Diabetes Meds (OAD)	Prescription Drug Event (PDE) Files	1
Breast Cancer Screening (BCS)	HEDIS®	1
Colorectal Cancer Screening (COL)	HEDIS®	1
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	HEDIS®	1
Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS®	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Trasitions of Care (TRC)	HEDIS®	1
Member Experience—CAHPS (BCBST CMS Score/Healthmine Mock Survery)	CMS Member Survey/ BCBST Mock Survey	2
Care Coordination		
Member Experience—HOS (BCBST CMS Score/Healthmine Mock Survey)	CMS Member Survey/ BCBST Mock Survey	2
Improving or Maintaining Physical Health The following 2 measures are included for C-SNP patients and are also part of the D-SNP program.		
Care for Older Adults (COA)—Functional Status Assessment	HEDIS®	1
Care for Older Adults (COA)—Medication Review	HEDIS®	1

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the measures in the 2026 quality program.

*While these measures are excluded from the program, they're still measures we focus on as a plan.

Prior Authorization No Longer Required for Medication Administration Codes 64612 and 64615

Effective retroactively to April 2025, providers can now bill CPT® codes 64612 (chemodenervation) and 64615 (bilateral chemodenervation) without prior authorization when paired with an approved medication.

This change streamlines the billing process and supports timely access to care for patients requiring these procedures. Claims submitted with these codes will be reimbursed as long as they're accompanied by an approved medication.

Upcoming Retrospective Audit of SNF and IRF Authorizations

We're planning a retrospective audit of Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IRF) authorizations for our Medicare Advantage products. The review will kick off in early 2026.

We'll look at submitted claims to make sure authorizations were issued correctly and followed CMS guidelines and our internal policies.

To help things go smoothly, please make sure your documentation is complete and easy to access. If you have any questions, please reach out to your Provider Network Manager.

New Post-Acute Care Partnership with tango and WellSky®

Soon, we'll begin working with tango and WellSky to manage skilled home health and post-acute facility services for Medicare and Medicaid dual-eligible special needs plans.

tango

Skilled home health services – nursing, therapy, aid and social work

WellSky

Post-acute facility services – skilled nursing facilities, inpatient rehab facilities and long-term acute care hospitals

We'll work with tango and WellSky to help manage:

- Referral coordination
- Prior authorization and continued stay reviews
- Transition of care support
- Provider and member experience oversight

If you have questions, please contact one of the options below:

- Home Health – **contractmanagement@tangocare.com**
- Post-acute – **PACSupport@WellSky.com**
- Phone – **1-888-224-1409**
- Web – **providerresourcecenter.com/bcbstn**

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Upcoming Changes for BlueCare Plus Tennessee Dual Eligible Members

Starting **Jan. 1, 2026**, we'll be making important updates to improve care for members with both Medicare and Medicaid. These changes will help make getting care easier and more coordinated for members. This will also simplify the claims process for providers.

What's changing?

Members who have BlueCare Plus Tennessee and BlueCare Medicaid will be moved to one of the BlueCare Plus Tennessee Fully Integrated Dual Eligible (FIDE) plans. This change only affects people who are dually eligible and currently enrolled in BlueCare Medicaid.

What does this mean for members?

These members will have their Medicare and Medicaid services managed under one plan. Members will get one ID card for both Medicare and Medicaid services, and the card will show the BlueCare Plus Tennessee plan name and policy number.

What does this mean for providers?

You'll send all claims (Medicare and Medicaid) to BlueCare Plus Tennessee. You won't need to submit a separate claim to BlueCare Medicaid. This will help make billing simpler and reduce delays.

Prior authorization requests for services will also go to BlueCare Plus Tennessee, using the member's BlueCare Plus Tennessee ID number (usually starts with ZEUY or ZEU9).

What are self-service options for providers?

To support these changes, providers should continue to use Availity to:

- Check member eligibility.
- View claim status.
- Submit prior authorization requests or check the status.

Note: BlueCare Plus Tennessee offers three plans. This update applies **only** to members with **BlueCare Plus (HMO D-SNP)℠ and BlueCare Plus Choice (HMO D-SNP)℠** plans who are also enrolled in BlueCare Medicaid.

Complete the 2025 Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. 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 by **clicking here**.

Medicare Advantage

This information applies to our Medicare plans unless specifically identified below.

New C-SNP Launching in 2026 for Members with Diabetes and Heart Disease

We're excited to announce the launch of a new Chronic Special Needs Plan (C-SNP) beginning in 2026. This innovative plan is specifically designed to provide tailored benefits and enhanced care coordination for individuals living with diabetes and/or heart disease. This plan reflects our ongoing commitment to improving the outcomes for these members with chronic conditions.

Health care providers play a crucial role in the success of this plan. During the enrollment process, providers will be requested to attest that their patients have the necessary underlying conditions to qualify for the C-SNP. Proper completion of this attestation will enable us to deliver personalized, high-quality care that meets the unique needs of this population.

For more information about the upcoming C-SNP or any questions, please contact your Provider Outreach or Network Representative.

Quality Care Initiatives

This information applies to our Medicare plans unless specifically identified below.

Supporting Timely Mental Health Follow-Up

The CDC recognizes that environmental and societal factors, including seasonal changes, can affect mental health. Winter's reduced daylight can increase isolation, and can contribute to and worsen mental health concerns, especially among vulnerable populations. Patients are especially vulnerable following a psychiatric hospitalization or ER visit for mental health concerns.

Timely follow-up care is critical to ensuring continuity of care, increasing patient engagement with treatment and improving outcomes.

Please keep the following HEDIS® measures in mind when coordinating care:

FUH – Follow-Up After Hospitalization for Mental Illness

- **Who**'s included: Patients 6 years of age and older who were discharged after an acute inpatient hospitalization for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm
- **What**'s required: A follow-up visit with a mental health provider, or with any practitioner, for any diagnosis of a mental health disorder, within seven days after discharge

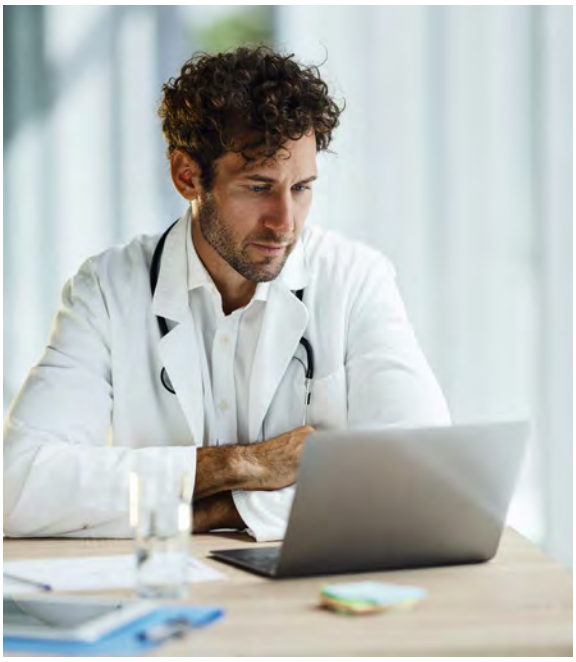
FUM – Follow-Up After Emergency Department Visit for Mental Illness

- **Who**'s included: Patients 6 years of age and older who were seen in the ER for a principal diagnosis of mental illness or any diagnosis of intentional self-harm
- **What**'s required: A follow-up visit within seven days of the ER visit

Key Documentation Requirements

- **What**: The follow-up visit must include a mental health diagnosis code

Your role is vital in making sure patients get the care they need during these critical timeframes. Thank you for your continued commitment to improving mental health.



Episodes of Care Program Announcements

The Division of TennCare has released important information for providers who participate in the Tennessee Health Care Innovation Initiative Episodes of Care (EOC) program. Review the reports below to ensure you're up to date:

- **2026 Memo of Changes** — Learn more about recent stakeholder feedback, the state's response and a summary of changes taking effect **Jan. 1, 2026**. TennCare made nine changes to the EOC program design for 2026.
- **2024 Program Results** — This report outlines the EOC program's annual cost and quality results for the 2024 performance period.

Note: This article only applies to providers in our BlueCare network who participate in the EOC program.

The Division of TennCare Journey Program is Ending This Year

The Division of TennCare is ending the Journey Program at the end of 2025. As part of this program, we previously selected specific providers in the BlueCare network performing total joint replacement or bariatric surgery to exit the Episodes of Care program and serve as Regional Journey Partners.

Beginning **Jan. 1, 2026**, these providers will no longer serve as Journey Partners, but they'll stay in our network and rejoin the Episodes of Care program. So, your patients can still visit them for care. If your patient needs a presurgical evaluation for a total joint replacement or bariatric surgery, please use our **Find Care tool** to find specialty providers in the BlueCare network. Your patients can also call BlueCare Customer Service at **1-800-468-9698** for help finding an in-network provider.

Pharmacy

This information applies to our Medicare plans unless specifically identified below.

Update on GLP-1 Fill Limits

Effective **Oct. 1, 2025**, BlueCare Plus Tennessee members are limited to one GLP-1 medication fill every 21 days. This change is to make sure members' use of these medications is safe and effective.

As a reminder, we cover these GLP-1 medications only when used as treatment for Type 2 Diabetes, and not when used only for weight loss:

- Mounjaro®
- Ozempic®
- RYBELSUS®
- Victoza®
- Exenatide
- Trulicity

In some cases, an override may be appropriate. For example, if a member experiences side effects from an initial prescription, a provider may prescribe a lower dose within the 21-day limit.

If you have questions about this new prescription limit for GLP-1s, please call our Provider Service line at **1-800-299-1407**.

2026 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. These can include, but aren't limited to:

- 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 2026 drug list changes:

- To see the 2026 Preferred Formulary and 2026 Essential Formulary changes, click **here**.
- To see the 2026 BlueAdvantage Formulary and 2026 BlueAdvantage Extra (PPO)SM formulary, click **here**.
- To see the 2026 BlueCare Plus Tennessee Formulary, click **here**.

Biosimilar Drugs

Effective **Jan. 1, 2026**, we're removing Humira (adalimumab) from our Essential and Essential Plus Formularies. We'll cover these biosimilars instead:

- Simlandi
- Adalimumab-adaz
- Hadlima

Additionally, we'll be removing Stelara from the Preferred, Essential and Essential Plus Formularies. We'll cover these biosimilars instead:

- Selarsdi
- Yesintek
- Imuldosa

We wanted to prepare you so you can:

- Proactively update members' prescriptions.
- Be prepared to answer questions about the preferred options.

We'll mail letters to members to notify them of the change. We'll also send providers a letter with a list of impacted members. We're loading new prior authorizations for the biosimilars to make sure members have a smooth transition with no additional prior authorization requests required.

If you have any questions, please reach out to the provider support team. We appreciate the care you give our members.

Step Therapy for Additional Medicare Part B Drugs

Beginning **Jan. 1, 2026**, Medicare Advantage and BlueCare Plus Tennessee will implement step therapy for additional Part B drugs. This affects members who are new to therapy. Prior authorization and step therapy will align with CMS regulations and will be required for the following Part B categories: **Alpha-1 Antitrypsin Deficiency, Autoimmune Infused, Botulinum Toxins, Immune Globulin IV (IVIG), Leqvio, Multiple Sclerosis (Infused), and Severe Asthma**. You can find our Part B Step Therapy guide **here**.

Step Therapy for Additional Provider Administered Specialty Products

Beginning **Jan. 1, 2026**, prior authorization and step therapy will align with medically accepted indications and will be required for the following categories: **Alpha-1 Antitrypsin Deficiency, Autoimmune Infused, Botulinum Toxins, and Multiple Sclerosis (Infused)**. You can view our Step Therapy Requirements for Provider Administered Specialty Medications **here**.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

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

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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.

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- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

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Commercial UM	1-800-924-7141
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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
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	1-800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***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**.