JUNE 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

Provider Enrollment Application Status Tracking

You can check the status of your enrollment application in Availity® by following these steps:

1. Log in to **Availity**.
2. Select the **Provider Enrollment, Updates and Changes** tile on the Home page.
3. Choose **Individual or Group**.
4. Select **Track a Request** under the **Request Type**.
5. Then, select your **Organization** from the dropdown menu using your **Tax ID**.
6. View the **Provider Enrollment Tracker** results.

If your application is pending, please respond to any requests for information as soon as possible. The sooner you send the requested information to us, the sooner we're able to review it.

Please note that submitting multiple applications slows down the review process. Make sure to only submit one application per provider.

If you have questions, email us at **providersupport@bcbst.com** or call **1-800-924-7141**.

Register for the 2025 All Blue Workshop℠

Registration for this year's All Blue Workshop officially opens June 3. Just click this **link** to sign up for the full-day, virtual event, set for Thursday, Aug. 14. You can also register by visiting the All Blue Workshop **page** on **provider.bcbst.com** after June 3. Space is limited, so be sure to register soon. For more information, please contact your Provider Network Manager.

Check Member Benefits and Eligibility in Availity as Blue Plans Update ID Cards

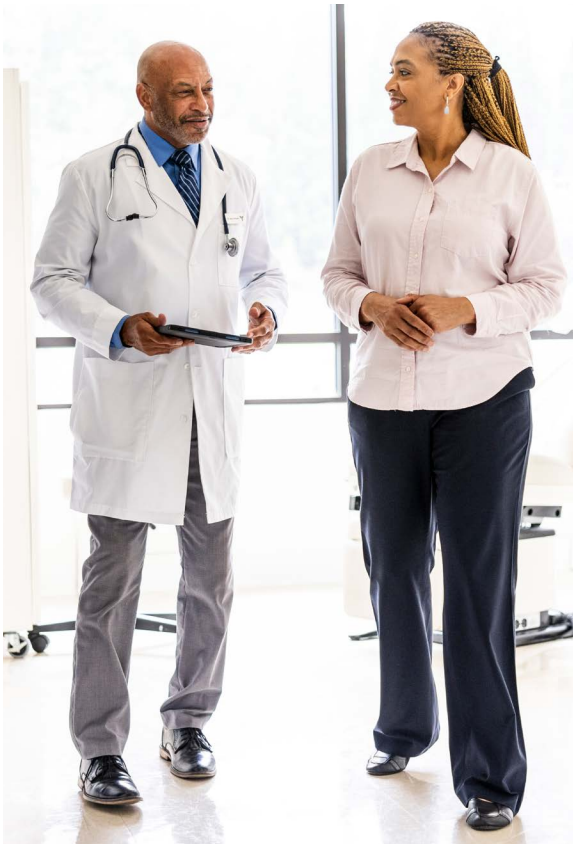
The Blue Cross Blue Shield Association is requiring all Blues plans to update Member ID cards by 2028. We don't have a timeline for our updates yet – but you may start seeing them from other plans soon.

We recommend using Availity to check for the most accurate member benefits and eligibility information. As we have more information, we'll share it in future BlueAlerts.

Coming Soon: New Reconsiderations and Appeals Tool in Availity

We're excited to announce our new online reconsiderations and appeals tool will launch later this year. The tool will be available in Availity. Today, providers submit reconsiderations and appeals by phone, fax, mail and email. This new tool will streamline that process.

Want to be an early adopter? Let us know by contacting your **eBusiness Regional Marketing Consultant**.



Find Your Authorizations Faster

You can save time and avoid phone calls by quickly checking an authorization status in Availity. Here's how:

1. Log in to **Availity.**
2. Click on **Payer Spaces** and choose the **BlueCross logo**.
3. Choose the **Authorization Submission/Review** application.
4. Go to the **Auth Inquiry/Clinical Update** drop-down arrow, then choose **BCBST**.
5. Choose the **case ID number** to see the latest status.

We're no longer faxing authorization status letters, but you can view and print them from here.* After choosing the case ID number, look for the letter section in the upper right to view and print the authorization letters.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

* This doesn't apply to Medicare Advantage.

Upcoming Provider Administration Manuals Delayed

To meet operational needs, we're delaying the release of the Provider Administration Manuals (PAMs) for the third quarter (July, August and September) for all lines of business. We'll publish the third quarter PAMs on July 15, 2025. Providers in our Commercial networks will be able to view their Commercial Preview PAM for the third quarter on May 15.

We appreciate your patience.

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 or 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 or denied or result in reduced reimbursement.

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

Change of Ownership Reminder

Anyone acquiring a provider facility or group 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 Provider Administration Manual.

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

Inclusive or Exclusive Billing for Behavioral Health Psychiatric Facilities

Please review the following guidelines for institutional and professional providers to ensure you're billing for inclusive services correctly.

Institutional providers (psychiatric hospital, residential treatment center, other psychiatric outpatient facility)

Your contract with us includes details about inclusive or exclusive service billing. You can find information under each section of your contract addressing your rates for each service, such as inpatient, intensive outpatient and partial hospitalization.

If the language about the rate for a particular service denotes it as **inclusive**, all professional or physician services must be provided as part of that rate. You shouldn't submit another claim for professional or physician services rendered in your facility as part of the service you're providing. Please ensure providers supporting these services are aware of the inclusive agreement.

Professional providers (psychiatrists, nurse practitioners, psychologists, therapists, primary care physicians)

When providing services at a psychiatric hospital, residential treatment center or other psychiatric outpatient facility, please confirm with the facility if professional services should be billed separately. If you're providing services at a facility whose rates are inclusive of professional services, you can't file a separate claim. Any amount we pay you for your service with this facility is subject to an overpayment recovery.

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

Commercial

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

Billing Guidelines for Hospice Services

If you've experienced any problems submitting claims for hospice services, you can use the following information to help make sure the process goes smoothly:

- Bill using an institutional claim form.
- Bill a separate line item for each date of service.
- Match the total days billed on the inpatient care with the from/through dates on the statement.
- Use Type of Bill (TOB) 081X or 082X in Form Locator 4 if the inpatient and outpatient services are on separate claims.
- Make sure the TOB determines the Place of Service (POS).
- Inpatient per diem is only reimbursed when a patient dies in a hospice facility. If a patient dies at home, the POS should be home, not the hospice facility.
- Hospice discharge date is eligible for payment and won't be considered as an exclusion.
- Make sure the discharge status reflects where the patient died.
- Bill with the hospice provider number and/or NPI referenced in the network attachment.
- Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., $8.7110 would be $8.72).
- In all cases, reimbursement for hospice services is based on:
  - Per diems allowed on a per day basis only.
  - The lesser of total covered charges or maximum allowable hospice fee schedule.

If you have any questions about billing for hospice services, please contact your Provider Network Manager.

Out of State (BlueCard) Authorizations

Out of state providers seeking prior authorization for our members can submit requests electronically through their normal provider portal. You can access the authorization from your local Blue Plan portal like you would for an in-state authorization. If the Blue Plan uses Availity, you can submit the authorization there by clicking on the **Authorization & Referrals** link. If a Blue Plan uses a different portal for authorizations, you should start the request on that portal.

To streamline the process and prevent the authorization from being delayed, please enter the ordering/requesting provider information and complete all necessary fields.

Save Time With High Tech Imaging Prior Authorizations

Please find out if your patients have High Tech Imaging (HTI) prior authorization requirements before starting the authorization process. Not all our Commercial plans require HTI authorization and checking on this can save you some time.

You can check when you log in to Availity to verify patient benefits. Just click the blue button labeled **Prior Authorization Requirements**, then look for the **High-Tech Imaging** category. If **Yes** is listed, an authorization is required, and you should continue with the process. If **No** is listed, an authorization isn't required.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Upcoming Prior Authorization Changes

You can easily find the latest changes to prior authorizations under Upcoming Prior Authorization Changes in the News & Updates section of our **Documents & Forms** page. Prior authorization changes are published at least 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)**.

BlueCare Tennessee

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

Transitioning from Pediatric to Adult Care

Young adulthood is a time of transition. This includes transitioning from a pediatric to adult health care provider. Your patients are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exams until their 21st birthday.

Consider these tips when working with young adults who are about to age out of pediatric care:

- Each EPSDT exam should include anticipatory guidance and health education. This is a great time to have conversations about transitioning to a new provider and the importance of continuing regular checkups and preventive care, including dental and eye exams, into adulthood.
- Begin discussing the transition of care early. For example, if your office transitions patients to adult care at age 18, start the discussion no later than the patient's 17th birthday. This gives them at least one year to find a new provider.
- Share a printed or electronic health summary with young adult patients that includes their medications, results from the most recent health visit, any diagnoses and vaccines.
- Make sure you get the name and contact information of the patient's new provider so you can send medical records. If your patients have complex medical or behavioral health needs, consider a "warm hand-off" visit with your patient, their family members and their new care team.
- Encourage patients to take ownership of their health in early adolescence. This includes scheduling appointments for immunizations and checkups, and managing their medical history, allergies and medications. Practicing these tasks will make it easier for young adults to manage their care independently when the time comes.

Promoting Well-Child Care

Sometimes patients go several years between well-child visits. Consider using patient reminder tools, such as letters, text messages and reports in your electronic medical record to make scheduling easier. Also, schedule the next well-child exam before patients leave your office so a plan of care is in place. Some practices find success offering extended or alternate office hours during evenings or weekends. If you're interested in expanding your office hours, consider asking families what times are most convenient for them.

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

Join Us for the June 2025 EPSDT Virtual Coding Workshop

Please plan to attend the first EPSDT coding workshop of 2025. It's scheduled for **June 12** from **noon to 1:30 p.m. ET (11 a.m. to 12:30 p.m. CT)**. During the virtual session, we'll provide important updates, and you'll hear from the Tennessee Chapter of the American Academy of Pediatrics.

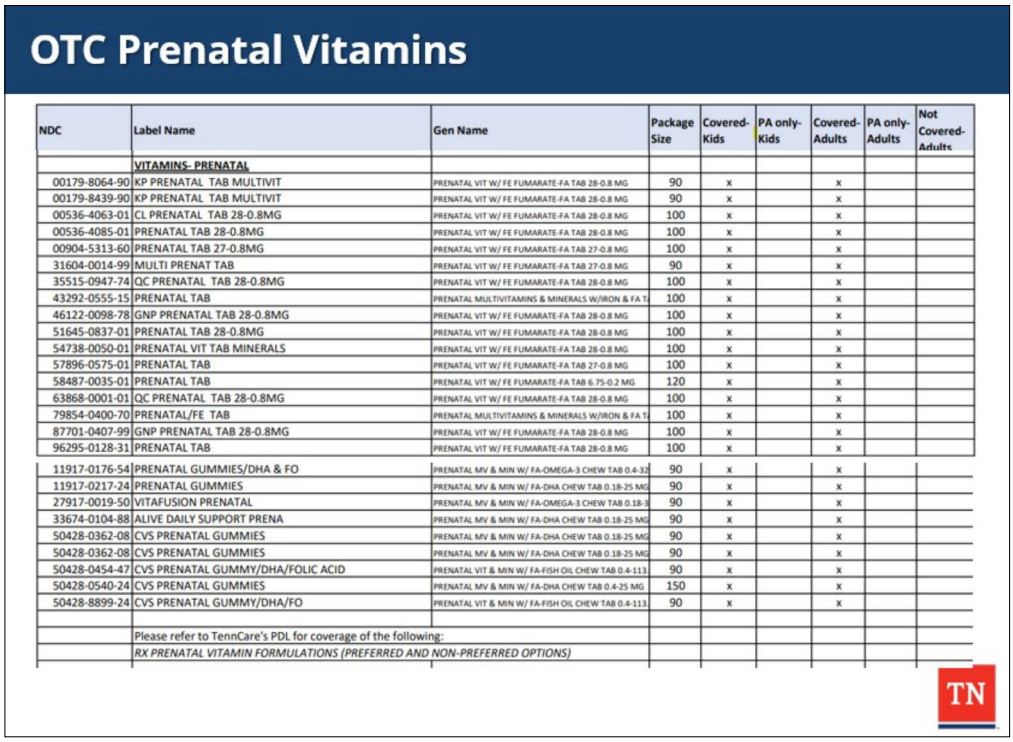
Registration is required. Please click **here** and fill out the registration form to save your spot. We hope you can attend and look forward to connecting with you.

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

Prenatal Vitamin Coverage for BlueCare and TennCare*Select* Members

The Division of TennCare has expanded coverage of prenatal vitamins on the TennCare Preferred Drug List (PDL) and the Covered Over-the-Counter (OTC) list. Updated lists were posted to the Optum-TennCare website.

The updated Covered OTC list is available **here**. Click on Covered OTC List (pdf) to view it. We've also included the list of covered OTC prenatal vitamins below:



OTC Prenatal Vitamins

NDC	Label Name	Gen Name	Package Size	Covered-Kids	PA only-Kids	Covered-Adults	PA only-Adults	Not Covered-Adults
	VITAMINS- PRENATAL							
00179-8064-90	KP PRENATAL TAB MULTIVIT	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	90	x		x		
00179-8439-90	KP PRENATAL TAB MULTIVIT	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	90	x		x		
00536-4063-01	CL PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
00536-4085-01	PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
00904-5313-60	PRENATAL TAB 27-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 27-0.8 MG	100	x		x		
31604-0014-99	MULTI PRENAT TAB	PRENATAL VIT W/ FE FUMARATE-FA TAB 27-0.8 MG	90	x		x		
35515-0947-74	QC PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
43292-0555-15	PRENATAL TAB	PRENATAL MULTIVITAMINS & MINERALS W/IRON & FA T	100	x		x		
46122-0098-78	GNP PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
51645-0837-01	PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
54738-0050-01	PRENATAL VIT TAB MINERALS	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
57896-0575-01	PRENATAL TAB	PRENATAL VIT W/ FE FUMARATE-FA TAB 27-0.8 MG	100	x		x		
58487-0035-01	PRENATAL TAB	PRENATAL VIT W/ FE FUMARATE-FA TAB 6.75-0.2 MG	120	x		x		
63868-0001-01	QC PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
79854-0400-70	PRENATAL/FE TAB	PRENATAL MULTIVITAMINS & MINERALS W/IRON & FA T	100	x		x		
87701-0407-99	GNP PRENATAL TAB 28-0.8MG	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
96295-0128-31	PRENATAL TAB	PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	100	x		x		
11917-0176-54	PRENATAL GUMMIES/DHA & FO	PRENATAL MV & MIN W/ FA-OMEGA-3 CHEW TAB 0.4-32	90	x		x		
11917-0217-24	PRENATAL GUMMIES	PRENATAL MV & MIN W/ FA-DHA CHEW TAB 0.18-25 MG	90	x		x		
27917-0019-50	VITAFUSION PRENATAL	PRENATAL MV & MIN W/ FA-OMEGA-3 CHEW TAB 0.18-3	90	x		x		
33674-0104-88	ALIVE DAILY SUPPORT PRENA	PRENATAL MV & MIN W/ FA-DHA CHEW TAB 0.18-25 MG	90	x		x		
50428-0362-08	CVS PRENATAL GUMMIES	PRENATAL MV & MIN W/ FA-DHA CHEW TAB 0.18-25 MG	90	x		x		
50428-0362-08	CVS PRENATAL GUMMIES	PRENATAL MV & MIN W/ FA-DHA CHEW TAB 0.18-25 MG	90	x		x		
50428-0454-47	CVS PRENATAL GUMMY/DHA/FOLIC ACID	PRENATAL VIT & MIN W/ FA-FISH OIL CHEW TAB 0.4-113	90	x		x		
50428-0540-24	CVS PRENATAL GUMMIES	PRENATAL MV & MIN W/ FA-DHA CHEW TAB 0.4-25 MG	150	x		x		
50428-8899-24	CVS PRENATAL GUMMY/DHA/FO	PRENATAL VIT & MIN W/ FA-FISH OIL CHEW TAB 0.4-113	90	x		x		
	Please refer to TennCare's PDL for coverage of the following:							
	RX PRENATAL VITAMIN FORMULATIONS (PREFERRED AND NON-PREFERRED OPTIONS)							

TN

The TennCare PDL now includes an updated list of preferred and non-preferred prescription prenatal vitamins. The following prescription prenatal vitamins are covered:

Prenatal Vitamins

Preferred Drugs		Non-Preferred Drugs	
• M-Natal Plus tabs	• Select **OTC** products (see **OTC** list)	• CitraNatal Mis B-Calm caps	• Select-OB chewables
• Niva-Plus tabs		• Completenate chewables	• Se-Natal 19 tabs
• Se-Natal 19 chewables		• Elite-OB tabs	• Tricare Prenatal tabs
• Thrivite Rx tabs		• Nestabs	• Vitafol gummies
• Trinatal Rx 1 tabs		• OB Complete tabs	• Vitafol-OB 65-1mg tabs
• Westab Plus tabs		• PNV-Select tabs	

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

Timely Filing Reminders

When submitting proof of timely filing in a reconsideration there are certain guidelines to follow.

What we can consider as proof:

- Retro eligibility
- Closed/rejected/returned claims
- Primary EOB
- Recovery date/audited claims
- Adjusted primary claim and new EOB

What we can't consider as proof:

- Copies of medical records
- Screen shots from your billing system or third-party billing system
- Indicating the provider is now par vs. non par
- Internet outages
- COVID-19 exceptions
- Cyber attacks

To find more information about submission timeline requirements please refer to your **BlueCare Tennessee PAM**.

To learn more about getting your electronic reports, call eBusiness Services at **(423) 535-5717, option 2**, Monday through Friday from 8 a.m. to 6 p.m. ET. Please note, submission dates of claims filed electronically that we don't accept due to transmission errors aren't accepted as proof of timely filing.

If BlueCare Tennessee is secondary to a commercial insurer or Medicare, claims must be submitted and received within 120 days from the date the primary insurer's remittance was produced.

Psychotropic Medication Monitoring in Children and Young Adults

Psychotropic medications affect how the brain works and cause changes in mood, awareness, thoughts and feelings. They're typically prescribed to children and teens to manage conditions such as attention-deficit/hyperactivity disorder, anxiety, depression and mood disorders. Recently, increases in psychotropic medication use has led to concerns that some young patients are being misdiagnosed with psychiatric disorders and treated with inappropriate medications. Our goal is to help promote the safe and appropriate use of psychotropic medications in children with behavioral health disorders by sharing resources and best practices. If you have questions about psychotropic medication use, please call **1-800-367-3403** to speak with a board-certified psychiatrist or consult an expert about treatment.

Strategies for Successful Care

Consider these tips when treating young patients with psychotropic medications:

Develop a plan for short- and long-term monitoring. Consider the type of medication, risk of side effects, the patient's need for ongoing psychosocial support and other factors when developing this plan. Keep in mind that children taking an antipsychotic medication need annual metabolic testing, including blood glucose and cholesterol testing.

Educate families and work with the Department of Children's Services (DCS) as needed. After performing an evaluation and proposing a treatment plan, educate families about the diagnosis, medication, expected benefits, potential side effects and alternatives to medication to ensure they can make an informed decision.

If your patient is in foster care, you must get consent from the child's regional nurse consultant before starting medication. Once treatment begins, DCS monitors the prescribing and drug use patterns of children in foster care to ensure these patients get safe, appropriate treatment. This may include working with DCS regional nurse consultants, the DCS chief medical officer or other personnel.

We're Here to Help

Short-term and long-term medication monitoring is medically necessary, and there are special considerations for children in DCS custody. We work with the Tennessee Chapter of the American Academy of Pediatrics to offer free training to help providers diagnose and manage patients with behavioral health needs. For more information about this training, visit **tnaap.org/programs/behip/behip-overview/**.

Ondansetron Infusion Coverage for Pregnant Patients With Hyperemesis

Ondansetron intravenous (IV) infusions and subcutaneous pumps for pregnant patients with hyperemesis are fully covered when administered by any in-network home infusion therapy (HIT) provider. Access to effective treatment for severe nausea and vomiting is a priority, and we're committed to supporting patient care through this coverage.

To refer a patient for this type of treatment, submit a referral and order to the HIT provider. No prior authorization is required for in-network providers. The HIT provider will contact the patient directly to schedule the visit. If the HIT provider can't offer subcutaneous pumps or IV infusion at home, IV treatment may be administered in the provider's office or at an outpatient infusion center.

Option Care and Continuum Rx are among our contracted, in-network providers that offer ondansetron therapy statewide. Out-of-network (OON) providers should only be used if an in-network provider is unavailable. Prior authorization is required for all OON services.

If you have any questions, please call the Provider Service number for your patient's plan:

- BlueCare – **1-800-468-9736**
- TennCare*Select* – **1-800-276-1978**
- CoverKids – **1-800-924-7141**

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.

Helping Your Patients Through Pregnancy

We offer several benefits to help make the pregnancy journey easier for your patients.

Here are some things you can do to help:

- Submit your Maternity Care Management Form online through Availity.
- Help your patients join the CareTN app to participate in the maternity program. The app lets them learn about prenatal appointments, car seat safety, depression and anxiety, and more.
- Talk to them about our BESMART program. This program helps patients with opioid use disorder during and after their pregnancy. And our Find Care tool lets you and your patients find in-network BESMART providers.

For more information on resources for your patients, such as diaper benefits and lactation counseling, visit our Maternity Support **page**. You can also find helpful information on the Get Care page on **bluecare.bcbst.com**.

Clarification Update: Coverage for Complex Rehab Technology (CRT) Maintenance

We want to provide clarification to an article we ran in the **March 2025** BlueAlert about CRT maintenance. The original article, with the clarification in bold, is below. Please note that the Tennessee Department of Commerce and Insurance's CRT Attestation Form must be submitted with the initial claim submission.

Original article:

Effective July 1, 2024, BlueCare, TennCare*Select* and CoverKids cover and reimburse medically necessary repairs on CRT annually for at least one preventive maintenance visit. The repairs must be provided by an authorized CRT equipment supplier. CRT providers are required to complete the Tennessee Department of Commerce and Insurance's CRT Attestation Form and submit it with their initial claim submission. All paid claims are subject to provider audit and recoupment if no attestation form is on file. For questions about billing for CRT maintenance, please refer to this grid:

Approach to Identify Wheelchair Device	**Use Wheelchair code + MS modifier** for Data Reporting/Segmentation of device (No payment)
Approach to Identify and Reimburse for Maintenance Service Only	Line 1 Billed on Claim—Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim—K0739MS (Indicates Maintenance; Results in Payment)
Approach to Identify and Reimburse for a Combined Visit of Repair and Preventive Maintenance Services	Line 1 Billed on Claim—Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim—K0739 + MS modifier (Indicates Maintenance; Results in Payment)
	Line 3 Billed on Claim—K0739 (without modifier) (Indicates Repair; Results in Payment)
Approach to Identify and Reimburse for a Repair Service Only	Line 1 Billed on Claim—Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim—K0739 (without modifier) (Indicates Repair; Results in Payment)

If you have questions about this process, please call the applicable Provider Service line on the last page of the newsletter.

Upcoming BlueCare Tennessee Reimbursement Changes

We're making some changes to our current drug pricing for professional providers and the way we reimburse services delivered by mid-level providers, including nurse practitioners and physician assistants. The updates to our current drug pricing will take effect **July 15, 2025**, and the changes to our mid-level payment reimbursement policy will take effect on **Aug. 15, 2025**. We've included in-depth information about both changes in the third quarter 2025 BlueCare Tennessee Provider Administration Manual, which we'll publish on July 15.

If you have questions about these upcoming changes, please contact your Provider Network Manager.

BlueCare Plus Tennessee

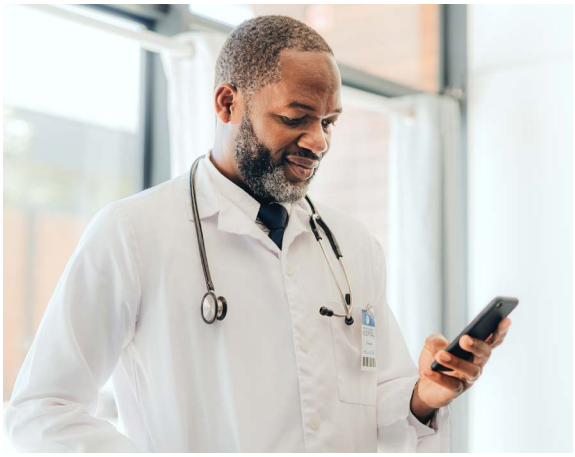
This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Reminder: 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**.

BlueCare Plus Tennessee and Medicare Advantage

This information applies to both BlueCare Plus Tennessee and Medicare Advantage lines of business.



Extended Peer-to-Peer Request Deadlines

We're extending the time frame to request a peer-to-peer discussion with a BlueCross Medical Director.

Providers are now able to ask for a peer-to-peer discussion on inpatient post-service requests when the denial decision has been rendered, and the member has been discharged within 10 business days following discharge.

As a reminder, when applicable, peer-to-peer requests must be submitted post-discharge and prior to a written appeal request to be valid.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless specifically identified below.

In-Home Chronic Wound Care Program

Effective **Oct. 1, 2024**, you can refer your patients with Medicare Advantage coverage who need chronic wound care to Esperta Health. Those interested in participating in the program must live in Middle or West Tennessee.

Chronic wounds approved for referral:

- Diabetic ulcers
- Arterial ulcers
- Venous ulcers
- Pressure injuries or ulcers
- Chronic venous insufficiency ulcers
- Malignancy-related ulcers
- Lymphedema-related ulcers
- Surgical wounds
- Burns
- Atypical wounds
- Autoimmune wounds
- Wounds caused by infections
- Non-healing wounds
- At-risk wounds*

*At-risk wounds include multiple or significant patient co-morbidities, recurrent infections, prior amputation(s), history of wound-related hospitalization, poor nutrition or a weakened immune system. A weakened immune system can be caused by chronic illnesses such as cancer, diabetes and COPD or by using immunosuppressant medications like steroids and biologics.

How to refer chronic wound patients to Esperta Health:

- Online by going to **espertahealth.com/referral**
- By phone at **1-833-377-3782**
- Faxing a patient referral to **(615) 278-1860**
- Emailing **customerservice@espertahealth.com**

For more information about Esperta Health, please visit **espertahealth.com**.

Faster Decisions for Medicare Advantage Prior Authorizations

Looking to fast track authorizations? Many authorizations can be approved automatically if you choose the appropriate Local Coverage Determination guideline when submitting clinical information. Choosing the first guideline that appears can cause the authorization to pend for nurse review, delaying your approval. Try using the LCD guidelines when appropriate. If your request meets all the criteria, you may get instant approval. If you have questions, please contact your **eBusiness Regional Marketing Consultant**.

Quality Care Initiatives

This information applies to all lines of business unless specifically identified below.

Behavioral Health Screening: An Essential Part of Well-Child Care

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

Screening recommendations related to behavioral health and 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
- Tobacco, Alcohol or Drug Assessment from age 11 through 21
- Depression and Suicidal Risk Screening starting at age 12 through 21

Evaluating young patients' development and behavioral health 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 Future/American Academy of Pediatrics Periodicity Schedule.

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.

Note: The information in this article applies to BlueCare and TennCareSelect.

Low Back Pain: Coding is Key

Patients with uncomplicated low back pain (LBP) should wait 28 days or longer after receiving a primary diagnosis before they undergo any imaging study (plain X-ray, MRI, or CT scan). A claim with only LBP coded with an imaging study opens a gap that can't be closed.

It's important to review the documentation and coding, along with the diagnosis of LBP on the claim, for "red flag" conditions (exclusions) where an imaging study should be ordered. This prevents a gap from opening if the exclusions are included on the claim.

Encourage patients with simple LBP to try conservative treatments like ice, heat, over-the-counter pain relief, stretching or back strengthening exercises and safe back habits.

Additional resources are available in our **Comprehensive Quality Measures Guide** including **LBP Coding Guide** and **LBP Coding Toolkit**. Providers can request resources by emailing the Commercial Quality Improvement team at **GM_Commercial_Quality_Improvement@bcbst.com**.

Note: The information in this article applies to Commercial plans.

Changes to Statin Therapy Attestations Start June 1

Attestations for patients in the Statin Therapy for Patients with Cardiovascular Disease (SPC) – Received Statin Therapy and the Statin Therapy for Patients with Diabetes (SPD) - Received Statin Therapy measures will no longer be available in the Quality Care Rewards (QCR) application in Availity as of June 1.

Please note, although attestation capability will no longer be available, you may fax measure exclusion information for either measure or proof of statins filled through cash pay, the Veteran's Administration (VA) and Patient Assistance Programs (PAPs) for the SPC measure to the Supplemental Data Collection team to **1-888-636-0162**. The information will be reviewed and submitted internally on your behalf if the documentation provided meets criteria.

If submitting information for review, it's important to note:

- Don't submit proof of statins filled at the pharmacy using the patient's Part D benefit for the SPC measure. This information isn't needed, as 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.
- Proof of 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.
- Information for SPC and SPD exclusions requires documentation from the medical record to support the exclusion.

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

Note: The information in this article applies to Commercial, Medicare Advantage and BlueCare Plus Tennessee plans.

Pharmacy

This information applies to all lines of business unless specifically identified below.

Removing Xhance® From Our Preferred Drug List

Beginning **July 1, 2025**, we're removing Xhance from our Preferred Drug List for Commercial lines of business. We'll send letters to members impacted by this change. If you have patients currently taking Xhance, please consider prescribing a covered alternative. To see the full list of covered drugs and preferred alternatives, please review the **2025 Preferred Formulary Guide**. If you have questions, please contact your Provider Network Manager.

Nuedexta® Prior Authorization Requirement

Beginning **July 1, 2025**, we're adding a new prior authorization requirement for Nuedexta to confirm diagnosis for our Preferred Drug List for Commercial lines of business. Members impacted by this change will receive notification letters. Detailed criteria for this prior authorization can be found on the **Prior Authorization Criteria** page on our website. If you have questions, please contact your Provider Network Manager.

Step Therapy for Additional Medicare Part B Drugs

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 aligns with CMS regulations and are required for the following Part B Eylea® biosimilars effective **June 1, 2025**:

- Ahzantive®
- Opuviz™
- Yesafili™
- Enzeevu™
- Pavblu™

Prior authorization and step therapy are required for the following Part B Soliris® biosimilars effective **July 1, 2025**:

- Bkemv®
- Epysqli®

You can find our Part B Step Therapy guide here. 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 specifically identified below. Please note these tips are educational only. Providers remain responsible for completion of claims submitted to BlueCross.

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

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers (**option 1**).

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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:

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- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
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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
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**.