SEPTEMBER 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

Troubleshooting Availity® Browser Issues

Some providers are experiencing issues loading Availity while using Google Chrome or Microsoft Edge. If you're experiencing similar issues, follow the steps below to troubleshoot the issue.

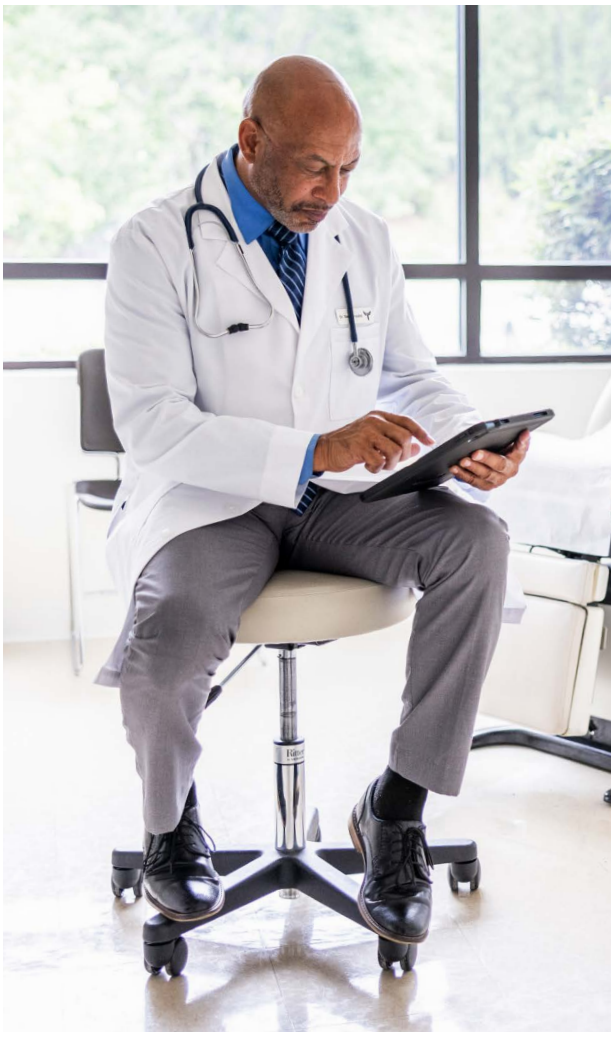
For problems with Availity while using Chrome:

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:

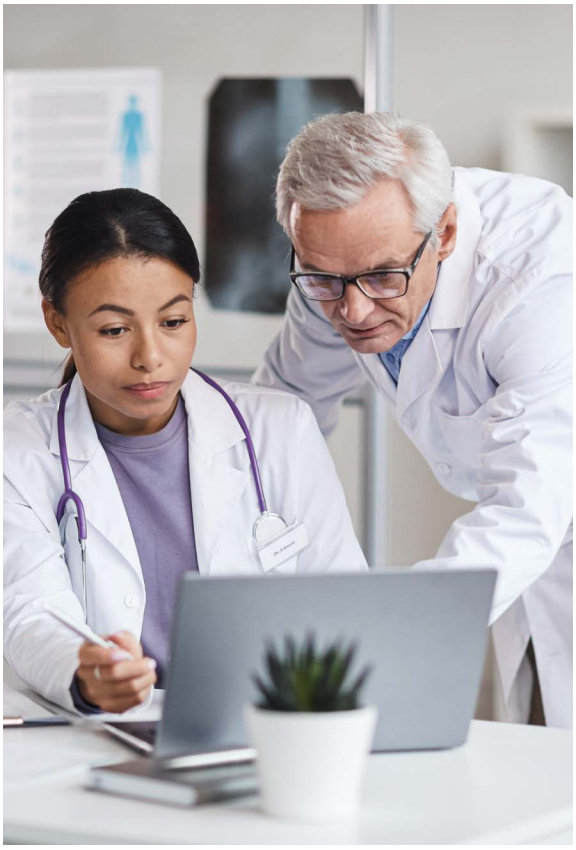
1. Close all tabs within the browser
2. Open a new tab and input **Ctrl + H** (Mac users **Command + H**)
3. Select the **trash can symbol**
4. Select **All time**, then select **Clear Data**
5. Open a new **InPrivate window** and go to **Availity.com** (do not use a bookmarked link)

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



Coming Soon: New Reconsiderations and Appeals Tool in Availity

We're excited to announce our new online reconsiderations and appeals tool in Availity, coming soon. Providers currently submit reconsiderations and appeals by phone, fax, mail and email. This new tool will streamline that process. For more information, please contact 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 here.* After choosing the case ID number, look for the letter section in the upper right to view and print the authorization letters.

* This doesn't apply to Medicare Advantage.

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

Taxonomy Code 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 Durable Medical Equipment (DME) provider contract, you'll need to file with the specific taxonomy indicated for each contracted service. If you don't submit the appropriate taxonomy codes, your claims may be rejected, denied or result in reduced reimbursement.

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

Change of Ownership Reminder

Providers being acquired or 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 PAM.

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

Provider Wait Time Surveys Coming Soon

If you haven't already, you'll soon receive our 2025 Provider Wait Times survey. Please be sure to share your feedback so we can continue to work to enhance our service to you.

Upcoming Payment Policy Changes

We're introducing several payment policies effective **Oct. 1, 2025**. Please review each policy below. Commercial providers can read more about these policies in the **Commercial preview Provider Administration Manual (PAM)** published Aug. 1. This information will also be available in the PAMs for all lines of business published on Oct. 1.

Physical Status Codes Filed with Anesthesia Claims

Applies to Commercial and BlueCare Tennessee

Consistent with Original Fee for Service Medicare payment policies, we won't provide additional reimbursement for anesthesia services based on the use of physical status modifiers P3 (ASA III), P4 (ASA IV) and P5 (ASA V).

Anesthesia Services with a Modifier QZ

Applies to Commercial and BlueCare Tennessee

Starting with Oct. 1 dates of service, please include a QZ modifier on claims for anesthesia services provided by a CRNA without medical direction by a physician. The reimbursement for these claims will be 85% of the appropriate fee schedule.

Discontinued and Reduced Services/Procedures Reimbursement Policy

Applies to Commercial, BlueCare Tennessee, Medicare Advantage and BlueCare Plus Tennessee

In surgical or procedural services represented with a CPT® code, the intended procedure isn't always fully completed. These situations are identified on professional services claims with modifier 52 or 53, and on facility claims requiring anesthesia with modifier 73 or 74.

- **Modifier 52:** Attach to codes when the surgeon completes the procedure but doesn't fulfill all requirements. This modifier indicates reduced services.
- **Modifier 53:** Use for procedures terminated by the surgeon. This modifier indicates a discontinued procedure.
- **Modifier 73:** Use when the procedure is discontinued before planned anesthesia.*
- **Modifier 74:** Use when the procedure is discontinued after planned anesthesia.*

*These modifiers apply only to procedures requiring anesthesia. They're used to cancel an operation before or after anesthesia is provided. If a laparoscopic or endoscopic procedure is converted to an open procedure or a procedure is changed or converted to a more extensive procedure, discontinued services modifiers don't apply.

Please review the chart below for reimbursement rates.

Term	Service	Modifier	Reimbursement Percentage
Professional	Reduced service	Modifier 52	50% of the appropriate fee schedule
Professional	Discontinued service	Modifier 53	25% of the appropriate fee schedule
Facility	Discontinued service **before** planned anesthesia	Modifier 73	25% of the appropriate fee schedule
Facility	Discontinued service **after** planned anesthesia	Modifier 74	50% of the appropriate fee schedule

Multiple Procedure Payment Policy Rule (MPPR) for Radiology

Applies to Commercial and BlueCare Tennessee

When designated multiple radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), the reimbursement for the technical component (Modifier TC) of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for Modifier TC of the second and each subsequent imaging procedure is then reimbursed at 50% of the appropriate fee schedule.

When designated multiple radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), the reimbursement for the professional component (Modifier 26) of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for Modifier 26 of the second and each subsequent imaging procedure is then reimbursed at 95% of the appropriate fee schedule.

When designated multiple global radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), as any technical or professional components of a designated procedure, the global procedure with the greatest allowable should reimburse at 100% of the appropriate fee schedule. The second and any subsequent global procedures will reimburse at 50% of the appropriate fee schedule.

This reduction will be applied to MRI, CT, and ultrasound radiology services.

If an applicable radiology CPT® code is submitted with more than one unit, the reduction will apply to the second and each subsequent unit. If two or more radiology CPT® codes are submitted for the same date of service, but only one of the codes is in the applicable reduction code set, the reduction won't apply.

A reduction won't apply in scenarios where:

- There's more than one separate patient encounter on a given date of service (Modifier XE)
- The service is performed on a separate organ/structure (Modifier XS)
- The service is performed by a different practitioner (Modifier XP)
- The use of a service is considered distinct because it doesn't overlap the usual components of the main service (Modifier XU)
- There's a RT/LT modifier appended to a designated imaging procedure

Note: When billing radiology codes, and more than one unit is filed for the same procedure/modifier, services should be billed on individual line items. Please use the appropriate modifiers to indicate repeat procedures, multiple distinct procedures performed on the same date of service, etc., to clearly delineate the clinical situation to prevent unnecessary denials. Following these billing guidelines will help prevent reimbursement delays, rejection of charges or a returned claim.

Professional Consultation Services Policy

Applies to Commercial and BlueCare Tennessee

Original Fee for Service Medicare doesn't allow reimbursement for consultation service CPT® codes 99242-99245 for office and other outpatient consultations and CPT® codes 99252-99255 for face-to-face medical consultations. Aligning with this policy, we won't reimburse services filed with consultation CPT® codes 99242-99245 and 99252-99255, including when reported with telehealth modifiers.

For these services, professional providers are asked to use the appropriate Evaluation and Management (E/M) CPT® code which most appropriately describes the type of consultation service provided (e.g., office visit, hospital care, nursing facility care or home service setting).

Same Day E/M and Preventive Medicine Exam Payment Policy

Applies to Commercial and Medicare Advantage

We will allow separate reimbursement for professional providers submitting claims for routine or problem-focused E/M services with a preventive medicine service during the same patient encounter using Modifier 25 on one of the claims. This includes CPT® codes 99381-99387.

We'll reimburse separately for these services as follows:

- Modifier 25 should be included on either the E/M or the preventive medicine/wellness service code.
- The appropriate diagnosis codes must be included on the claim for the respective services.

If these 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%.

Sexually Transmitted Infections Testing – Reimbursement Policy

*Applies to Commercial**, BlueCare Tennessee, Medicare Advantage and BlueCare Plus Tennessee*

For professional providers submitting claims for sexually transmitted infection (STI) testing, there are single STI CPT® codes (87491, 87591, 87661), which are differentiated by the specific causative infectious agent. Separately, there's a comprehensive STI CPT® code (87801), which is used if more than one organism is tested.

We'll deny claims with two or more single STI testing CPT® codes performed by the same provider on the same date of service and ask providers to refile with the more comprehensive STI CPT® test code.

**FEP is excluded from this payment policy.

If you have questions about these payment policies, 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.

Authorizations for Out-of-State Members

Prior authorization requests for out-of-state members can be submitted electronically through Availity. To do this, simply:

- Log in to Availity.
- Select the **Authorization and Referrals** tile.
- Enter the ordering/requesting provider information and complete all necessary fields.
- Select **Medical Policy** or **General Pre-Certification/ Pre-Authorization**.
- Enter the three-digit prefix.

For more information, view the **InterPlan tool**. You can also reach out to your **eBusiness Regional Marketing Consultant**.

New Commercial Prior Authorization Submission Process

Beginning in September, we'll be using Cohere Health technology to review most prior authorizations for our Commercial lines of business. For your convenience, you'll continue to submit requests directly to us through Availity.

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

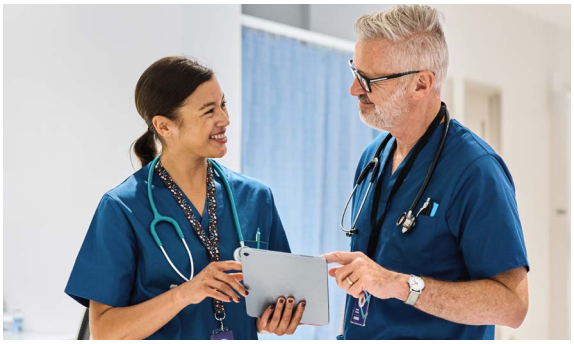
Billing for Commercial Claims

To help us pay you accurately and process your claims in a timely manner, remember these tips:

Primary diagnosis codes – According to the International Classification of Disease (ICD), certain diagnosis codes can only be billed in the first listed or primary diagnosis code field. There's an identifier in some ICD 10-CM guidelines for these codes. We'll edit the claim line if a primary-only diagnosis code is billed in a position other than first listed or primary.

Professional and technical component indicators – When both the professional and technical components for radiology, lab or other diagnostic procedures are performed, it's appropriate to bill the service as a global procedure (i.e., without a 26 or TC modifier appended to the CPT® or HCPCS code). Improper billing could result in claim denial and delayed payment.

Note: This article only applies to Commercial, Commercial Host and FEP plans.



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.

Save the Date: TennCare Provider Services Town Hall

TennCare is hosting a town hall for new providers on **Oct. 23 from 10:30 to11:30 a.m. CT (11:30 a.m. to 12:30 p.m. ET)**. The topics covered will include onboarding, website navigation, contracting with the managed care organizations and more. Please mark your calendars and make plans to attend. TennCare will share registration details in early September, so be on the lookout for more information soon.

If you have questions, please email **provider.experience@tn.gov**.

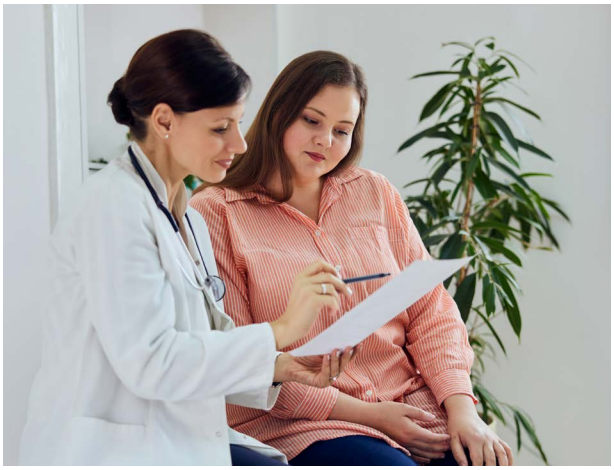
Billing Guidance Clarification: Provider Maternity Payments

In the **April 2025 BlueAlert**, we announced some changes to the billing instructions for providers to earn extra payments associated with prenatal and postpartum care. We wanted to clarify the billing guidance for the postpartum payment. The evaluation and management (E/M) code submitted on claims with Category II code 0503F should be 59430, not 59530 as previously published.

When billing for the postpartum payment, please take these steps:

- Continue to submit charges with the Category II code 0503F and its associated $75 payment on the claim.
- Submit E/M code 59430 on the claim.
- During the postpartum period (seven to 84 days after delivery), providers may submit two claims and earn two payments for postpartum care.

For more information about payments and billing instructions, please see our **Maternity Support webpage**.



Be on the Lookout for Verida, Inc. Information Requests

When BlueCare and TennCare*Select* members use Verida, Inc., the carrier conducts regular pre- and post-trip audits to make sure the transportation is only for covered services and the visits go as scheduled. As part of these audits, Verida may call your office to verify your patients' appointments. This is a normal part of Verida's process, and you may release the requested information.

Please note: This doesn't apply to CoverKids members.

Updated Psychiatric Residential Treatment Request Form

We recently updated our **BlueCare Tennessee Psychiatric Residential Treatment Request Form**.

Please replace any copies you have of the previous form and make sure you're using the newest version. If you have questions, please contact your Provider Network Manager.

FAQs for Behavioral Health Providers

The Tennessee Department of Mental Health and Substance Abuse Services' frequently asked questions contain important information for behavioral health providers about compliance with state requirements. Please review these FAQs for more information about:

- Mobile crisis
- The emergency involuntary admission process
- Mandatory prescreening agents
- Crisis stabilization units

If you have questions about the information covered, please contact your Provider Network Manager.

Tennessee Department of Health (TDH) Legislative Updates for OB/GYN Providers

New state legislation took effect on July 1, 2025, expanding mandatory prenatal screenings for syphilis and hepatitis. It also requires all hospitals and birth centers to share information about post-birth warning signs with their patients before discharge. You can review TDH's memo **here** for more information about these new guidelines.

To ensure OB/GYN providers across the state have access to timely information when changes (such as new legislation) occur, TDH has developed the TDH OB/GYN Network. Please complete the **TDH OB/GYN Network** Survey to join the network and get future announcements about important updates.

Make Sure All Patients Benefit From Well-Child Care

Children and teens with intellectual and developmental disabilities often have numerous visits to specialists or primary care practitioners. Even though they see their providers frequently, these young patients also need a TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exam every year. These checkups are an essential part of maintaining the health and well-being of all children and teens.

Your patients with BlueCare or TennCare*Select* coverage are eligible for well-child care on the same schedule recommended by the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**.

Help Expand Access to EPSDT Services

Many parents and guardians caring for children covered by BlueCare Tennessee have jobs that don't allow them to bring their kids in for visits during regular office hours. Consider offering appointment times later in the evening or on weekends to help ensure more kids and teens get preventive care.

For more helpful tips about pediatric care, including a copy of the Periodicity Schedule, see our **EPSDT Booklet for Providers**.

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

Protecting Moms and Babies

Vaccines are a safe and important way to protect pregnant patients and their babies from serious illnesses. The CDC and American College of Obstetricians and Gynecologists (ACOG) recommend three key vaccines during pregnancy:

- **Flu vaccine:** Recommended during flu season. It helps protect both mom and baby from influenza, which can be more dangerous during pregnancy.
- **Tdap vaccine:** Given between 27 and 36 weeks of pregnancy. It protects against tetanus, diphtheria, and pertussis (whooping cough), which can be life-threatening for newborns.
- **RSV vaccine:** Given between 32 and 36 weeks of pregnancy during RSV season (typically September through January). It helps prevent severe RSV illness in infants.

Addressing Vaccine Hesitancy

Many pregnant patients have questions or concerns about vaccines. Providers play a key role in helping them feel confident. Here's how:

- Speak clearly and confidently. For example: "You're 32 weeks pregnant and can get these vaccines today."
- Listen to concerns and answer questions with empathy.
- Share your own experience or that of other patients, when appropriate.
- Offer the vaccine directly or refer patients to where they can get it.

A CDC study found during the 2019–20 flu season, 61.2% of pregnant patients received the flu vaccine. Those who got a direct offer or referral from their provider were much more likely to get vaccinated [1]. This shows how much your recommendation matters.

1. https://www.acog.org/news/news-articles/2020/10/flu-vaccination-coverage-among-pregnant-people-2019-20

HEDIS® Measures

Vaccination during pregnancy supports the Prenatal Immunization Status (PRS-E) HEDIS® measure. This tracks whether patients received the flu and Tdap vaccines during pregnancy. Meeting this measure helps improve care quality and supports performance goals.

Helpful Resources

- **BlueCare Tennessee Maternity Support**: Offers education and support for pregnant members.
- **Vaccines During Pregnancy**: A guide for providers on vaccine timing and coding.
- **CDC FluVaxView**: Data and insights on maternal vaccine coverage and strategies to improve uptake.
- **ACOG Immunization Guidance**: Clinical recommendations and patient education tools.

Trauma-Informed Care: Best Practices for Pediatric Patients

Children and teens in state custody can have complex behavioral and emotional health needs, including trauma from past events. Incorporating aspects of trauma-informed care (TIC) into your approach when caring for children and teens in state custody can help ensure they get the right level of care.

The **National Child Traumatic Stress Network** defines TIC as a treatment framework designed to understand, recognize and respond to the effects of trauma. Its goal is to support stable, safe and nurturing relationships that build resiliency. Tips for incorporating TIC in your practice include:

- **Recognizing signs of past trauma.** These can include nightmares, trouble sleeping, headaches, fatigue, feelings of fear, anger or sadness, and stomach pain. Patients may also be irritable, highly reactive and guarded, or have trouble managing stress and emotion.
- **Approaching trauma as you would other conditions.** TIC in a medical setting may include triage, gathering a complete medical history, surveillance and screening, diagnosis, care coordination, and management strategies such as medication therapy, anticipatory guidance for foster parents and caregivers, referral to other providers, and follow-up care.
- **Using active-listening skills and creating an emotionally safe space for discussing trauma.** Practicing empathy and listening to children and caregivers in an active, nonjudgmental way helps facilitate discussions about trauma and trauma management. **Cultural competency** is also an important component of TIC. To help children understand what's going on, you may consider explaining why you need to ask sensitive questions or perform an exam.

For more tips and information about TIC, review these helpful resources:

- **American Academy of Pediatrics – Trauma-Informed Care**
- **The National Child Traumatic Stress Network – Health Care Providers**

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

In late 2025, we'll review BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2024, and June 30, 2025. The retrospective ASH review includes an in-depth look at documents that may not have been required at the time claims were submitted. If you submitted a claim with an ASH code between these dates, we may contact you for additional records. **Note:** We may recover payment if we don't receive records within the requested time frame.

If you have questions about ASH review or ASH claims guidelines, please see the **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

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

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 our Medicare Advantage and Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Update to Master Authorization List for Skin Substitutes Codes

Starting **Nov. 1, 2025**, prior authorization may be required for some skin substitutes codes for Medicare Advantage and BlueCare Plus Tennessee members. Please check the master authorization list on **provider.bcbst.com** to see if a specific code now requires prior authorization. If you have questions, please call us at your patient's plan number:

- Medicare Advantage – **1-800-924-7141**
- BlueCare Plus Tennessee – **1-800-299-1407**

Quality Care Initiatives

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

Focusing on Antibiotic Stewardship

Cold and flu season will be here soon. It's a time when patients often ask for antibiotics to ease their symptoms. However, antimicrobial resistance (AMR) is one of the most serious global public health problems. To combat AMR, the CDC advises optimizing how you use and prescribe antibiotics to protect patients from harm.

National Antibiotic Awareness Week is Nov. 18–24, 2025

The theme for the World AMR Awareness Week (WAAW) 2025 is "Act Now: Protect Our Present, Secure Our Future." AMR is a growing global health and socioeconomic crisis. It has significant impacts on human and animal health, food production, and the environment.

Drug-resistant pathogens pose a threat to everyone, everywhere, and more public and stakeholder awareness is needed. This year's theme calls on the global community to educate stakeholders on AMR, advocate for bold commitments and take concrete actions in response to AMR.

Reducing Health Disparities by Improving Antibiotic Stewardship

Health disparities are closely linked with social, economic and environmental disadvantages or other characteristics historically linked to discrimination or exclusion. These disparities could be created or worsened in communities with fewer resources to allocate to antibiotic stewardship activities that focus on improving antibiotic prescribing and use.

If not addressed, members may experience harm due to inappropriate use of antibiotics. This includes allergic reactions, side effects, overmedication, medication errors, **C. diff infections**, or **greater burden of antimicrobial resistance**.

HEDIS® Measure: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

Patients 3 months of age and older

Goal of the measure: Patients with acute bronchitis/bronchiolitis shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies, or the patient continues to worsen. Report and document if the patient has an exclusion or a competing diagnosis of infection such as otitis media, sinusitis, pneumonia or pharyngitis.

Note: Every episode counts, and patient compliance will be counted for every visit where acute bronchitis/bronchiolitis is diagnosed.

Improving Quality: Metabolic Risks and Monitoring for Patients on Antipsychotic Medication

Health screenings are important for patients on antipsychotics due to the potential side effects and long-term health risks associated with these medications. Antipsychotics, while effective in managing symptoms of psychiatric disorders, can lead to metabolic changes, cardiovascular issues, and other health complications.

Regular health screenings help in early detection and management of these potential side effects. For instance, antipsychotics can cause weight gain, increased blood sugar levels, and elevated cholesterol, which can lead to diabetes and heart disease. Monitoring weight, blood glucose, and lipid profiles can help in timely intervention, reducing the risk of developing these conditions.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) and **Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)** are two HEDIS® measures focused on ensuring patients on antipsychotics get the appropriate screenings for risk and early detection of health issues.

- **APM-E** measures the percentage of children and adolescents 1–17 years of age who had antipsychotic prescriptions and had blood glucose and cholesterol testing during the measurement year.
- **SSD** measures the percentage of patients 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Consider these tips to help meet these quality measures:

- Educate patients on potential side effects of antipsychotics and the need for regular metabolic monitoring and diabetes screenings. Repeat education at all visits.
- Include metabolic screening labs and diabetes screening in the annual well-care visit and more frequently if indicated.
- Review the patient's medications closely to determine if they're at risk.
- Coordinate care between primary care and behavioral health providers to ensure all medications are identified and needed screenings are completed with any necessary follow-ups.

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

Pharmacy

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

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.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
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**.

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