of Tennessee

FEBRUARY 2026

BlueAlert℠

of Tennessee | Mission driven FOR 80 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.

Keep Your Information Current

Please make sure your information is accurate in your CAQH account. Keeping this information current helps make sure that all communications from us are delivered successfully.

INSIDE THIS ISSUE

Updates to the Durable Medical Equipment (DME) Network

Effective **March 6, 2026**, we'll partner with CareCentrix to manage our DME network. This change is part of a broader response to rising health care costs nationwide. By working with CareCentrix, we can help reduce the out-of-pocket costs for our members while maintaining the same access to DME services and products you currently order.

We'll continue to review DME prior authorization requests in-house through the first half of 2026. After that, CareCentrix will begin reviewing and approving DME prior authorization requests for all our networks. We'll share more details about this transition soon. If you have questions, please contact your Provider Network Manager.

Member ID Card Changes Coming for All Blue Plans by 2028

The Blue Cross Blue Shield Association is requiring all Blue plans to update Member ID cards by 2028. Updates will include removing the suitcase icon, which identifies members with the BlueCard benefit.

Please check Availity® to confirm a member's benefits or eligibility.

We're still in the planning phase, but providers may start seeing updated cards from members with other Blue plans or BlueCard benefits soon.

Continue to check the BlueAlert for updates.

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 FAQs document **here**.

About the Provider Exclusion Screening Process

The health and safety of our members and your employees is important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are ineligible persons, and therefore, excluded from participation in Medicare or Medicaid programs. At minimum, registry and exclusion checks must include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, HHS-OIG List of Excluded Individuals and Entities, System for Award Management, and the Tennessee Terminated Providers List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the "Provider Networks – Federal Exclusion Screening Requirement" section of the **Commercial** and **BlueCare Tennessee Provider Administration Manuals**.

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**.

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 **by following these steps** 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 Inquiries, Reconsiderations and Appeals Tool in Availity

We're excited to announce our new online inquiries, reconsiderations and appeals tool in Availity is launching soon. Providers currently submit by phone, fax, mail and email. This claims dispute tool streamlines that process.

We encourage providers to submit inquiries, reconsiderations and appeals in Availity as soon as the tool is live. To learn more about this process, join one of our webinars hosted by eBusiness. Choose from one of these February 2026 dates/times:

- Tuesday, Feb. 10 at 11 a.m. ET – **Webinar Link**
- Thursday, Feb. 12 at 1 p.m. ET – **Webinar Link**

During the interim, we've disabled the "Message this Payer" feature as we move 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**.

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. 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). These providers are 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.

Example 1:

- The member's policy uses 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 example, 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.

Example 2:

- The member's policy uses Network S.
- The health care group practice is contracted in Network P and S and the BH Comprehensive Network.
- In this example, 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.

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.

Dental Benefits Reminders

February is National Children's Dental Health Month. It's a good time to remind patients about taking care of their dental health and the dental benefits available to them.

Member Benefits

Our members' benefits include dental care services such as cleanings, exams and other routine procedures at no extra cost. These services are an important part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and well-child appointments. We encourage you to talk with families about the importance of dental health and to help them take advantage of these benefits.

Note: This article doesn't apply to CoverKids.

Renaissance® Provides Member Dental Benefits

Renaissance is now the dental benefit manager for TennCare members. Renaissance manages all dental benefits, including claims and provider support. Please make sure your office is familiar with Renaissance's processes and resources. For more information about your patients' dental benefits, visit TennCare's **Dental Services** page.

Maternal Behavioral Health: Screen Early, Talk Often

Perinatal mood and anxiety disorders are among the most common complications during pregnancy and the first year after birth. Consistent screening can help you catch concerns sooner, connect your patients to care, and improve outcomes for both parents and infants.

Tips for Your Team

- **Use validated tools like the Edinburgh Postnatal Depression Scale (EPDS) or PHQ-9.** Document the instrument name, score and follow-up plan if needed. Complete the screening during pregnancy and again seven to 84 days after delivery.
- **Bill using CPT® 96160 and modifier TH** for the screening. Make sure it's captured at least once in the perinatal period to receive the additional behavioral health screening payment.
- **If screening results are positive**, contact the patient within 30 days to verify connection to care and available support.
- **Ask simple, supportive questions** like "How have you been feeling emotionally?"

For additional resources, check out our **Maternity Support** page.

Foster Care Medical Home Resources

Children and teens in foster care often have unique medical and behavioral health challenges. To help meet these needs, we've worked with TennCare to develop resources to help providers become a Foster Care Medical Home. These providers specialize in coordinating comprehensive care for this vulnerable population.

Foster Care Medical Homes serve as a partner for children in foster care. They help foster children receive timely, consistent and holistic care. These providers play a critical role in addressing physical health, behavioral health and developmental needs, while also supporting foster families and case workers.

Training Opportunities Through the Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

TNAAP offers training and resources for providers interested in becoming a Foster Care Medical Home. These programs cover best practices for caring for children in foster care, including trauma-informed care, coordination with child welfare agencies and strategies for improving health outcomes.

We're working to build a strong network of Foster Care Medical Homes across Tennessee. By joining this network, you can make a meaningful difference in the lives of children and teens who need stability and support. If you're interested in learning more about becoming a Foster Care Medical Home, visit the **Foster Care Medical Home page** on the TNAAP website.

Filing Deadlines for Provider-Submitted Crossover Claims

Crossover claims should come from a Medicare or Dual Special Needs Plan (DSNP). Providers submitting crossover claims should be limited to certain situations, and should only occur after they've allowed at least 60 days for Medicare or DSNP to cross the claim to BlueCare Tennessee.

Providers have 365 days from the Date of Service (DOS) or 180 days from the paid date on the Medicare MSN/DSNP EOB, whichever is greater, to submit a claim for cost-share reimbursement.

Crossover claims should be submitted within one year from the date of service or six months from the Medicare pay date. After the initial filing (within those timeframes), if BlueCare Tennessee rejects, returns or denies the claim, providers must resubmit the corrected claim within six months from the rejected, returned or denied date to be within timely filing guidelines.

BlueCare Plus Tennessee

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

Changes to the Healthy Food Benefit

This year, members with certain long-term conditions may be able to get a healthy food benefit. It's a Special Supplemental Benefit for the Chronically Ill (SSBCI). If they qualify, they can use their monthly flex card allowance to pay for healthy food. However, all members can use their allowance on over-the-counter (OTC) items and transportation.

Not all members will qualify for the healthy food benefit. Members can check for eligibility and allowance information in the MyTotal Benefits app. They'll use the same login info for both bcptncard.com and the app.

If you have patients who aren't getting this benefit but think they should, please complete the attestation form during their next visit. You can fax the completed form to **1-855-876-1461**.

Changes for BlueCare Plus Tennessee Dual Eligible Members

Effective **Jan. 1, 2026**, we made important updates to improve care for members with both Medicare and Medicaid. These changes help make getting care easier and more coordinated for members. They also simplify the claims process for providers.

What changed?

Members who have BlueCare Plus Tennessee and BlueCare Medicaid have been 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.

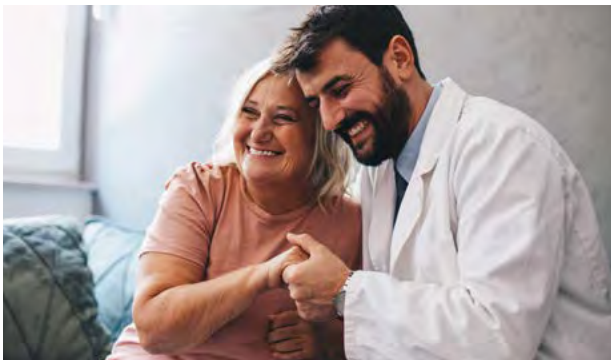
What does this mean for members?

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

What does this mean for providers?

Providers should send all claims (Medicare and Medicaid) to BlueCare Plus Tennessee. You don't need to submit a separate claim to BlueCare Medicaid. This helps make billing simpler and reduces delays.

Prior authorization requests for services should 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 2026 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.

Outpatient Procedure Authorization Timelines

Outpatient procedures will be authorized for a 60-day timeframe. Requests to change the date of service can only be submitted within one week prior to the end of the 60-day authorization period. Any change requests made before this time frame won't be granted. Providing actual scheduled dates can help avoid delays in care or authorization issues. Please make sure your scheduling complies with these guidelines

BlueCare Plus Tennessee and Medicare Advantage

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

Coming Soon: Home-Health and Post-Acute Care Management

We're developing a partnership to help manage home health and post-acute care services for Medicare and Medicaid dual-eligible special needs plans. Check future BlueAlerts for updates.

Quality Corner

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

HEDIS® Measurement Year 2025 Medical Record Requests to Begin Soon

Each year, we're required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA uses these measures to determine whether members received the care and screenings they needed and if the care improved health.

You'll soon receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management, and assessment of nutrition and physical activity for children.

Note: BlueCross and BlueCare Tennessee providers are required to submit copies of requested medical records, and it's your contractual responsibility to ensure the records requested are provided. If you use a copy service or vendor, please alert them of the need to respond promptly to record requests.

Please call us at **(423) 535-3187** if you need help using any of these methods to submit your records:

- Remote access into your electronic medical records
- Secure email
- Fax
- On-site collection
- Our web-based portal

HEDIS® is a registered trademark of NCQA.

THCII Episodes of Care Quarterly Report Release

New quarterly reports for BlueCare Episodes of Care Quarterbacks will be available on **Feb. 19, 2026**. If you're having trouble accessing your quarterly report, please call **(423) 535-5717, option 2**, or email **eBusiness_Service@bcbst.com**.

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Payment Update

The 2024 Final Performance Reports for BlueCare Tennessee and Commercial lines of business were released in August 2025 to Quarterbacks participating in the Episodes of Care program. Payments and auto-recoupments were issued in December 2025 for Quarterbacks who earned a gain-share or risk-share amount, as reflected on the cover page of their 2024 Final Performance Reports. If you have questions about your payment or report, please contact your Provider Network Manager.

Controlling High Blood Pressure

Hypertension increases the risk of heart disease and stroke, which are the leading causes of death in the United States. In addition to heart disease and stroke, uncontrolled hypertension can also cause kidney failure and retinal eye disease. Treatment and the appropriate medication are critical to patient success.

Controlling Blood Pressure (CBP) is a high-impact measure for Medicare Star Ratings, NCQA Accreditation and the CMS Quality Rating System. The measure directly affects health plan performance scores and reimbursement incentives.

Best Practices for Patients With High Blood Pressure

- Document your patient's blood pressure at every visit.
- Allow the patient to get settled and retake their blood pressure at the end of the visit if the first reading was greater than 140/90. If multiple readings are taken on the same date, use the lowest systolic and lowest diastolic reading for the medical record.
- Exclude readings during procedures/tests.
- Also exclude patients who are on hospice or receiving palliative care and patients who are pregnant, have had a kidney transplant or nephrectomy, or who have end-stage renal disease or advanced illness/frailty.
- Only the last reading in the calendar year must be in range to successfully close the CBP measure.
- Readings taken in-office or patient-reported from a digital device are accepted.

Coding (CPT® II Codes for Blood Pressure)

- 3074F: Systolic <130 mm Hg
- 3075F: Systolic 130–139 mm Hg
- 3078F: Diastolic <80 mm Hg
- 3079F: Diastolic 80–89 mm Hg

Strategies To Improve CBP Scores

- Follow a standardized process for measurement and documentation.
- Follow up with your patients about abnormal readings.
- Talk to your patients about lifestyle changes and medication adherence.
- Encourage your patients to monitor and document blood pressure readings at home.
- Conduct a monthly review of out-of-range readings and gap closures.
- Offer patient incentives.
- Use 90-day medication fills when appropriate.

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**.