MARCH 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're partnering 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 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. In the meantime, if you have questions, please contact your Provider Network Manager.

CAHPS® Surveys Starting Soon

Gaining insight into how your patients feel about their health care experience can benefit you and your patients. Most patients will be more engaged, have higher adherence rates and feel more confident in the care they receive when they're highly satisfied with their provider's customer service, communication and coordination of care.

That's why the Consumer Assessment of Healthcare Providers & Systems (CAHPS) annual survey, conducted by an outside entity, is so important to providers as well as health plans. The National Committee for Quality Assurance and CMS use this anonymous survey to evaluate care and services provided to your patients.

All lines of business measure member experience using some version of the CAHPS survey. Each year, randomly selected members are asked to complete a survey between March and June about their health care experience. **Please encourage your patients to participate in all surveys sent by us and outside organizations so we're better able to identify opportunities for improvement.**

Simple Tips to Improve Quality Care for Patients

When patients are trying to understand medical conditions and recommended treatments, they sometimes feel overwhelmed by the information. Building a trusted relationship with a provider is also a key component that can affect treatment success. Here are some easy tips that can help you make sure your patients get the information they need.

1. Explain things in ways that are easy to understand. When talking with patients about a medical condition or treatment plan, try to avoid medical jargon. Consider using shared decision-making tools to help patients learn more about their condition and options for treatment.
2. Make eye contact with your patients and spend time listening carefully to them. Ask your patients or their caregivers if they have concerns or questions. These actions help build trust and foster engagement. The National Institutes of Health (NIH) recommends asking open-ended questions that require patients to answer more than a simple yes or no.
3. Be as respectful as possible about patients' thoughts and beliefs and try to continue conversations at the next visit if they refuse care. For example, if parents don't want their child to receive a needed vaccination, work with them to find one action you can agree on, like scheduling a follow-up appointment.
4. Use the teach-back method, which involves asking patients to explain what they need to do in their own words. According to the NIH, this technique lets you see if patients need more information or if they understand the information you presented.
5. Coordinate care by talking with patients about services they get from other providers. When you see your patients, ask if they've recently been to the ER or a specialist. Also, discuss any services or medications they've received elsewhere and contact other providers to request information about test results and treatment plans.

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 you 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 check your Provider Administration Manual (PAM). You can also find additional information in the FAQs document **here**.

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 sends 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 manually enter 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**.

New Inquiries, Reconsiderations and Appeals Tool in Availity

Our new online inquiries, reconsiderations and appeals tool is now available in Availity. Providers previously submitted by phone, fax, mail and email. This claims dispute tool streamlines that process.

We encourage providers to begin submitting inquiries, reconsiderations and appeals in Availity.

Please note that effective **April 1, 2026**, all in-state providers will be required to submit inquiries, reconsiderations and appeals through Availity. After April 1, 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.

Supporting Maternal Nutrition During National Nutrition Month

Good nutrition is one of the most powerful tools expectant parents have to support a healthy pregnancy, and you play a central role in helping them get there. As we recognize National Nutrition Month, it's a good time to reinforce the conversations that help patients feel confident, informed and supported throughout their pregnancy.

Encourage Balanced, Accessible Meals

Patients often arrive with questions about what they should eat, what they should avoid and how to manage symptoms that make healthy eating harder. A quick discussion about balanced meals, nutrient-dense foods and realistic substitutions can go a long way. As you guide those conversations, the American College of Obstetricians & Gynecologists (**ACOG**) offers patient-friendly resources and clinical recommendations under the **For Healthcare Providers** section.

Clarify Anticipated Weight Gain

Setting clear expectations around healthy weight gain can reduce stress and support better outcomes. Many patients aren't sure what's considered typical or safe. Walking them through ranges based on pre-pregnancy BMI helps them understand what to expect and when to reach out with concerns.

Offer Nutrition Counseling Early

Nutrition needs can change quickly during pregnancy. When patients have conditions like diabetes, hypertension or hyperemesis gravidarum, specialized counseling helps them manage symptoms and reduce risks. Consider connecting patients to a registered dietitian or local programs that can provide more targeted support.

Refer Eligible Patients to WIC

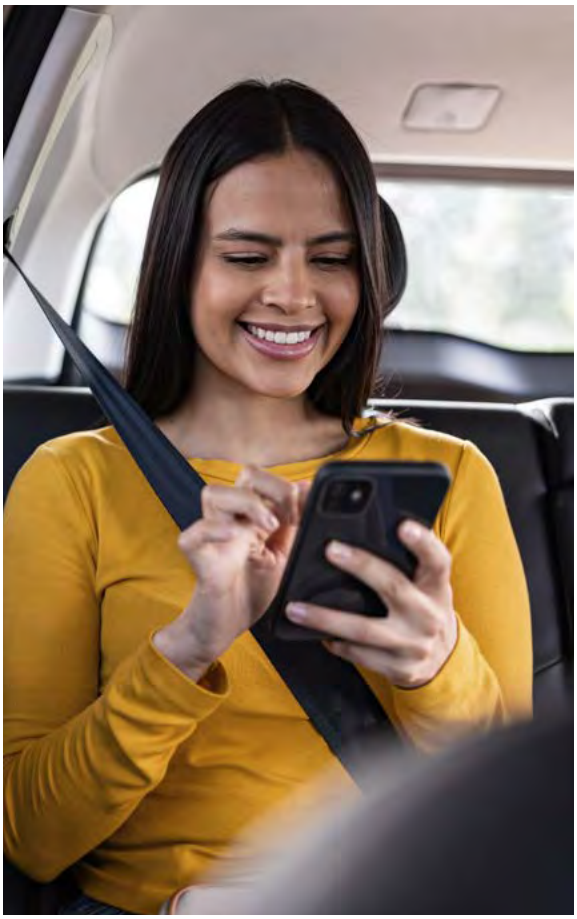
The Women, Infants and Children (WIC) program remains one of the most effective ways to access healthy foods during pregnancy. Many who qualify don't realize they're eligible. A brief referral often creates the nudge they need to apply. WIC also offers nutrition education, breastfeeding support and other services that strengthen maternal health throughout pregnancy and after birth.

Well-Care Visits, Sports Physicals and Transportation Benefits

Many young patients go several years between checkups. This is especially true for teens and young adults. Because an office visit for an illness, shots, prescription refills or other reason may be the only chance you have to conduct a well-care check, TennCare Kids Screening Guidelines allow reimbursement for both a "sick" and "well" visit on the same day. More than one well visit is allowed per year.

Additionally, stand-alone sports physicals and their corresponding codes aren't covered services. However, by converting that appointment into a complete well-care visit, you can meet all requirements of the sports physical and receive reimbursement for a covered service.

Spring is a great time to schedule sports physicals and/or well-care exams. For more about combining visits, view our **EPSDT Provider Guide**.



Is transportation a barrier to care?

If you have patients who can't get to covered medical services or pick up prescriptions because they don't have transportation, let them know we can help. Our transportation vendor, Verida, can get them to and from their covered medical visits or the pharmacy at no charge.

Your BlueCare and TennCare*Select* patients can arrange transportation through Verida's member portal or by calling the Verida toll-free customer service number for their plan, regardless of the distance they need to travel. The Verida Call Center is open 24 hours a day, 365 days a year.

- BlueCare: **1-855-735-4660**
- TennCare*Select*: **1-866-473-7565**
- Member portal: **member.verida.com**

Patients can also call Nurseline, which is available 24/7. They can speak to a registered nurse any time, day or night, to get answers about symptoms, medical conditions and other basic health concerns.

- Nurseline: **1-800-262-2873**

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

Help Children in State Custody Get Well-Child Care

When a child enters the Department of Children's Services (DCS) custody, we may not know much about their medical history, including immunization history, past trauma and prescribed medications. Performing an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening when children and teens enter state custody is an essential step in identifying medical, behavioral health and dental care needs. We need your help to make sure these children get these important visits.

Within 72 hours of entering DCS custody, children and teens must have a medical exam. This exam should then be followed by a comprehensive EPSDT checkup within 30 days. (The exam performed within the first 72 hours may serve as the EPSDT exam if it contains all necessary components.) Following these checkups, children and teens in state custody should continue to get preventive care according to the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**.

For more information about caring for children in state custody, click **here**. To review the components of EPSDT visits, please see our **EPSDT Provider Guide**.

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

BlueCare Plus Tennessee

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

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.

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**.

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**.

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 Advantage and Medicaid dual-eligible special needs plans. Check future BlueAlerts for updates.

Provider Reimbursement Rates Changing April 1

The Medicare Advantage Quality+ Partnerships Program offers enhanced reimbursement to providers who achieved quality scores of 4-stars and above with coding accuracy during the 2025 measurement period (Jan. 1 through Dec. 31, 2025).

Starting **April 1, 2026**, star ratings based on last year's performance will affect each provider's reimbursement rates. Participating providers will receive arate adjustment notification letter and a rate attachment with the new fee schedule by April 1. Your contract amendment will include information about your base rate, the quality escalator and total earning potential.

Quality Corner

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

Improving Retention in Evidence-Based Treatment for Opioid Use Disorder (OUD): Why It Matters and How to Act

Medication for opioid use disorder (MOUD) is the gold standard for reducing overdose risk and supporting recovery. Yet retention remains a major challenge. Nationally, only about 25% of adults needing OUD treatment receive MOUD, and many discontinue early, significantly increasing relapse and mortality risk.

The HEDIS® Pharmacotherapy for Opioid Use Disorder (POD) measure helps track retention. It calculates the percentage of patients 16 and older who start MOUD and remain on treatment medication for at least 180 days without an eight-day gap. Covered medications include buprenorphine (oral, implant, injection), naltrexone and methadone.

Why Retention Matters

Longer engagement improves outcomes, reduces overdose risk and strengthens quality scores tied to value-based care. Adherence also reduces the risk of patients requiring higher levels of care such as ER and inpatient hospitalization, improving quality of life and optimizing health care resources.

Practical strategies to improve POD performance and care retention:

- Educate patients and families on the benefits of sustained MOUD.
- Proactively monitor adherence and address gaps quickly.
- Integrate behavioral health and peer support to enhance engagement.
- Document accurately and submit claims promptly to reflect continuity of care.

By prioritizing retention and leveraging POD as a quality benchmark, providers can drive better outcomes and close critical gaps in OUD care. Partner with care teams, leverage data and implement retention strategies to help every patient have the best chance at long-term recovery.

HEDIS® is a registered trademark of NCQA.

Sources:

- **NCQA Pharmacotherapy for Opioid Use Disorder (POD) - NCQA**
- **CDC Medications for Opioid Use Disorder (MOUD) Study | Overdose Prevention | CDC**
- **Treatment for Opioid Use Disorder: Population Estimates — United States, 2022 | MMWR**

Helping More Patients Stay on track With Colorectal Cancer Screening

Colorectal cancer is one of the most common cancers – and one of the most preventable. Regular screening can catch problems early, when they may be easier to treat. But many people still aren't getting screened on time, especially those who face more barriers to care. That's why screening guidance now starts at age 45.

The HEDIS® Colorectal Cancer Screening (COL-E) measure looks at whether patients ages 45-75 are up to date. Here's what counts and how you can help close gaps in care.

Screening Options	
Colonoscopy	The gold standard. Covered at 100% on most plans. Counts if completed every 10 years.
Flexible Sigmoidoscopy	Counts if completed every five years.
CT Colonography	Counts if completed every five years.
sDNA with FIT	Counts if completed every three years.
FIT or FOBT	FIT requires a yearly sample. Guaiac-based FOBT requires three samples.

What to Document

Accurate documentation helps close gaps and accurately reflects the care you provide. Make sure the record includes:

- The date of the screening
- Results, unless the test is listed only in the medical history section

The interval that closes the gap depends on the type of screening completed.

Who's Excluded From the Measure

Patients may be excluded if they:

- Are enrolled in hospice
- Are receiving palliative care
- Have a history of colon cancer or total colectomy
- Are age 66+ with advanced illness and frailty
- Died during the measurement year

How We're Supporting Screening Efforts

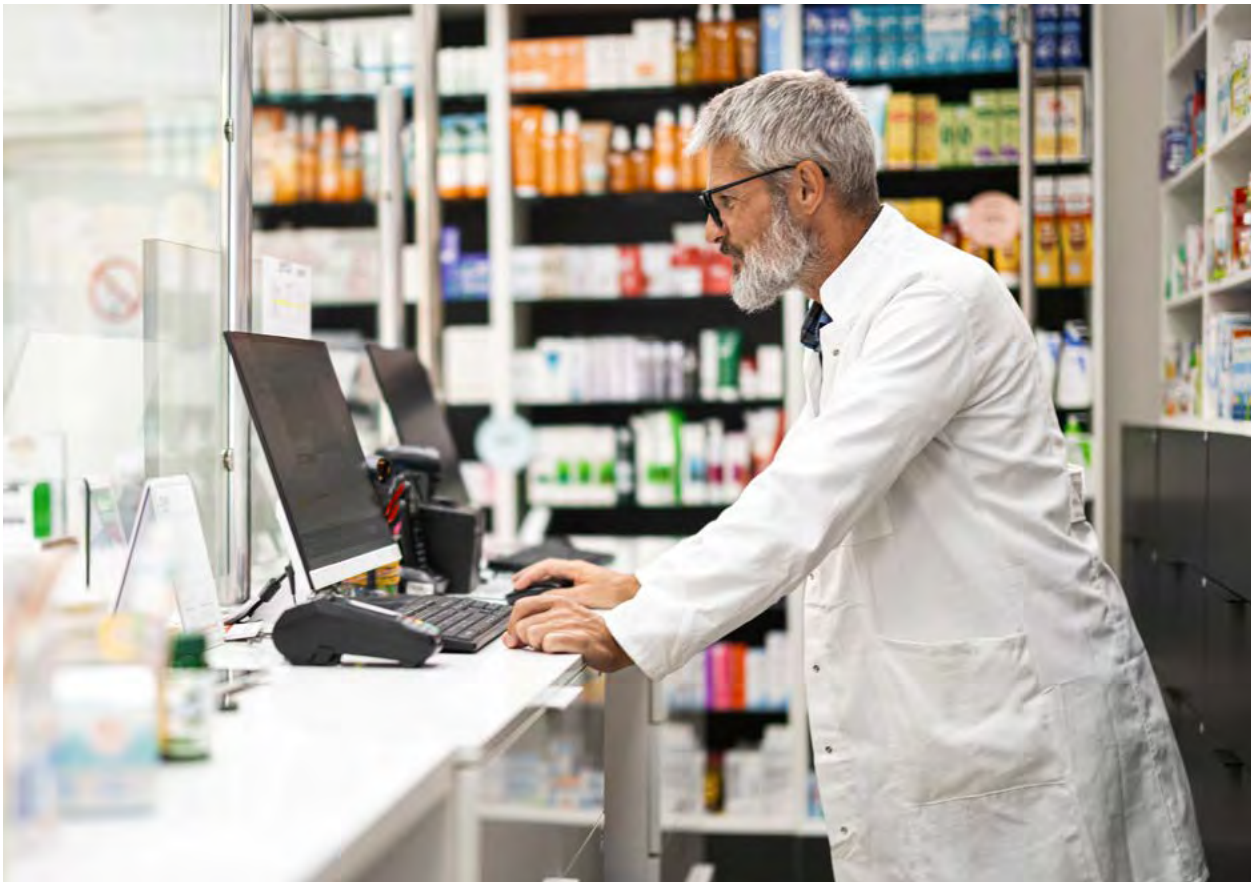
We're working alongside you to help more members get screened by sending reminders, sharing easy-to-understand educational materials and offering preventive care opportunities that fit real-life schedules. Together, we can help more Tennesseans stay on top of this important preventive care.

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**.