of Tennessee
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2023 All Blue Workshop℠ Provider Questions & Answers

Thank you for you attending the 2023 All Blue Workshop. We received a number of questions during this years' presentations, and we've compiled them below for your reference. We hope you find this helpful.

Will there be an option to download this event?
You can download the presentation by logging in to Availity and visiting the Resources tab in our Payer Spaces. You can also download it from the All Blue Workshop page at provider.bcbst.com.

We're receiving denials from BlueCare for the incorrect taxonomy code. Does BlueCross have their own list of taxonomy codes? We do not have issues with other payors.
BlueCross doesn't have our own list of taxonomy codes. You may call Provider Services at 1-800-924-7141 to get a report with the specific taxonomy code that we have on file for your providers.

Has 99211 been deleted from CPT® coding as of 2023?
No, 99211 is still a valid CPT code for BlueCare and BlueCross lines of business.

What is BlueCare doing about children with ADHD who can't get the formulary medications due to a shortage in medication nationwide?
BlueCare is aware of the shortage of ADHD medication, specifically with Adderall, Vyvanse, Ritalin and their generics. BlueCare is working with members to track down medication in their area. If you have members that need assistance, please point them toward our customer service lines, which can be found on the last page of each BlueAlert.

Is BlueCross helping find dentists that accept TennCare?
DentaQuest administers and manages dental services for our BlueCare members. Please reach out to DentaQuest Customer Service at 1-877-418-6886.

How do we find out who our Network Managers are?
You can find out who your assigned Network Manager is by clicking here.

Do you have the website address for the felony and sex offender registry?
sor.tbi.tn.gov/home
tn.gov/didd/divisions/reportable-event-management/abuse-registry.html
tn.gov/correction/redirect-agency-services/foil.html

We continue to receive denials when multiple codes are billed together, such as 45385 and 4538059. The reason provided is that benefits are included in the payment/allowance for another service/procedure that has been adjudicated. We then have to submit a reconsideration with medical records. Do you know why this continues to happen?
Please share your concerns, including claim examples, with your assigned Provider Network Manager for review.

Are providers required to be location specific or just linked to the groups?
If a provider is linked to your group, you should also provide us with address information for the other location(s) where the provider renders services.

Regarding the 12-month inactivity, does this apply to Medicaid only or does this include Commercial as well?
The 12-month inactivity report applies to Medicaid lines of business; however, a provider may be removed from Commercial networks if they have no claims activity within 18 consecutive months (provider NPI does not appear on claims in previous 18 months).

Is there a different provider representative for Behavioral Health? Who can help us with claim denials?
Yes, there is a different provider representative for Behavioral Health. Please reach out to your assigned medical Provider Network Manager and they will be happy to get you in touch.

Is there a list of all the prefixes for BlueCross?
No, we don't have a comprehensive list of prefixes, but there is a prefix locator tool on the global website BCBS.com.

Is BlueCare Plus covering the cognitive assessment and care plan, procedure code 99484?
Yes, procedure code 99484 is a covered service for BlueCare Plus.

Model of Care Training does not work when we try to submit and we're having trouble accessing and completing the training. What is the deadline for this training?
Please reach out to eBusiness, at (423) 535-5717 if this link doesn't work - BCP Model of Care

How often are the BlueCross fee schedules updated in Availity®?
BlueCross fee schedules are updated in Availity on a quarterly basis.

Why is 96372 being denied due to prior authorization? This is a therapeutic code and has never needed a prior auth before. Additionally, we were never given a written policy for this change.
Please reach out to your assigned Provider Network Manager, with specific claim details.

Do BlueCare claims go to the State or to BlueCare? When I call BlueCare, I am told claims go to BlueCare, but TN Medicaid say claims go to them. And when I do send claims to BlueCare, the payment comes from TN Medicaid. Example: the patient is Medicare/Medicaid eligible, traditional Medicare Part B and BlueCare for Medicaid MCO. Medicare auto cross over to Bureau of TennCare.
The claims go to BlueCare, our Medicaid line of business.

Will there be an Availity update to do a live chat like that of BCBS of VA? When a payment can't be found in Availity but the reps say it exists, how do we get a copy of the message?
There are no current plans for live chat, but we can suggest this for future consideration. If you have a ticket number from speaking to an agent, please share with your assigned Network Manager and they can assist.

We're encouraged to use Availity to check claim status but that takes up to 10 days to get a response. If we call to check the claim status, the wait to speak to a BlueCross rep is extremely long. What is BlueCross doing to help providers follow up with claim status? The time is being spent on waiting is taking away from clinic staff being able to address patient concerns.
Our operations and development teams are coordinating on a large project to change our back-end processes to update the way messages are delivered to operational agents to improve messaging response times.

Will there be an option for adding PWK to pending claims in Availity in the future? Right now, it's still done by fax. Having the ability to upload in Availity would be great.
PWK will be handled just like it is today, but instead of faxing the PWK coversheet and medical records, the PWK form can be completed online. The process will be the same as the fax version in that the Account Control Number (ACN) will be on the PWK form as well as on our electronic claim. We are currently testing PWK and hope to release it as soon as possible.

Does BlueCross have any plans to allow providers to submit reconsiderations and appeals through Availity or the BlueCross website instead of faxing or mailing?
We're currently working with Availity to accept online reconsiderations/appeals with a goal of piloting the program in 2024.

If we submit BlueCare claims that deny because the patient is incarcerated at the time of service, the remit doesn't indicate that, so we have to call BlueCare. Is there a way for BlueCare to apply a denial code that indicates the incarceration up front?
Facilities may not have knowledge of the member's enrollment in TennCare*Select* under this program prior to treatment. To accommodate the facility's needs, TennCare*Select* allows retro-authorization requests for these members.

A specific denial explanation code of WX0 has been created for services that deny due to no prior authorization for this population. This code indicates that the facility needs to request a retro-active authorization in order for the claim to be considered for adjustment if authorized.

If the member's eligibility is made retroactive, the provider has 120 days from the remit date of the denial on the claim to request a retro-active authorization. If the member's eligibility is NOT retro-active, the provider has 24 hours or next business day to request an authorization. Any UM requests made outside of this time frame may be denied non-compliant.

Covered services include:
*Medical and behavioral health services performed in a hospital or other health care facility for more than 24 hours.
*All medically necessary services (including professional) associated with the above mentioned episode of care
*Supplies and equipment (e.g., diabetic supplies, casts, etc.) that are provided during the episode of care
Note: If supplies and/or equipment are provided thereafter, the jail/prison authorities have this responsibility. If a provider files a claim for services not covered under the TennCare for Prisoners program, the claim will be denied XNN.

My practice is a walk-in clinic, but we have a provider that's going to start primary care. I need a training class for my provider and for myself (RHIT). Could you suggest a seminar or online class?
Please reach out to your assigned Provider Network Manager to set something up.

We file 96127 and 96110 with the child wellness visit but we're not being paid. Are these for reporting only or am I filing incorrectly?
Please see the section on the Developmental Screening Code in the BlueCare Tennessee PAM: 508C BlueCare Tennessee Provider Administration Manual at provider.bcbst.com. You may also submit an inquiry via the Availity portal.

Is there a list of select plans for the $0 copay?
Yes. Please visit this **link.**

Is the PAF billed under 96160?
Please refer to page 343 in the Provider Administration Manual.

When I send messages through Availity, the only response I receive is often a generic response thanking us for using the messaging system before closing out the messaging thread without providing an answer. Upon review with a rep, I determined that the reps thought they were providing answers. Is BlueCross aware of this glitch, and if so, what steps have been taken to resolve this?
We can share this example with our Operations teams to ensure they are aware of the issue.

Are you reporting that the AWV has been completed to Medicare or where can we find that information?
Yes, we report this to CMS.

We are a MAT Provider. Our office needs a specific billing code for alcohol counseling, and the code we used was denied.
Please reach out to your assigned Provider Network Manager with claim examples and they can help you.

Is the Medicare Advantage Population Health Program only for current Medicare patients and NOT Medicaid patients?
Yes, the Population Health Program covered during the 2023 All Blue Workshop is only for Medicare Advantage.

Should our BlueCard claims be paid according to our BlueCross BlueShield Tennessee provider agreement?
The Local Plan applies pricing and reimbursement rules consistent with provider contractual agreements. The member's Home Plan adjudicates the claim based on eligibility and contractual benefit. Provider payable claims will be paid by the Local Plan based on the provider's contract and are subject to the member's benefit plan.

We have a PPO plan in Mississippi that will not pay as in-network for our services rendered in Tennessee. We have billed to BlueCross BlueShield of Tennessee, but the Mississippi plan will not adhere to the PPO policy for BlueCard.
Please contact your Provider Network Manager for claim specific issues.

BlueCross BlueShield of Tennessee will reimburse providers for BlueCard claims submitted according to the BlueCross BlueShield of Tennessee claims filing guidelines when:
- The member is eligible for benefits.
- The services are covered under the member's plan.
- The provider hasn't already been paid for the services.

*The Home Plan determines what services are considered eligible under the member's plan including all medical policy determinations (e.g., medical necessity, investigational, routine, etc.).

Are members responsible for their own prior authorizations for BlueCard?
You should remind patients that they are responsible for obtaining pre-certification/preauthorization for outpatient services from their BCBS Plan. Participating providers are responsible for obtaining preservice review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility, in BCBST PAM). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:
1. 48 hours to notify the member's Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

*Each BlueCross and/or BlueShield Plan determines its medical policies related to prior authorization requirements. Home Plans may require prior authorization based on the type of service or location of service. The services requiring prior authorization may vary from those determined by BlueCross BlueShield of Tennessee.

Providers may elect to verify any prior authorization requirements via telephone or by utilizing Availity, BlueCross BlueShield of Tennessee's secure area on its website, provider.bcbst.com, or by utilizing the Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization router tool bcbst.com/providers/router/bcbsa_router.html

We have multiple incidents where we haven't been paid per our BCBST contract for our ASC - denying implants. When we appeal and it's upheld by the Home Plan, BCBST says they cannot override the Home Plan. This is contrary to our understanding of BlueCard.
In these cases, all involved providers should reach out to their Provider Network Manager for claim specific issues.
BlueCross BlueShield of Tennessee will reimburse providers for BlueCard claims submitted according to BlueCross BlueShield of Tennessee guidelines when:
- The member is eligible for benefits.
- The services are covered under the member's plan.
- The provider hasn't already been paid for the services.

*The Home Plan determines what services are considered eligible under the member's plan including all medical policy determinations (e.g., medical necessity, investigational, routine, etc.).

The contiguous county program is NOT working. Anthem continually denies the claims. BlueCross will pay and then recoup. We have claims going back to January 2022 that are still not processed.
For specific claim issues please reach out to your Provider Network Manager. For billing guidelines for services rendered in the overlapping service area, please see pages 275 – 276 in our Commercial Provider Administration Manual here.

Are patients with Anthem plans also responsible for obtaining their own authorizations, as mentioned in the BlueCard authorization slide?
Each BlueCross and/or BlueShield Plan determines its medical policies for prior authorization requirements. Home Plans may require prior authorization based on the type of service or location of service. The services requiring prior authorization may vary from those required by BlueCross BlueShield of Tennessee.
Providers may choose to verify any prior authorization requirements via telephone or with Availity. Providers can also do this with our Inter-Plans Medical Policy and Pre-Certification/Pre-Authorization router tool on provider.bcbst.com.

What if we are contracted in Tennessee, the member is in Tennessee, but the member's home plan is in a state where we're not contracted (Michigan, for example). Would this member be eligible for services in TN?
For specific claim issues please reach out to your Network Manager. For billing guidelines for services rendered in the overlapping service area, please see pages 275 – 276 in our Commercial Provider Administration Manual here.

We have BlueCarePlus members that are attributed to our facility but are not patients in our facility. How do we get them removed from our attribution list? Their gaps in care are negatively affecting our quality scores.
You can email a list to IO at BlueCarePCP_GM@bcbst.com.

Why does a provider in an outpatient Behavioral Health organization require hospital admitting privileges?
Admitting privileges aren't required for professional counselors or psychologists - clinical or clinical child and adolescent psychologists (this includes psychologists and psychoanalysts).

I have a provider with the correct address in CAQH but their real time claims adjudication address is wrong. How do I update that address?
Please review CAQH and Availity information to confirm they match. You may also contact Provider Service at 1-800-924-7141 (option 2 for) further assistance.

Will we have access to the CAQH information in the presentation to share with others?
Yes. You're free to share the presentation with those who couldn't attend the workshop. You can download it by logging in to Availity and visiting the Resources tab in our Payer Spaces or by visiting the All Blue Workshop page on provider.bcbst.com. If you have trouble downloading the presentation, your Network Manager can help you.

Can we bill concurrently for SLP and OT for any of these codes?
For specific claim issues please reach out to your Provider Network Manager. You can also find more information about our billing guidelines in our Provider Administration Manual here.

Are codes for an LPC 90791 and 90834 required to have the HO modifier also, or a different modifier?
For specific claim issues please reach out to your Provider Network Manager. You can also find more information about our billing guidelines in our Provider Administration Manual here.

Will the rate increase for Behavioral Health providers apply to BlueCare or just Commercial BlueCross plans?
These increases only apply to our Commercial plans.

When we try to submit an auth on our BlueCard patients, the requests will not go through to the Home Plan. We have been trying for months.
Please submit BlueCard authorization requests through Availity under the **Patient Registration** tab: Click **Patient Registration > Authorizations & Referrals > Authorization Request**. Please note that the type of electronic authorizations allowed depends on the BlueCard Home Plan. Please contact your eBusiness Marketing Consultant for more information.

Where can we find the reason for claim denial on the remittance advice in Availity? Some sites only show us what was denied, not why the claim was denied.
This information can be found in Availity in the **Claims & Payments Remittance Viewer** under the **Service Line Information Claim Adjustment Section.**

You can also refer to the last page of your remittance advice by visiting the **Remittance Advice Notes Explanation Page** in our **Payer Spaces,** under **Print/View Your Remittance Advice.** Please contact your eBusiness Marketing Consultant for more information.

When we message BlueCross, we don't usually get a response. Is there a reason this isn't monitored (per your customer service reps)?
We appreciate your utilizing our digital messaging feature in Availity. We do our best to make sure we respond to all messages as quickly as possible. We have updated our back-end reporting as an additional step in the checks and balances process. If you continue to have these types of issues, please contact our eBusiness team at (423) 535-5717 (option 2) with specific examples.

How do we submit authorizations for imaging or sleep study with BlueCross Sapphire?
Imaging authorization requests for our Medicare Advantage members should be submitted through Availity. Visit our **Payer Spaces** and navigate to **Authorization/Advance Determination Submission** and then **NIA - Magellan**.

For sleep study authorizations, visit our **Payer Spaces** and navigate to **Authorization/Advance Determination Submission** and then **Outpatient.** Please contact your eBusiness Marketing Consultant for more information.

Are there plans to add the following capabilities to Availity for Medicare Advantage: checking prior authorization status and appeal status, reconsiderations and disputes, uploading records and pulling overpayment letters.
We're sorry but these capabilities are not currently available but we're looking at adding these enhancements in the future. Please contact your eBusiness Marketing Consultant for more information.

Why isn't the Behavioral Health fee schedule in Availity?
Behavioral Health fee schedules are available in Availity. If you can't locate them, please reach out to your Behavioral Health Network Manager for assistance.

How can we request more detailed reasons for claims denials in Availity?
Enhancement requests can be submitted by clicking the **Give Feedback** button in Availity. Be sure to include a detailed request with the transaction number in your feedback. Please contact your eBusiness Marketing Consultant for more information.

Is there a time limit as to when BlueCross can recoup?
In general, Commercial, Home and Host plans have 18 months from the claim paid date limit to recoup funds. BlueCare is two years plus the current year. A few exclusions/exceptions do apply. For more information, or line of business specific questions, please reach out to your assigned Network Manager.

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