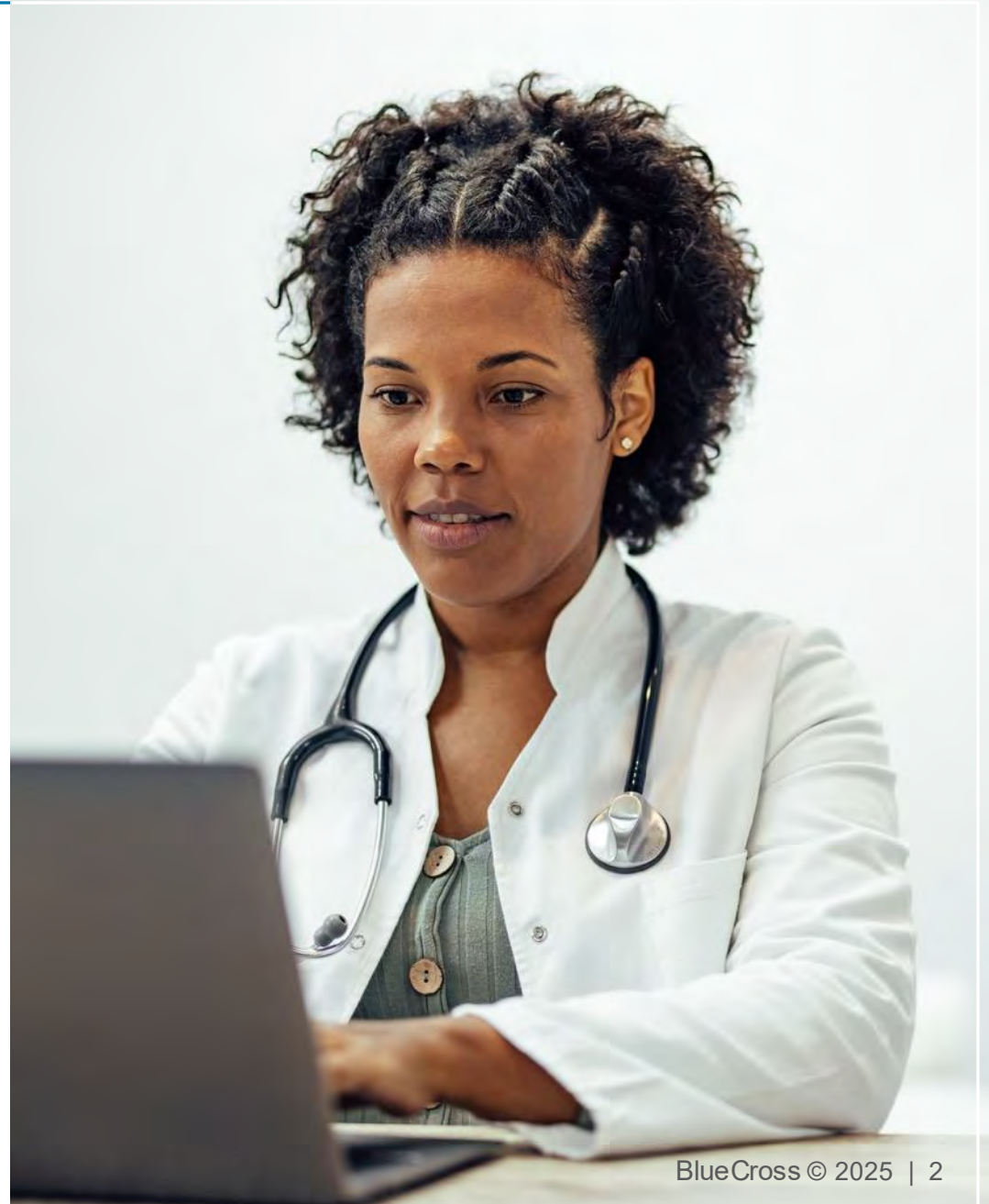


Welcome 2025 All Blue WorkshopSM



To get credit for attending today, please email
your name, group/provider and Tax ID to
ABW_QA_feedback@bcbst.com





BLUECARE TENNESSEE



ALL Blue 2025

BlueCare Tennessee

Promoting Well-Child Care

- › Well-Child rates remain low in several areas of Tennessee, especially in rural and underserved communities in the Middle and West regions.
- › Since COVID-19, fewer children are getting well-child visits—and screening rates drop sharply during the teen years.
- › These missed visits mean missed opportunities to detect developmental, behavioral, and physical health issues early.
- › BlueCare Tennessee members often face higher health risks and rely on regular checkups to stay healthy.
- › We need your help encouraging families—especially those with teens—to schedule annual screenings.

EPSDT Components

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits have seven components:

- › Comprehensive health and developmental history
- › Comprehensive unclothed physical exam
- › Hearing and vision screening
- › Age-appropriate developmental/behavioral screening
- › Lab tests/procedures
- › Immunizations
- › Health education

Assess Your Patients' Development at Key Ages

In addition to regular hearing and vision assessment, screening recommendations related to healthy development include:

- › Developmental screening at ages 9, 18 and 30 months
- › Autism spectrum disorder screening at ages 18 and 24 months
- › Behavioral/social and emotional screening at each wellness exam, from the newborn visit to age 21

When scheduling EPSDT visits, let parents and guardians know if their child will be getting a developmental screening at their upcoming visit and discuss the importance of these services.

Supporting Children's Health and Development

Tennessee Early Intervention System (TEIS)

If a child has a developmental delay or disability, TEIS offers therapy, family training, and service coordination for infants and young children under age 3.

Call: **1-800-852-7157**

WIC (Women, Infants, and Children Program)

WIC provides nutrition education, breastfeeding support, and healthy food benefits to pregnant women, infants, and children under age 5.

Call: **1-800-DIAL-WIC (1-800-342-5942)**

TennCare Free Diaper Benefit

TennCare now covers up to 100 diapers per month for children under age 2. This benefit helps reduce financial stress and supports infant health.

TennCare Connect: **1-855-259-07011**

Supporting Children's Health and Development (cont.)

Tennessee Disability Pathfinder

A statewide resource hub that connects families to disability services including early childhood supports, therapy providers, educational help, and transportation.

Help Line: **1-800-640-4636**

Tennessee Community Compass

Community Compass is a centralized online tool that connects families with nearby food assistance, housing, mental health care, transportation, childcare and more.

Call: **1-866-202-0684** for help navigating services

Review Our EPSDT Tool Kit

Our tool kit makes it easier for providers to find information about EPSDT and well-child care. It includes:

- › The American Academy of Pediatrics periodicity chart and coding information
- › Contact information
- › Best practices shared by providers across the state
- › Details about transportation and community outreach
- › An inside look at our claims processes



Find the Tool Kit Online

bluecare.bcbst.com/providers/BlueCare_EPSDT_Provider_Booklet.pdf

Transportation Benefits

TRANSPORTATION BENEFITS

What's Covered?

BlueCareSM and TennCare*Select* member benefits include transportation to and from the pharmacy and TennCare-covered services.*

- › This service option is available to patients at no cost.
- › Verida, our transportation vendor, is open 24 hours a day, seven days a week.
- › Transportation options may include a bus pass, shared ride or mileage reimbursement.
- › In most cases, patients must schedule their transportation two business days before their appointment.

* **Note:** CoverKids and TennCare*Select* / QMB only members **don't** have transportation benefits.

TRANSPORTATION BENEFITS

Scheduling Transportation

BlueCare

Our members can call Verida at **1-855-735-4660** or use the online portal at: member.verida.com.

Providers scheduling transportation on their patient's behalf can use the facility portal at: facility.verida.com.

TennCareSelect

Our members can call Verida at **1-866-473-7565** or use the online portal at: member.verida.com.

Providers scheduling transportation on their patient's behalf can use the facility portal at: facility.verida.com.

Maternity Provider Incentives



Type of Visit	Prenatal	Postpartum	Mental Health Screening
Timeframe for visit	During the first trimester of pregnancy or within 42 days of the patient's BlueCare Tennessee or CoverKids enrollment	Within seven to 84 days of delivery	At least once during the perinatal period using a standardized tool for depression and anxiety
Steps to Receive Payment	<p>Bill the visit using category II code 0500F, and please remember to:</p> <ul style="list-style-type: none">• Include the appropriate Evaluation & Management (E&M) Code (99202-99205 or 99211-99215) confirming pregnancy.* <p>*In situations where the provider billing 0500F didn't perform a separate visit to confirm the pregnancy and the prenatal profile was started on the first visit, the provider may bill the appropriate E&M codes at \$0.00 charges. This step will show there wasn't a separate visit for confirmation only prior to beginning the prenatal profile and the provider is simply following the rules for billing the code.</p> <ul style="list-style-type: none">• Submit your Maternity Care Management Form online through Availity. Note: You must submit the Maternity Care Management Form within 30 days of the prenatal visit.• Bill the \$25 fee associated with 0500F.	<p>Bill the visit using category II code 0503F, and please remember to:</p> <ul style="list-style-type: none">• Include the postpartum code 59430.• Bill the \$75 fee associated with 0503F. <p>Note: We'll allow for reimbursement of two claims for code 0503F during the 84-day postpartum period.</p>	<p>Bill CPT® 96160 with a TH modifier to show you completed the service, and please remember to:</p> <ul style="list-style-type: none">• Bill the \$28.35 payment for performing this screening. <p>Note: No specific diagnosis code is required for payment.</p>
Reimbursement	\$25 per patient	\$75 per patient/per claim	\$28.35 per patient

Maximizing Disability Benefits

Disability Benefit Qualification

> Adults

- The adult must have the inability to do any substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment that is expected to last for a continuous period of 12 months or longer or expected to result in death.



Different Types of Benefits

Supplemental Security Income (SSI) is for children and adults without a work history.

Social Security Disability Insurance (SSD or SSDI) is for adults with a work history.

The Social Security Administration (SSA) **does not** grant partial or short-term disability benefits.

Disability Benefit Qualification

› Children

- The child must have a physical or mental condition, or a combination of conditions, that results in “marked and severe functional limitations.” This means that the condition(s) must very seriously limit a child’s activities. The child’s condition(s) must have lasted or be expected to last at least 12 consecutive months or must be expected to result in death.



Different Types of Benefits

Supplemental Security Income (SSI) is for children and adults without a work history.

Social Security Disability Insurance (SSD or SSDI) is for adults with a work history.

The Social Security Administration (SSA) **does not** grant partial or short-term disability benefits.

Accessing These Benefits

BlueCare has partnered with Centauri to support our members through the application process.

- › Service is free for BlueCare and Katie Beckett members.
 - TennCare*Se/ect*, CoverKids, and CHOICES/ ECF CHOICES members are not eligible for Centauri.
- › If the member is approved, they can receive up to \$967 a month in extra income.
- › Refer your patients by emailing BlueCareReferralRequest@bcbst.com.

REPRESENTATION IN SSA PROCESS

- Application submission
- Schedule SSA appointment
- Adjudication of claim
 - Collection of supporting evidence
 - Consultative Exam
- Claim decision
- Appeal (as appropriate)
- Reconsideration submission
- Representation at Administrative Law Judge level

Benefits Reminder: Lactation Consultant Services

LACTATION CONSULTANT SERVICES

Member Benefit

As of June 1, 2023, lactation consultant services are covered through patients' Medicaid and CoverKids benefits during pregnancy and postpartum. Providers in our network may bill for outpatient lactation services.

- Claims for lactation services should include the appropriate CPT® codes and modifiers:
 - 98960 U8 (single individual per 30 min.)
 - 98961 U8 (2-4 patients per 30 min.)
 - 98962 U8 (5-8 patients per 30 min.)
- Please also use the appropriate number of units to signify the length of the visit.

Benefits Reminder: Adult Dental Benefits

DENTAL BENEFITS

Dental Care Eligibility

As of Jan. 1, 2023, TennCare covers dental services for members of all ages.*

- › Adults who are pregnant or have recently given birth have the same benefits as other adults.
- › Those enrolled in Employment and Community First CHOICES will continue to get supplemental covered dental benefits for waiver members.
- › DentaQuest manages dental benefits for our members. You can verify member eligibility through DentaQuest's member portal here: govservices.dentaquest.com/.

* Adults enrolled in CoverKids don't have dental benefits. Only CoverKids members under age 19 have dental benefits.

DENTAL BENEFITS

Covered Services

Covered dental services include:

- › Regular exams
- › Cleanings
- › Fillings
- › Crowns
- › Other medically necessary services



Connect Your Patients

To help your patients with BlueCare Tennessee coverage find a dentist participating with their plan:

Visit dentaquest.com and select **Find a Provider**.

DENTAL BENEFITS

Upcoming Changes

TennCare will have a **new Dental Benefits Manager** effective Nov. 1, 2025.

- › Starting Nov. 1, contact Renaissance customer service at **1-866-864-2526**.

Case Management Referrals in Quality Care Rewards

Case Management Referrals

Primary care providers can leverage the Quality Care Rewards (QCR) application in Availity to refer patients enrolled in BlueCare Tennessee and CoverKids for care management services.

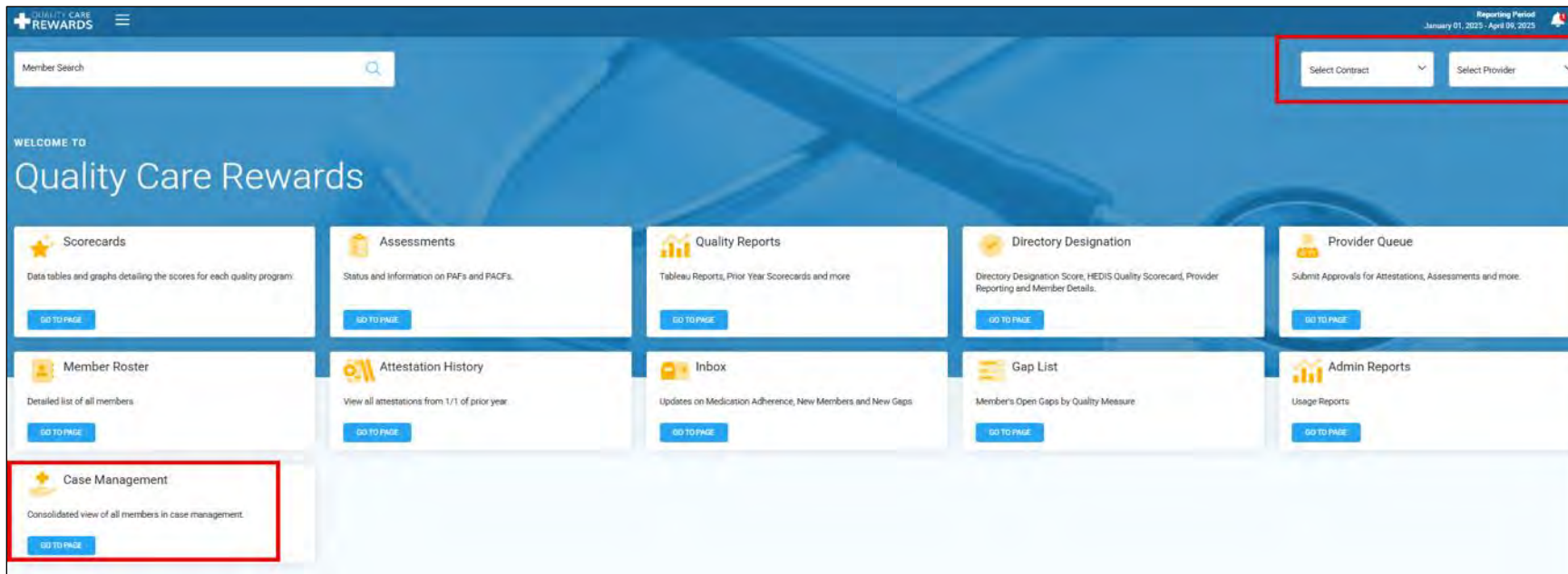
Care Management supports include:

- › Comprehensive support to patients, including condition management.
- › Access to community-based resources.
- › Facilitation of service access such as specialist appointments, durable medical equipment, and home health.
- › Enhancement of patient knowledge and compliance with treatment.
- › Discharge planning.
- › Medication management.
- › Help locating contact information for member outreach.

AVAILITY QUALITY CARE REWARDS

Initiating a Referral

To initiate a referral, navigate to the Availity home screen and select contract or provider and the Case Management tab.



Resources

You can find the **BlueCare Tennessee and CoverKids Quality Care Rewards User Guide** in the **Resources** section of the QCR application.

If you have questions or would like to schedule training for your practice, please contact your eBusiness Regional Marketing Consultant.

Middle TN

Faye Mangold

Faye_Mangold@bcbst.com

[\(423\) 535-2750](tel:(423)535-2750)

West TN

Vivian Williams

Vivian_Williams@bcbst.com

[\(901\) 544-2622](tel:(901)544-2622)

East TN

Faith Daniel

Faith_Daniel@bcbst.com

[\(423\) 535-6796](tel:(423)535-6796)

Behavioral Health

New Programs

New and expanded behavioral health services include:

- › Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment (BESMART)
- › Continuous Treatment Team (CTT)
- › Comprehensive Child and Family Treatment (CCFT)
- › Family Intervention Treatment Team (FITT)
- › Infant and Early Childhood Mental Health (IECMH)
- › Intensive Care Coordination (ICC)
- › Specialized Child and Family Treatment (SCFT)
- › Supported Housing (Enhanced, Medically Fragile, Specialized)

Discharge Summaries Available in Availity

Save time by adding discharge summaries directly in Availity.

- › Go to **Payer Spaces**.
- › Select the **Authorization Submission Review** application.
- › Select **Auth Inquiry/Clinical Update** and open the existing authorization.
- › Go to the **Clinical Update** section at bottom of page.
- › Add **Discharge** information.

For more information:

- › Please contact your eBusiness Regional Marketing Consultant for your Availity questions or training needs.

Why it matters

- › Streamlines follow-up care
- › Ensures continuity of care
- › Reduces potential readmissions

New UM Authorization Management Requirements Coming Jan. 1, 2026

Starting in 2026, health insurers will be required to respond to urgent prior authorization requests within 72 hours and standard (non-urgent) requests within seven calendar days. This change aims to reduce wait times and improve access to necessary medical care.

For providers, this change will streamline prior authorization workflows, allowing for a more efficient and transparent process overall. It's imperative that providers follow the guidance on the next slides so the MCO's ability to make a timely medical necessity decision isn't impacted.

New UM Authorization Management Requirements Coming Jan. 1, 2026 (cont.)

› **Comprehensive Documentation:**

- Ensure all relevant clinical information is included, such as detailed patient history, treatment plans, and progress notes.
- Clear justification: Provide a clear rationale for the requested services, highlighting the medical necessity and expected outcomes.

› **Use BlueCare Request forms** to ensure you have all the needed information included in your request. You can always include additional records upon submission if necessary.

New UM Authorization Management Requirements Coming Jan. 1, 2026 (cont.)

› **Compliant order for treatment:**

- Legibly signed by MD and/or independently licensed clinician depending upon the level of care to include credentials
- Signature can be “wet or electronic”
- Dated timely in relation to the services being requested

› **Timely Communication:** Maintain regular communication with MCOs to address any questions or additional information requests promptly.

BEHAVIORAL HEALTH

Behavioral Healthcare in Pediatrics (BeHiP)

- › BeHiP is a collaborative training program with the Tennessee Chapter of the American Academy of Pediatrics. It gives pediatric providers tools and strategies for screening, assessing and managing patients with behavioral health and substance use disorders.



Behavioral Healthcare in Pediatrics (BeHiP) (cont.)

- › In 2024, **448** pediatric providers received training at **24** events and through online modules.
 - **202** providers earned CME credits via 8 online modules.
 - **112** total providers specialty-trained as Foster Care Medical Home (FCMH) providers in 2024.
 - **6,683** total providers trained by BeHiP since 2012 inception.
 - **11** video conferences completed with **134** collaborative participants in the Northeast and East regions of Tennessee.

Behavioral Healthcare in Pediatrics (BeHiP) (cont.)

- › Online modules, as well as virtual and in-person training, are available. Free CME credits are awarded upon completion.
- › For more information, visit tnaap.org and select **BeHiP** under the **Programs** tab.

BEHAVIORAL HEALTH

Provider Resources

BlueCare Tennessee Provider Page:

bluecare.bcbst.com/providers

Behavioral Health Provider Page:

provider.bcbst.com/working-with-us/behavioral-health

Find Your Provider Network Manager:

provider.bcbst.com/contact-us/my-contact

Telehealth Guide:

[bcbst.com/docs/providers/quality-initiatives/BlueCare Tennessee Telehealth Guide.pdf](https://bcbst.com/docs/providers/quality-initiatives/BlueCare_Tennessee_Telehealth_Guide.pdf)

Behavioral Health Case
Management/Peer Support:

1-888-416-3025

Tennessee Redline:

1-800-889-9789

Tennessee Statewide Crisis Phone Line:

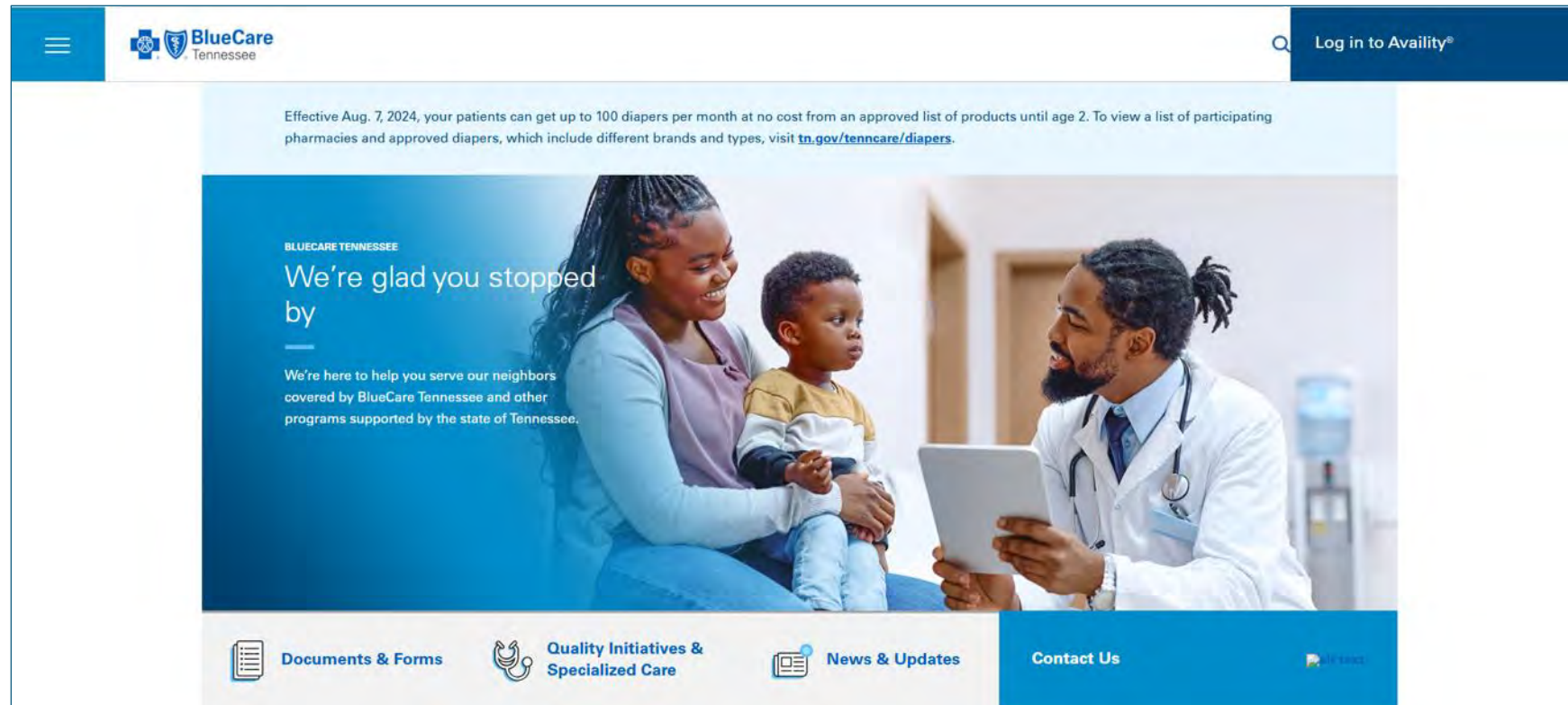
1-855-274-7471 or 988

Tennessee Child and Adolescent
Psychiatry Education and Support (TCAPES):

1-833-281-5020

BlueCare Website: Provider Administration Manual (PAM)

BlueCare Tennessee for Providers



Provider Administration Manuals

The following can be located on the BlueCare website (bluecare.bcbst.com)

- › Prior Authorization lists for Medical and Behavioral Health, High-Tech Imaging and Specialty Pharmacy.
- › FAQs – TN Medicaid number requirement and how to obtain a TN Medicaid number.
- › 12-Month Inactivity Report



Requirement Reminders

- › Monthly Screening/Federal Exclusion Screening
- › Out-of-Network Referrals
- › Non-discrimination Compliance Training
- › Abuse, Felony and Sexual Offender Registry Screening
- › Ownership and Control Disclosure (OWDC)

When a Provider May Bill a TennCare Enrollee

TennCare providers. Providers who are registered with TennCare and who accept some form of TennCare reimbursement for their services. Examples of TennCare providers include the following:

- Providers enrolled with a TennCare Managed Care contractor (a Managed Care Organization, the Pharmacy Benefits Manager, the Dental Benefits Manager)
- Providers who are not enrolled with a TennCare MCC but who furnish services under single-case agreements with TennCare MCCs
- Providers who deliver emergency services to TennCare enrollees
- Providers of Medicare crossover services
- Providers of services in one of TennCare's Home and Community Based Services waivers

[Click here for the full policy on When a Provider May Bill a TennCare Enrollee](#)

CIRCUMSTANCES WHEN A TENNCARE PROVIDER MAY BILL A TENNCARE ENROLLEE:

TennCare's payment, when combined with any applicable TennCare copays, is considered "payment in full." By agreeing to participate in TennCare, a provider agrees to accept TennCare's payment as payment in full. See Rules 1200-13-13-.08(1) and 1200-13-14-.08(1).

Applicable copays. Certain services have copays for some enrollees. The list of copays and the groups of TennCare enrollees to whom they apply is provided in the table below. However, it should be noted that providers cannot refuse services because of an enrollee's failure to make a copay.¹

Non-covered services. When the service the provider is furnishing is not covered by TennCare, and the provider has informed the enrollee that the service is non-covered before providing the service, the provider may bill the enrollee. A service may be non-covered for one of three reasons:

Financial responsibility statements. In order for a provider to document that he properly informed an enrollee that a service is "non-covered," he may choose to use a financial responsibility statement.

Financial responsibility statements must be written at no higher than a 5th grade level, as measured by the Fogg index, the Flesch Index, the Flesch-Kincaid Index, or other recognized readability instrument. The statement must be signed by the enrollee. There must be two copies—one retained by the provider and one given to the enrollee.

Subcontracting

SUBCONTRACTING

Helpful Reminders

1

Providers and vendors who participate in the BlueCare and TennCare*Select* networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee.

2

BlueCare Tennessee providers and vendors must submit the BlueCare Tennessee Subcontracting Request Form along with the signed agreement located on **bluecare.bcbst.com/providers** to request approval for all subcontracts.

3

BlueCare Tennessee providers will submit these requests to
TennCare_Provider_Subcontracts@bcbst.com

4

BlueCare Tennessee vendors will submit requests to **Vendor_Relations_GM@bcbst.com**

5

A subcontract is for the purpose of providing TennCare covered services, and our BlueCare Tennessee Integrity Dept. must review these requests and provide written approval.

6

Our Integrity team needs to ensure the contract meets CMS requirements. The requirement is for the provider to obtain written approval from each participating MCO.

SUBCONTRACTING

2025 BlueCare Tennessee Required Training

G. Subcontracting

Prior Approval

Providers and Vendors who participate in the BlueCare and TennCareSelect networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior approval, claims for services provided by the subcontractor could be denied and previous payments could be subject to recoupment.

BlueCare Providers and Vendors shall submit the BlueCare Subcontract Request Form along with the signed Exhibit: EXHIBIT [X] DOWNSTREAM/SUBCONTRACTING PROVIDER COMPLIANCE WITH REQUIREMENTS OF BLUECARE TENNESSEE PROVIDER AGREEMENT located on BCBST.com to request approval of all subcontracts. The subcontractor Request Form is located at the following link:

[Forms | Providers | BlueCare Tennessee \(bcbst.com\)](#)

BlueCare Providers will submit these requests to TennCare_Provider_Subcontracts@bcbst.com

BlueCare Vendors will submit these requests to Vendor_Relations_GM@bcbst.com.

Fraud, Waste and Abuse Training

In addition, Deficit Reduction Act/Fraud Waste and Abuse training shall be provided to the employees of subcontractors supporting the BlueCare Tennessee contract. The date the training was provided as well as the attendees should be documented.

Exclusion Screening

BlueCare Tennessee Providers/Vendors must also require that their subcontractor screen all employees prior to hiring and every month after hiring against the federal exclusion OIG List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) databases. The results of the screenings should be documented.

Source: BlueCare Tennessee Provider Administration Manual

SUBCONTRACTING

2025 BlueCare Tennessee Required Training (cont.)

Quick Links	Office Administration
Administrative Information	<ul style="list-style-type: none">• Apply for a Medicaid ID• Care Management Contacts• Claim Status Check Form• Community Outreach Referral Fax Form• Home Health Missed Visit Form• Optum Provider Claim Review (PCR) Reference Sheet• Overpayment Information• Provider Subcontracting Exhibit• Provider/Vendor Subcontracting Form• TennCare Provider Registration
Authorizations and Appeals	
Behavioral Health	
Coverage and Claims	
Current Lab Testing Policies	
Manuals, Policies & Guidelines	
Long-Term Services and Supports (LTSS)	
Quality Care and Tennessee Health Care Innovation Initiatives	
Specialty Care	Patient Administration
Required Training & Health Equity	
Division of TennCare Announcements, Memos & Resources	School-Based Forms
News & Updates	

The BlueCare *Subcontracting Request Form* and *Provider Agreement* can be found at the following locations under [Documents & Forms – Administrative Information](#) of our website:

- › [508C Subcontracting Request Form \(bcbst.com\)](#)
- › [508C Exhibit \[X\] Downstream/Subcontracting Provider Compliance with Requirements of BlueCare Tennessee Provider Agreement \(bcbst.com\)](#)

Member PCP Assignment in Availability

Changing PCP Assignment in Availity

We've developed this application to make our PCP assignment process more efficient and improve the turnaround time on requests.

- › The BlueCare PCP Change Maintenance Application is intended to replace the PCP change form process outlined in our Provider Administration Manual. You can find it in Availity Payer Spaces.
- › The application launched May 1, 2023.

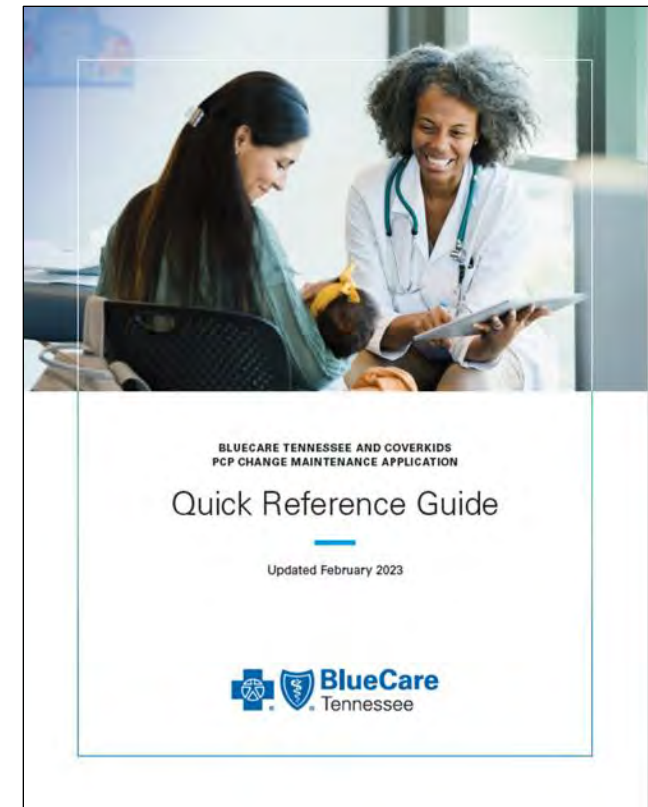
Using the application:

- › Updates are made in real time.
- › Once you submit a PCP change, you'll see the patient in your assigned member roster, and your patient will be able to access their updated digital ID card in our BCBSTNSM mobile app. A new Member ID card will also be mailed to your patient automatically.

Review Our QRG for Step-by-Step Instructions

You can find the BlueCare Tennessee and CoverKids PCP Change Maintenance Application Quick Reference Guide (QRG) in the Resources section of Availity Payer Spaces.

If you have questions or would like to schedule training for your practice, please contact your eBusiness Regional Marketing Consultant. You can find the name of your contact [here](#).



CAQH & Data Verification

DATA VERIFICATION PROCESS

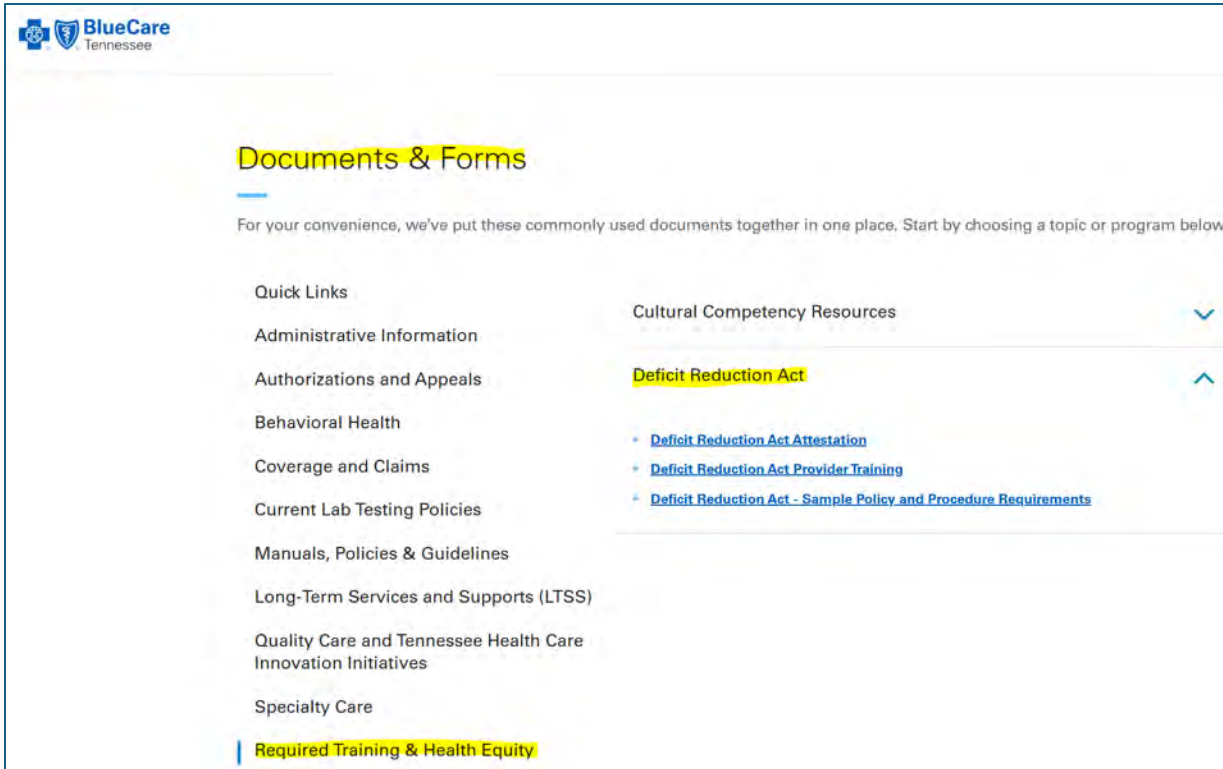
CAQH

Review of the Council for Affordable Quality Healthcare® (CAQH) and Data Verification Forms

- › Be sure CAQH ProView is current. This is a requirement for credentialing, re-credentialing and maintaining network participation.
- › Keep state licensure current and keep track of expiration dates.
- › You will need to visit the CAQH website each quarter to attest your information is up to date for each provider and location.
- › If either of these numbers expire it will result in network termination. Providers would then need to reapply via Provider Enrollment to request network participation.

Deficit Reduction Act, Fraud and Abuse

2025 BlueCare Required Training



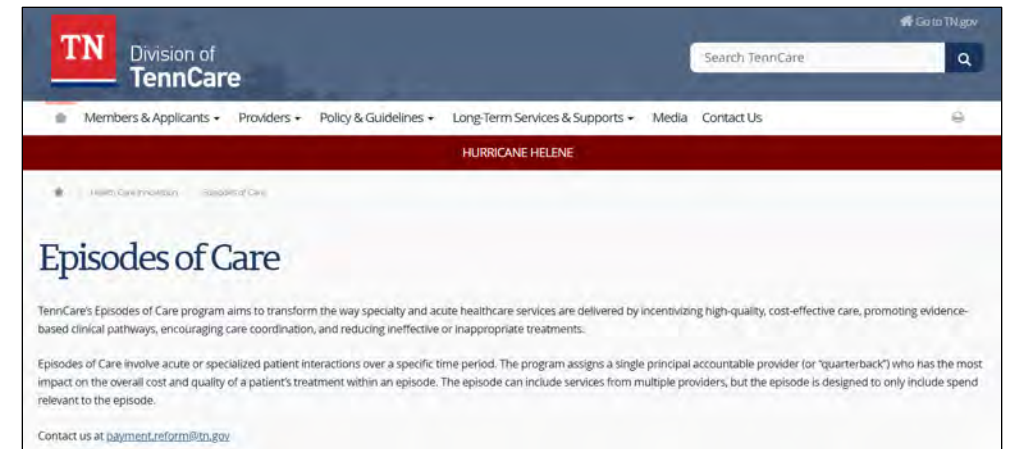
<https://bluecare.bcbst.com/providers/tools-resources/documents-forms>

- › [Deficit Reduction Act Attestation](#)
- › [Deficit Reduction Act Provider Training](#)
- › [Deficit Reduction Act - Sample Policy and Procedure Requirements](#)

Tennessee Health Care Innovation Initiative (THCII)

2025 BlueCare Required Training

- › In February 2013, the State of Tennessee launched a state-wide initiative, Tennessee Health Care Innovation Initiative (THCII), to begin transitioning its TennCare health care payment system to an episode-based payment system that rewards patient-centered high-quality care, promotes the use of clinical pathways and evidence-based guidelines, encourages coordination, and reduces ineffective and/or inappropriate care.



2025 BlueCare Required Training (cont.)

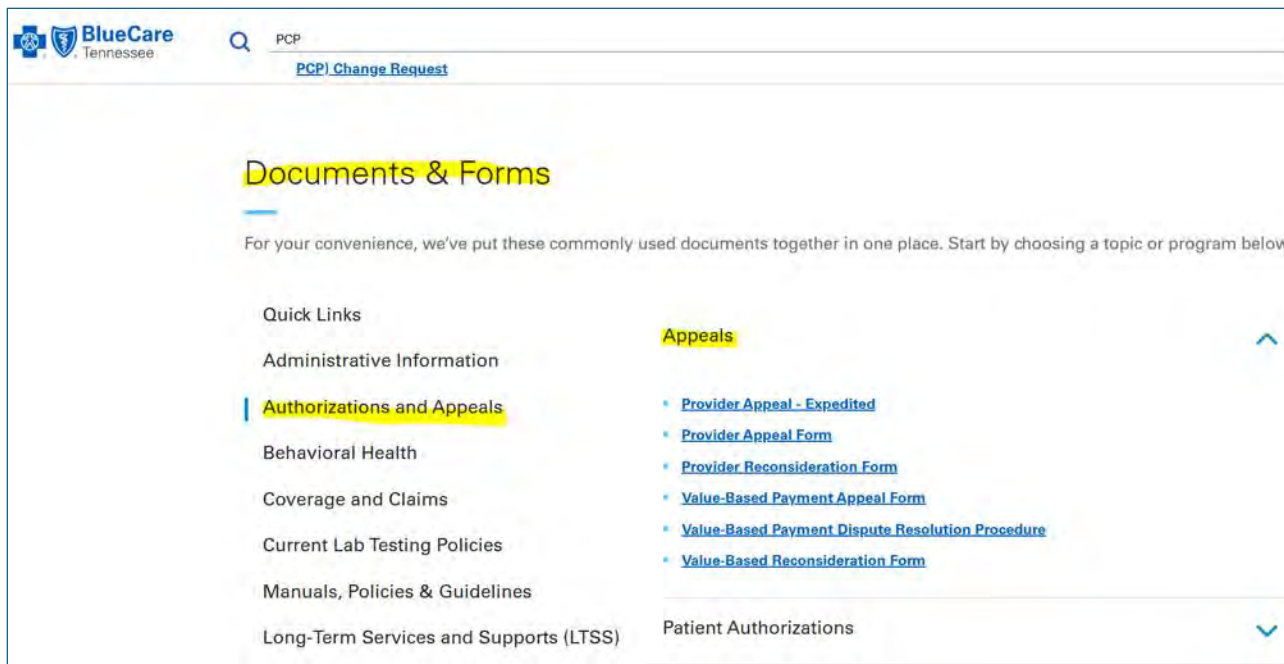
- As of 2020, the Episodes of Care program has 48 episodes in performance. Each Wave includes a specific number of episodes of care as assigned by the State of Tennessee. To see each Wave and the episodes of care within each Wave, please go to the State of Tennessee website at <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html>.
- To help you learn more about the Tennessee Health Care Innovation Initiative, we developed Frequently Asked Questions and a Provider Guide that can be accessed on the Provider page on the company websites at <https://bluecare.bcbst.com/providers/quality-care/thcii.html> and <http://www.bcbst.com/providers/episode-of-care.page>.

2025 BlueCare Required Training (cont.)

- › Episodes of Care reports are available on Availity, BlueCare Tennessee's secure web portal. Just log on and scroll to the link "Tennessee Health Care Innovation Initiative." Select the reporting period and line of business to review. Providers can also find more information on the State of Tennessee's website at <http://www.tn.gov/tenncare/section/health-care-innovation>.

Authorizations and Appeals

Authorizations & Appeals



BlueCare Tennessee

PCP

[PCPI Change Request](#)

Documents & Forms

For your convenience, we've put these commonly used documents together in one place. Start by choosing a topic or program below.

Quick Links

- Administrative Information
- Authorizations and Appeals**
- Behavioral Health
- Coverage and Claims
- Current Lab Testing Policies
- Manuals, Policies & Guidelines
- Long-Term Services and Supports (LTSS)

Appeals

- [Provider Appeal - Expedited](#)
- [Provider Appeal Form](#)
- [Provider Reconsideration Form](#)
- [Value-Based Payment Appeal Form](#)
- [Value-Based Payment Dispute Resolution Procedure](#)
- [Value-Based Reconsideration Form](#)

Patient Authorizations

Patient Authorizations

- [Bariatric Surgery Authorization Request Form](#)
- [BlueCare Tennessee/CoverKids Prior Authorization List](#)
- [BlueCare Tennessee Medical Emergency Diagnosis Code List](#)
- [Complex Rehabilitation Technology DME Authorization Request](#)
- [Durable Medical Equipment Request Form](#)
- [High-Cost Lab Prior Authorization List](#)
- [High-Tech Imaging Prior Authorization List](#)
- [Initial Member/Caregiver Training Checklist](#)
- [MCG Site Guideline Transparency](#)
- [New Guidelines for Complex Rehabilitation Technology Repair](#)
- [Prior Authorization Request Form](#)
- [Private Duty Nursing/Home Health Plan of Care](#)
- [Private Duty Nursing Home Plan of Care Agreement](#)
- [Recertification Member/Caregiver Training Checklist](#)
- [Request Out of Network Benefits](#)
- [Skilled Nursing Facility and Inpatient Rehabilitation Fax Form](#)
- [Ventilator Weaning and Sub-Acute Tracheal Suctioning Request](#)

<https://bluecare.bcbst.com/providers/tools-resources/documents-forms>

Claims Reconsiderations and Appeals (PDRP)

CLAIMS RECONSIDERATIONS AND APPEALS

Provider Dispute Resolution Procedure (PDRP)

DESCRIPTION OF THE DISPUTE RESOLUTION PROCESS.

A. **INQUIRY/RECONSIDERATION.**

Providers should contact a representative of the BlueCare Tennessee division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g., the Claims Service Department if there is a question concerning a claims-related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Network Management Division for assistance in directing their inquiries to the appropriate BlueCare Tennessee representative. BlueCare Tennessee may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g., an office manager). If a party cannot respond immediately to the other party's inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

B. **APPEAL.**

If not satisfied, a party may submit a written appeal within sixty (60) days after receiving the other party's response to its inquiry/Reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/Reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

C. **BINDING ARBITRATION.**

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within sixty (60) days after it receives a response to its appeal. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Cultural Competency in Health Care

How Culture Affects Health Care

Culture shapes how people experience their world. It's a vital component of how health care services are delivered and received.

- › Sometimes, people from different cultures have different perceptions about illness and competent treatment.
- › People's perceptions of health care can influence clinical encounters and their willingness to take medication or have surgery. Acknowledging your patients' beliefs, perceptions about illness and self-care practices is an important part of delivering quality, culturally competent care.

Promoting Cultural Competency

Culturally competent health care begins with an awareness of your own cultural beliefs and practices and recognizing that people from other cultures may not share them. Validating and signaling an openness to social and cultural perceptions and expectations that differ from your own helps ensure people get the care they need to prevent, identify and treat health care problems.

Tips for Providing Culturally Competent Care

1

Support health literacy, especially for those with limited English proficiency. Communicate clearly, slow down the pace of the conversation and use plain language to explain information about conditions and treatments. Use an interpreter if necessary.

2

Ask open-ended questions and look for answers. The occurrence of acute and chronic medical conditions can vary among people of different ethnicities and cultures. Your observations and questions can help improve the quality of care and remove barriers in patients' health care.

3

Adapt service delivery. Moving toward culturally appropriate service delivery means being knowledgeable about cultural differences and sensitive, understanding, non-judgmental, and respectful in conversations with people whose culture differs from your own.

4

Make cultural knowledge a key part of your practice's policies and procedures. Please ensure employees are trained on appropriate communication methods.

5

Use the teach-back method. This involves asking people to repeat information you've shared in their own words and can help gauge their understanding of the discussion.

6

Consider involving extended family members in care planning, if appropriate. In many cultures, families are deeply involved in individual's medical decisions.

Note: Please make sure you have your patient's consent to discuss their health information with others.

Resources for More Information

- › Non-Discrimination Compliance Information for Providers: Learn more about relevant laws and regulations, language assistance planning, filing a discrimination complaint, and third-party resources.
- › Cultural Competency in Health Care Provider Guide: Review more about culture, health equity and how to deliver culturally competent care.
- › Quality Care Interactions training: We offer free access to this evidence-based training, which is accredited for up to one hour of CME, CEU or CCM credits.

Resources for More Information (cont.)

- › Learn more here:
bluecare.bcbst.com/forms/Provider%20Forms/Quality_Interactions_Cultural_Competency_Training.pdf
- › Find the training and guide in the **Provider Tools and Resources** section of bluecare.bcbst.com/providers.

BlueCare Plus Tennessee

What is a Dual Eligible Special Needs Plan (D-SNP)?

D-SNP is a special needs Medicare Advantage plan serving people who are eligible for both Medicare and Medicaid.







› Individuals are eligible for D-SNP if they:

- Live in the plan service area of Tennessee
- Have both Medicare Part A and B
- Are eligible for full Medicaid/TennCare benefits or Medicaid cost-sharing assistance under Medicaid/TennCare. This includes:
 - FBDE (Full Benefit Dual Eligible)
 - QMB+/Only (Qualified Medicare Beneficiary)
 - SLMB+ (Specified Low Income Medicare Beneficiary)

Member Benefits

2025 Changes			
Benefit	BlueCare Plus	BlueCare Plus Choice	BlueCare Plus Select
Transportation	150 supplemental legs	\$280 Combined Flex card allowance for: Supplemental Transportation OTC/Healthy Food	\$275 Combined Flex card allowance for: Supplemental Transportation OTC / Healthy Food Housing Utilities
OTC / Healthy Food	\$200 Combined Flex card allowance for: OTC / Healthy Food Housing Utilities		
Housing Utilities		\$100 Flex Card Allowance	
D E N T A L			
Routine / Preventative	\$0 Copay	Medicaid Benefit Only - Dentaquest	Medicaid Benefit Only - Dentaquest
Comprehensive	\$3000 Total Annual allowance \$1000 allowance on Major Restorative Services		
V I S I O N			
Routine Exam Glasses / Frames / Contacts	\$500 Annual Allowance includes: 1 Routine eye exam AND 1 Pair of glasses (Lens and Frames) OR Contact Lenses	\$500 Annual Allowance includes: 1 Routine eye exam AND 1 Pair of glasses (Lens and Frames) OR Contact Lenses	\$500 Annual Allowance includes: 1 Routine eye exam AND 1 Pair of glasses (Lens and Frames) OR Contact Lenses
H E A R I N G			
Routine Exam Hearing Aid Fitting	1 Routine Hearing Exam 2 Devices every 3 years	1 Routine Hearing Exam 2 Devices every 3 years	1 Routine Hearing Exam 2 Devices every 3 years

How Do I Identify a BlueCare Plus Tennessee Member?

BlueCare Plus	BlueCare Plus Choice	BlueCare Plus Select
 CHRIS B HALL Subscriber ID: ABCD12345678 Group No. 129884 Copayments: Office Visit \$0 Specialist Visit \$0 ER Visit \$0 Hospital Stay \$0 RXBIN 004336 RXPCN MEDDADV RXGRP RX76AD Issuer 80840 MedicareRx Prescription Drug Coverage	 CHRIS B HALL Subscriber ID: ABCD12345678 Group No. 129884 Copayments: Office Visit \$0 Specialist Visit \$0 ER Visit \$0 Hospital Stay \$0 RXBIN 004336 RXPCN MEDDADV RXGRP RX76AD Issuer 80840 MedicareRx Prescription Drug Coverage	 CHRIS B HALL Subscriber ID: ABCD12345678 Group No. 129884 Copayments: Office Visit \$0 Specialist Visit \$0 ER Visit \$0 Hospital Stay \$0 RXBIN 004336 RXPCN MEDDADV RXGRP RX76AD Issuer 80840 MedicareRx Prescription Drug Coverage
 An Independent Licensee of the BlueCross BlueShield Association Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider. Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare. Prior authorization required for admissions and other selected medical services. Report all emergency admissions within one working day. This card is for identification, not for proof of eligibility. Medical/Dental Tennessee Providers Submit Claims to: BlueCare Plus Operations 1 Cameron Hill Circle Ste 0002 Chattanooga, TN 37402-0002 CMS-H3259 749 (08/22)	 An Independent Licensee of the BlueCross BlueShield Association Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider. Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare. Prior authorization required for admissions and other selected medical services. Report all emergency admissions within one working day. This card is for identification, not for proof of eligibility. Medical/Dental Tennessee Providers Submit Claims to: BlueCare Plus Operations 1 Cameron Hill Circle Ste 0002 Chattanooga, TN 37402-0002 CMS-H3259 749 (08/22)	 An Independent Licensee of the BlueCross BlueShield Association Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider. Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare. Prior authorization required for admissions and other selected medical services. Report all emergency admissions within one working day. This card is for identification, not for proof of eligibility. Medical/Dental Tennessee Providers Submit Claims to: BlueCare Plus Operations 1 Cameron Hill Circle Ste 0002 Chattanooga, TN 37402-0002 CMS-H3259 749 (08/22)

2025 Member Incentives

Healthcare Service	2025 Incentive
Annual Wellness Visit (AWV)	\$50
Colorectal Cancer Screening (COL)	
-Sigmoid/Colonoscopy	\$50
-Fecal Occult Blood Test/FIT Kit	\$15
Breast Cancer Screening	\$25
Diabetic Retinal Eye Exam	
-Eye Care Professional	\$50
-Non-Eye Care Professional	\$15
Annual Health Needs Assessment (HNA)	\$25

Patient Assessment & Care Planning Form (PACF) and Interdisciplinary Care Team (ICT)

CMS requires all SNPs to coordinate the delivery of care through an exchange of ongoing communications across different providers and settings to ensure seamless care.

Servi ce	Code s	Coverage Notes	Amount
PACF	96160 96161	<ul style="list-style-type: none">Submitted once per calendar yearCompleted with the “Welcome to Medicare” Exam or AWW	\$155.00
ICT	99366 - 99368	<ul style="list-style-type: none">Completed and returned PACF, medical records, or conversations with the plan care coordination team, medication reconciliation post discharge inpatient stay	\$54.00

Patient Assessment & Care Planning Form (PACF) and Interdisciplinary Care Team (ICT)

How to submit PACFs

- › In Availity® under the Quality Care Rewards (QCR) Tool on [Availity.com](https://www.availity.com)
- › Fax: **(423) 591-9504**

Need training or help?

- › Call eBusiness (423) 535-5717, option 2
- › Email ebusiness_service@bcbst.com

Provider Model of Care (MOC) Training

Who?

- › All participating physicians in the BlueCare Plus network
- › Noncontracted providers in cases of continuity of care

When?

- › New physicians: Upon completion of contracting and credentialing
- › Required annually
- › Encourage to complete at the beginning of each year

Provider MOC Training (cont.)



Online Training

- › Each individual physician can complete training on their own
- › Access via Availity or BlueCare Plus Website
- › **BCP Model of Care Attestation** (bcbst.com)
- › Physician attestation automatically captured and tracked



Group (HV) Training

- › Completed in a group setting (Staff meeting, QI meeting, etc.)
- › High Volume attestation form must be completed and returned
- › Compliance tracked via attestation form
- › Form available from assigned network manager or sam_hatch@bcbst.com

2025 Quality Program Measure Changes

› Diabetes

- The **Hemoglobin A1c Control for Patients With Diabetes (HBD)** measure will be replaced with the **Glycemic Status Assessment for Patients With Diabetes (GSD)** measure.

› Pharmacy

- The **Polypharmacy – Multiple Anticholinergic Medications (Poly-ACH)** measure will move from the monitoring section into the scored section of the program as a single-weighted measure.

› Transitions of Care

- The **Notification of Inpatient Admission (NIA)** and **Receipt of Discharge Information (RDI)** components will be removed from the scoring of the **Transitions of Care (TRC)** measure.

› Member Experience

- The **Member Experience – CAHPS** measure weight reduces from 4 to 2.

› Care for Older Adults (COA)

- Pain Assessment retired from scoring
- Functional Status reinstated

› Monitoring Status

- Concurrent Use of Opioids and Benzodiazepines (COB)
- Member Experience – HOS: Improving or Maintaining Mental Health
- Member Experience – HOS: Improving or Maintaining Physical Health

2025 Quality Program Measures - COA

› Who is included in the COA measures?

- For Medicare SNPs, the COA measures focus on medication review and functional status assessment for members age 66 and older.

› Medication Review

- **CPT Codes: 90863, 99483, 99605, 99606**
- **CPT II Code: 1160F (review of all medications documented in the medical record)**
 - Medication list, signed and dated during the measurement year, by the prescribing practitioner or clinical pharmacist.

Measure Name
Controlling High Blood Pressure (CBP)*
Glycemic Status Assessment for Patients With Diabetes (GSD) <=9%
Medication Adherence for Cholesterol (Statins)
Medication Adherence for Hypertension (RAS Antagonists)
Medication Adherence for Non-Insulin Diabetes Medications (OAD)
Plan All-Cause Readmissions (PCR)
Breast Cancer Screening (BCS-E)
Care for Older Adults (COA) - Medication Review*
Colorectal Cancer Screening (COL-E)
Eye Exam For Patients With Diabetes (EED)*
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Kidney Health Evaluation for Patients With Diabetes (KED)
Osteoporosis Management in Women Who Had a Fracture (OMW)
Polypharmacy - Multiple Anticholinergic Medications (Poly-ACH)
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Statin Therapy
Statin Use in Persons with Diabetes (SUPD)
Transitions of Care (TRC)
Care for Older Adults (COA) - Functional Status Assessment*

2025 Quality Program Measures – COA (cont.)

› Functional Status Assessment

- **CPT 99483, CPT II 1170F (Functional Status Assessed)**
- Documentation in the record must include evidence of a complete functional status assessment and the date performed.
- **Notation for activities of daily living (ADL)**
 - At least five examples including bathing, dressing, eating, transferring getting in and out of chairs, using the bathroom, walking
- **Notation for instrumental activities of daily living (IADL)**
 - At least four examples including shopping for groceries, driving or using public transportation, using the telephone, cooking or meal prep, housework, laundry, taking medication, handling finances

2025 Quality Program Measures - FMC

Follow-Up After Emergency Department Visit (FMC)

> **Which chronic conditions are considered for FMC?**

- Events are included for patients diagnosed with two or more of these conditions during the prior or current measurement year, but prior to the ED visit.

Eligible Chronic Conditions

Chronic respiratory conditions COPD, asthma, and emphysema	Alzheimer’s disease and related disorders
Chronic Kidney Disease	Depression
Heart Failure	Acute myocardial infarction
Atrial fibrillation Acute myocardial infarction	Stroke and transient ischemic attack

2025 Quality Program Measures – FMC (cont.)

› Actions needed for compliance

- **Patients must have a follow-up service on or within seven days of the ED visit (eight days total) via:**
 - An outpatient, telephone or telehealth visit, including those for behavioral health services in a clinic, at home or at a community health center
 - Case management visit
 - Complex care management services
 - E-visit or virtual check-in

Important Contacts

Provider Service Line:

1-800-2991407

8 a.m. – 6 p.m. (ET) Monday – Friday

BlueCare Plus Tennessee Wesbite:

bluecareplus.bcbst.com

PACF/Medical Records Fax:

(423) 591-9504

Utilization Management:

Phone: **(423) 591-9504**

Fax: **1-866-325-6698**

East/Middle Regions:

Sam Hatch,
Provider Quality Manager

Phone: **(423) 463-4185**

Email: **sam_hatch@bcbst.com**

West/Middle Regions:

Tiffany Jackson,
Provider Quality Manager

Phone: **(901) 544-2595**

Email: **tiffany_jackson@bcbst.com**

Resources

Resources

- › [Resources & Links](#)
- › [BlueCare Tennessee Website](#)
- › [Authorization & Appeals](#)
- › [BlueCare Provider Administration Manuals](#)
- › [BlueCare PCP Assignment Policy & Maintenance](#)
- › [Monthly Screening/Federal Exclusion Screening Requirements](#)
- › [Background Checks, Registry Checks and Exclusion Checks](#)
- › [Subcontracting](#)
- › [When a Provider May Bill a TennCare Enrollee](#)
- › [CAQH & Data Verification](#)
- › [Health Literacy and Cultural Competency Provider Tool Kit](#)

Resources (cont.)

- › [Deficit Reduction Act and Fraud & Abuse Training](#)
- › [Tennessee Health Care Innovation Initiative \(THCII\)](#)
[Episodes of Care](#)
- › [Provider Dispute Resolution Procedure \(PDRP\)](#)
- › [Ancillary Providers](#)
- › [Behavioral Health](#)
- › [Contact Us](#)

Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association

eBusiness



Availity®

EMPOWERING YOUR DIGITAL WORLD



ALL Blue 2025

Agenda

Availity® Multi-Payer

- › Patient Registration
 - Eligibility & Benefits
 - Authorizations & Referrals
- › Claims & Payments
 - Claim Status
 - Remittance Viewer
 - Claims & Encounters

Availity® Payer Spaces

- › Applications
- › Resources
- › News & Announcements

Eligibility & Benefits

Need Help? [Watch a demo](#) about Eligibility and Benefits

New Request

EB Eligibility & Benefits

Feedback

Fields marked with an asterisk * are required.

* Organization

BCBS eBusiness Marketing - Faith

* Payer

BCBS TENNESSEE

Provider Information

Select a provider or enter one of the following: Provider NPI or Provider Tax ID

Provider

ABC Medical Group

Search for a provider by name, NPI, tax ID, taxonomy code, or address

Provider NPI

1234567890

Service Information

* As of Date

03/21/2024

* Benefit / Service Type

Health Benefit Plan Coverage - 30 x

clear

☐ Submit another patient

Submit

Patient Information

Member Search

Enter member information, then click on **Search**. If there are member search records, they will be displayed below.

Member Search Option(s)

Member ID/Policy Number

Member ID/Policy Number

Member ID/Policy Number, Member Last Name, Date of Birth

Member ID/Policy Number, Member Last Name, Member First Name

Member ID/Policy Number, Member First Name, Date of Birth

Member Last Name, Member First Name, Date of Birth

BlueCareSM Tennessee Member Eligibility & Benefits

HALL, KRISTOPHER

C/O BRANDY MATTHEWS
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402

Edit

Print

Feedback

Member Status	Date of Birth	Gender	Current Plan Effective Date	Relationship to Subscriber
Active Coverage	Aug 6, 1959	Male	Jan 1, 2015 - Dec 31, 2199	Self

Check Medicaid NPI

Prior Authorization Requirements

Coverage Questions?

Patient Cost Estimator

General Exclusions

Member Card

Member ID:

Group Number:

Group Name:

Plan Begin Date:

ZECMBCTEST00

125000

TENNCARE/BLUECARE

Jul 1, 2023

of Tennessee

Payer: BCBS TENNESSEE

Other or Additional Payer Information

No additional payer information provided.

ELIGIBILITY & BENEFITS

Check Medicaid Registration by NPI

- All NPIs billed on a claim must be on file with TennCare.
- NPIs not on file will result in a rejected claim.

Check Medicaid NPI

Prior Authorization Requirements

Coverage Questions?

Patient Cost Estimator

General Exclusions

Member Card

Check Medicaid Registration by NPI

Billing

1234567890

This provider is on file with BlueCross as a TennCare-registered provider.

Rendering

Ordering

1234567880

This provider is NOT on file with BlueCross as a TennCare-registered provider, please visit <https://www.tn.gov/tenncare/providers/provider-registration.html> for more information.

Service Facility

Purchased Service

Prescribing

Referring

Submit

ELIGIBILITY & BENEFITS

Prior Authorization Requirements & Coverage Questions

[Check Medicaid NPI](#)[Prior Authorization Requirements](#)[Coverage Questions?](#)[Patient Cost Estimator](#)[General Exclusions](#)[Member Card](#)

Prior Authorization Requirements

Prior Authorization Requirements

Transaction: 4977710a-540c-4cab-b41f-1056067427c1
Date: Mar 21, 2024 3:06 PM
Customer ID: 818271

Subscriber: KRISTOPHER HALL
Member ID: ZECMBCTEST00
DOB: 1958-05-06
Gender: Male
Plan/Coverage Date: Jan 01, 2015

CHIROPRACTIC SERVICES
Effective 04/01/2023, Chiropractic services do not require an authorization.
* See Chiropractic Services in Benefit Summary for details

CHOICES
* All services must be on the member's approved Plan of Care.
* Group 1 CHOICES services do not require authorization unless Enhanced Services

DME Codes and supplies that do not require prior authorization (regardless of cost) are listed below:
Surgical Codes should be billed with the surgical procedure. If a DME item is used within the procedure prior authorization is not required for the DME item. Please refer to the Outpatient (OP) prior authorization list for the surgical procedure.
No authorization is required for Upper Extremity Orthotics
No authorization is required for all Diabetic equipment/supplies (including all Continuous Glucose Monitor (CGM) and insulin pumps)
No authorization is required for Ankle Foot Orthotics (AFO)
No authorization is required for Compression garments/stockings (except for E0677 this requires authorization)
No authorization is required for hearing aids, vision and cochlear implants for under 21 years of age for BlueCare/TenriCareSelect or under 19 years of age for CoverKids (except for V2025, V2762, V2781 these require authorization)
No authorization is required for Supplies (examples are wound, trash, Foley, ostomy supplies, etc.)

Durable Medical Equipment (DME) - Orthotics and Prosthetics >\$500

OUTPATIENT REHAB / THERAPIES
* Prior Auth Required? No Prior Authorization under age 21. Prior authorization required age 21 and older

HOME HEALTH SERVICES
* Prior Auth Required? Yes, except for therapy visits for members under age 21

Close Print

Coverage Questions? “Fast Path”

Contact Payer


For more help, contact BlueCross using Fast Path by calling 1-833-FST-PATH (1-833-378-7284) and provide transaction ID 003741 during normal business hours.

Close

ELIGIBILITY & BENEFITS

Member Card

[Check Medicaid NPI](#)[Prior Authorization Requirements](#)[Coverage Questions?](#)[Patient Cost Estimator](#)[General Exclusions](#)[Member Card](#)



Kristopher Hall

Member ID
ZECMBCTEST00

Group No. 125000

VER: 5.1


Primary Care Provider (PCP)
Collins, Kevin L.

BlueCare™

Effective Date: 04/11/2024
Member DOB: 08/06/1959

Benefit Level: G

Copayments:
PCP \$5
Specialist Visit \$5
ER Visit \$10
Hospital Stay \$5



bluecare.bcbst.com
Member Service: 1-800-468-9698
Network Provider Outside Tennessee:
1-800-676-2583 (BLUE)
Provider Service: 1-800-468-9736
Prior Authorization: 1-888-423-0131
Advanced Radiological Imaging Auth:
1-888-693-3211
24/7 Nurseline: 1-800-262-2873

Providers: File all claims with local BCBS Plan.
Prior Authorization is required for certain services. Benefits will not be provided for unauthorized services or for non-emergency services provided by out-of-network providers.

Members: Always show this card and tell your provider to check for prior authorization. Remember, you get your care from your primary care provider (PCP), listed on the front of this card, except in an emergency. Call your PCP within 24 hours of any emergency care. This card is for identification, not for proof of eligibility.

BlueCare Tennessee Claims
Service Center 1 Cameron Hill
Circle Suite 0002
Chattanooga, TN 37402-0002

702 (09/21)

Additional Information

› Patient Cost Estimator

- Real Time Claim Adjudication on Payer Spaces (RTCA)

› General Exclusions

ELIGIBILITY & BENEFITS

BlueCare Member Benefits

> Coverage Level

- Funding Type = Medicaid
- Note: Validate the NPIs involved
 - Check Medicaid NPI button on previous slide

> Annual Deductible

> Benefit Information

▼ Health Benefit Plan Coverage - 30

Active Coverage

Insurance Type: Medicaid
Plan / Product: BLUECARE MIDDLE
Coverage Level: Individual

- FUNDING TYPE = MEDICAID
- NOTE - THIS MEMBER HAS A MEDICAID PLAN. VALIDATE THE NPI(S) INVOLVED IN THIS MEMBER'S CARE TO ENSURE NO DISRUPTION IN CLAIMS PROCESSING.

Information / Details	Individual	Family
Annual Deductible	<div>Network Not Applicable</div> <div>\$0 / Service Year(s) -\$0 Year to Date</div>	<div>\$0 Remaining</div> <div>\$0 / Service Year(s) -\$0 Year to Date</div>

Benefit Information

Expand

▶ Audiology Exam - 71

▶ Chiropractic - 33

▶ Dental Care - 35

▶ Durable Medical Equipment - DM

ELIGIBILITY & BENEFITS

Commercial Member Eligibility & Benefits

- › Prior Authorization Requirements
- › Coverage Questions? (Fast Path)
- › Patient Cost Estimator (RTCA)
- › General Exclusions
- › Member Card
- › Coordinator of Benefits (COB)

HALL, CHRIS B
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402

EditPrintFeedback

Member Status	Date of Birth	Gender	Current Plan Effective Date	Relationship to Subscriber
Active Coverage	Aug 6, 1959	Male	Jan 1, 2019 - Dec 31, 2199	Self

Prior Authorization Requirements

Coverage Questions?

Patient Cost Estimator

General Exclusions

Member Card

Member ID: QM1902218823
Group Number: 100000
Group Name: CHRIS B HALL ENTERPRISES
Plan Begin Date: Jan 1, 2024

 of Tennessee

Payer: BCBS TENNESSEE

Other or Additional Payer Information

Secondary Payer

Payer: NO OTHER INSURANCE
Group or Policy Number: NOTPROVIDED
COB Date: Apr 6, 2024

ELIGIBILITY & BENEFITS

Health Reimbursement Account (HRA)

Plan Maximums and Deductibles

Out of NetworkIn NetworkAll Networks

▼ Health Benefit Plan Coverage - 30

Active Coverage

Insurance Type: Preferred Provider Organization (PPO)

Plan / Product: HRA (NETWORK P)

Coverage Level: Employee and Children

- FUNDING TYPE = COMMERCIAL

Information / Details		Individual		Family	
Annual Deductible	In Network	<div><div></div><div>\$2,500 / Calendar Year(s)</div></div>		<div><div></div><div>\$5,000 / Calendar Year(s)</div></div>	
		<div><div></div><div>\$2,108.42 Remaining</div></div>		<div><div></div><div>\$4,608.42 Remaining</div></div>	
		<div><div></div><div>-\$391.58 Year to Date</div></div>		<div><div></div><div>-\$391.58 Year to Date</div></div>	
Out Of Pocket	In Network	<div><div></div><div>\$5,000 / Calendar Year(s)</div></div>		<div><div></div><div>\$10,000 / Calendar Year(s)</div></div>	
		<div><div></div><div>\$4,558.03 Remaining</div></div>		<div><div></div><div>\$9,558.03 Remaining</div></div>	
		<div><div></div><div>-\$441.97 Year to Date</div></div>		<div><div></div><div>-\$441.97 Year to Date</div></div>	

Benefit Descriptions	
Plan / Product: HRA (NETWORK P)	Plan / Product: HRA (NETWORK P)
Coverage Level: Individual	Coverage Level: Individual
• HRA BALANCE	• HRA DEDUCTIBLE REMAINING
Plan / Product: HRA (NETWORK P)	Plan / Product: HRA (NETWORK P)
Coverage Level: Individual	Coverage Level: Family
• HRA BALANCE REMAINING	• HRA BALANCE
Plan / Product: HRA (NETWORK P)	Plan / Product: HRA (NETWORK P)
Coverage Level: Individual	Coverage Level: Family
• HRA DEDUCTIBLE	• HRA BALANCE REMAINING
	Plan / Product: HRA (NETWORK P)
	Coverage Level: Family
	• HRA DEDUCTIBLE
	Plan / Product: HRA (NETWORK P)
	Coverage Level: Family
	• HRA DEDUCTIBLE REMAINING
	• HRA BALANCE
	• MEMBER
	• MEMBER PAYS FIRST
	• HRA REIMBURSES AT 80% OF THE FOLLOWING COST SHARES WHERE APPLICABLE
	• HRA REIMBURSABLE FOR COPAY? NO
	• HRA REIMBURSABLE FOR COINSURANCE? NO
	• HRA REIMBURSABLE FOR DEDUCTIBLE? YES

- › HRA Balance
- › HRA Balance Remaining
- › HRA Coverage Level Details

Claims & Payments

› Claims Status & Payments

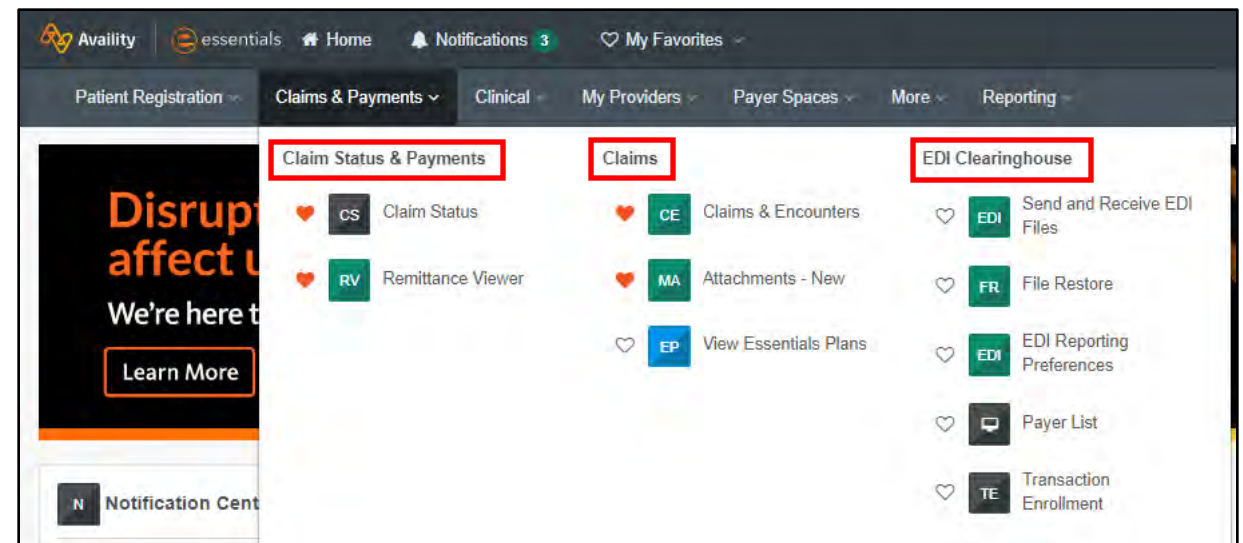
- Claim Status
- Remittance Viewer

› Claims

- Claims & Encounters
- Attachments – New (used for PWK attachments)

› EDI Clearinghouse

- Send and Receive EDI Files
- File Restore
- EDI Reporting Preferences



Claim Status

Availity | Essentials | Home | Notifications | My Favorites | Tennessee | Help & Training | Faith's Account | Logout

Patent Registration | Claims & Payments | Clinical | My Providers | Myel Space | More | Reporting | Advanced Search

Home > Select > Search | Need Help? Learn More

Claim Status

Give Feedback

Organization: eBusiness Marketing Claims - Faith | Payer: BCBS TENNESSEE

Member: | **Service Dates** | Check Number | Claim Number | HIPAA Standard

Fields marked with an asterisk * are required.

* Provider Tax ID: 4212312311 | Select a Provider: ABC Velocis Group | * Provider NPI: 1246789 | Payer Assigned Provider ID: |

* Service Dates: 03/01/2024 to 03/08/2024

* Claim Status: All (selected) | Pending | Rejected | Denied | Paid

Claim Status Version 2.0

Search by:

- > Member
- > Service Dates
 - Allows search by specific claim status
- > Check Number
- > Claim Number
- > HIPAA Standard

Claim Status

CS

Claim Status

Give Feedback

Export to CSV

Print this Page

Return to Results

New Search

Edit Search

View EOB

Message this Payer

Dispute Claim

Patient Information

Patient

Subscriber ID

Chris Hall

900110000

Patient Account Number

Gender

M

Claim Information

Status

Service Dates

Received Date

Claim Number

DENIED

03/01/2024 - 03/01/2024

03/01/2024

Line of Business

Total Billed

Total Paid

Total Patient Responsibility

BA01

\$147.00

\$0.00

\$0.00

Payment Information

Check/EFT #

Provider ID

Payment Date

Payee Provider ID

03/07/2024

Line Level Information

Service Dates	Procedure Codes	Reason/Remark Code	Billed	Paid	Allowed	Not Covered	Deductible	Co-insurance	Co-Pay
03/01/2024	99213	ZY0	\$147.00	\$0.00	\$0.00	\$147.00	\$0.00	\$0.00	\$0.00
03/01/2024									

- › Export to CSV
- › Return to Results
- › View EOB (Remittance)
- › Message this Payer

Claims Reconsiderations & Appeals

Background:

- › Backlog causing delays in processing reconsiderations.
- › Resolving this issue is one of our company's top priorities this year.

Process:

- › Provider Dispute Resolution Procedure (PDRP): [PDRP Form](#)
- › Reconsideration Form: [Reconsideration Form](#)
- › Appeal Form: [Appeal Form](#)

Reconsiderations & Appeals

Our Solution:

- › Online reconsiderations and appeals tool
- › eBusiness Marketing Team Map: [eBusiness Marketing Team Regional map.pdf](#)

Paperwork (PWK) Attachments – New Claims Submission

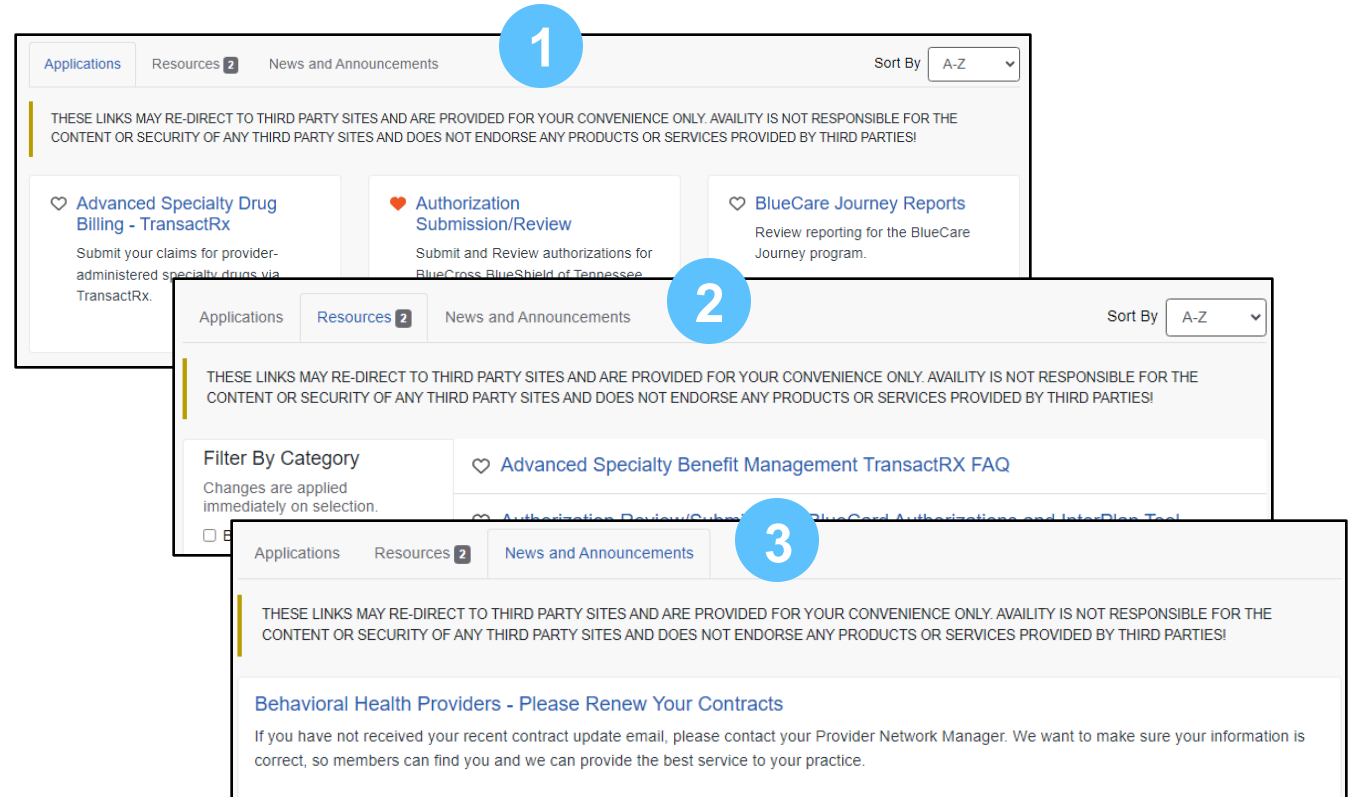
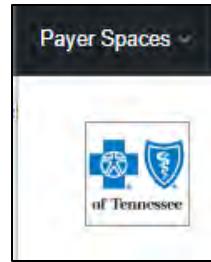
The screenshot shows the 'Attachments Dashboard' in the 'Provider Work Queue'. At the top right, there are two buttons: 'Provider Verification' and 'Send Attachment'. A red box and arrow labeled '1' point to the 'Send Attachment' button. Below the dashboard, a modal form is open. In this form, a red box labeled '2' highlights the 'Attachment Control Number' field, which has a dropdown arrow next to it.

➤ This is not for claims that have been previously processed. **PWK is for new claims only.**

This screenshot shows the 'Attach Supporting Documentation' form. A red box labeled '3' highlights the 'Reason 1' dropdown menu. Below it, a blue box labeled '4' highlights the 'Add Attachment' button. Other fields visible include 'Patient Control Number', 'Attachment Control Number', 'Service From', and 'Service To'.

Introduction to Payer Spaces

- 1 Applications
- 2 Resources
- 3 News and Announcements



PAYER SPACES

Applications

Applications

Resources 1

News and Announcements

Sort By A-Z

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

Advanced Specialty Drug Billing - TransactRx

Submit your claims for provider-administered specialty drugs via TransactRx.

Authorization Submission/Review

Submit and review authorizations for BlueCross BlueShield of Tennessee

Avalon

BlueCare Journey Reports

Review reporting for the BlueCare Journey program.

BlueCare PCP Maintenance

Review and update BlueCare, TennCare Select, & BlueCare Plus patient populations

Contact Preferences & Communication Viewer

Update your contact information and view your important messages and documents.

Fee Schedule Viewer

View your fee schedules for BlueCross contracts

Medication Assisted Treatment

Review your BESMART Quality Metrics Report - Q4 2024 Reports are now available

National Consumer Cost Tool Reports

Q1 2025 Data available - Review data submitted for member cost tool

Print/View Your Remittance Advice

Review and print copies of your legacy remittance advices

Provider Enrollment, Updates, and Changes

We are waiving EFT requirements for provider enrollment. See News and Updates

Quality Care Rewards (QCR Platform)

Review gaps and track incentives for providing quality care.

RC Claim Assist

Provides data needed to correctly bill drugs administered under medical benefits

Real Time Claims Adjudication

Estimate liability and submit claims for BCBS Tennessee medical plans.

THCII Reporting

Episodes of Care Q1 2025 Interim Reports will be available 2/20/2025

THCII TN Health Link Enrollment

Enroll BlueCare members eligible for THL to your organization.

Resources

Applications

Resources 1

News and Announcements

Sort By A-Z

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

Filter By Category

Changes are applied immediately on selection.

☐ BlueCare Tennessee (49)

☐ Commercial (42)

☐ Quick Reference Guides (38)

☐ Provider Resources (35)

☐ Medicare Advantage (32)

☐ Dual Special Needs Plan (31)

☐ BlueCard (17)

☐ Pharmacy (13)

☐ Dental (11)

☐ Other (6)

☐ Quality Care Rewards (5)

Advanced Specialty Benefit Management TransactRX FAQ

Authorization Review/Submission - BlueCard Authorizations and InterPlan Tool

Authorization Review/Submission - Chiropractic

Authorization Review/Submission - Durable Medical Equipment

This guide provides step-by-step instructions to help you request initial authorizations for DME services through Availity

Authorization Submission Review _View Letters and Update Existing Auth

Authorization Submission/Review - Clinical Update / Concurrent Review Authorizations

Authorization Submission/Review - Behavioral Health

News and Announcements

ApplicationsResourcesNews and Announcements

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

[LabCorp Termed from BlueCare Tennessee Networks](#)

Starting Nov. 12, 2024, LabCorp providers will no longer be in our BlueCare Tennessee networks. To find an in-network BlueCareSM, TennCareSelect or CoverKids coverage, use our online Find Care tool or call the Provider Service line.

[Humira Removed from Preferred Formulary Starting 1/1/25](#)

[Behavioral Health Providers - Please Renew Your Contracts](#)

If you have not received your recent contract update email, please contact your Provider Network Manager. We want to ensure your information is correct, so members can find you and we can provide the best service to your practice.

[Important Information from TennCare: Medicaid Renewals Started April 1](#)

TennCare began the reverification process for our BlueCare, TennCareSelect and CoverKids members on April 1. For more information, visit tn.gov/tenncare and select Preparing for Renewals.

[New Customer Service Resource Team for Tennessee Providers](#)

[BCBS Tennessee Eligibility and Benefits Upgrades](#)

[BlueEssential Care Plans Available in Quality Care Rewards Application](#)

In addition to mail, you can now review, approve and/or request edits to your BlueEssential patients care plans in the QCR application. See the May 2021 BlueAlert for more information.

[Coronavirus Updates & F.A.Q. - BlueCare/TennCare Select](#)

Review updates from BlueCare and the Department of TennCare regarding COVID-19.

[Coronavirus Updates & F.A.Q.](#)

Thank you for all you do for BlueCross members. We're reaching out to answer some questions we've received from our network providers about COVID-19. Coronavirus is a rapidly changing situation, so we'll continue to update you as we learn more.

[BlueAlert](#)

[2024 Special Needs Plan Model of Care \(MOC\) Training Now Available](#)

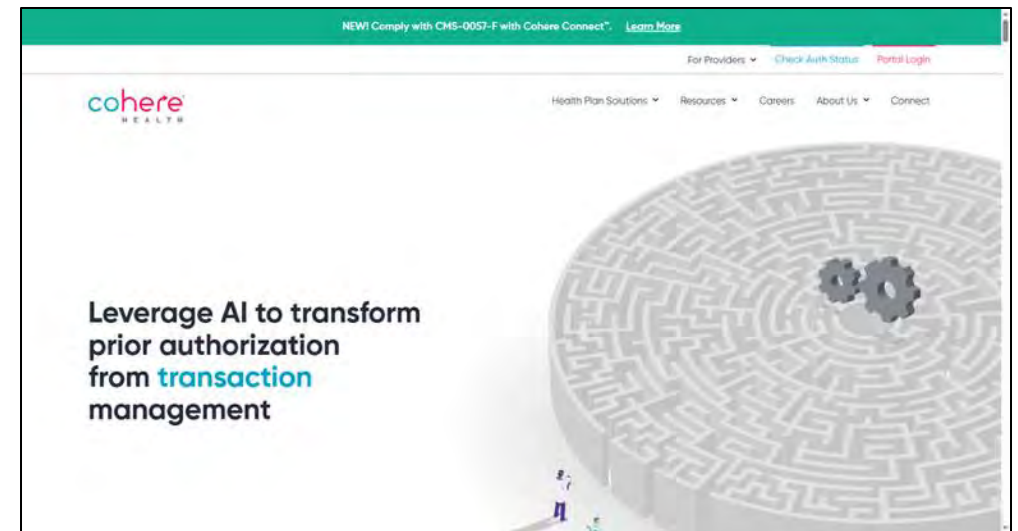
Providers participating in BlueCare Plus Tennessee (HMO D-SNP)SM special needs plans are contractually required to complete our MOC training after initial contracting, then every year after. This training promotes quality of care and cost effectiveness through coordinated care for members.

BlueCross © 2025 | 109

Cohere Health – Commercial Authorizations

2025 Roadmap:

- Commercial authorizations will transition to Cohere in waves throughout 2025. FEP will be excluded from the Cohere transition and will remain on Availity.
- Always start the authorization on Availity.
- Continue to check for authorization status, view letters and request peer-to-peer review on Availity.

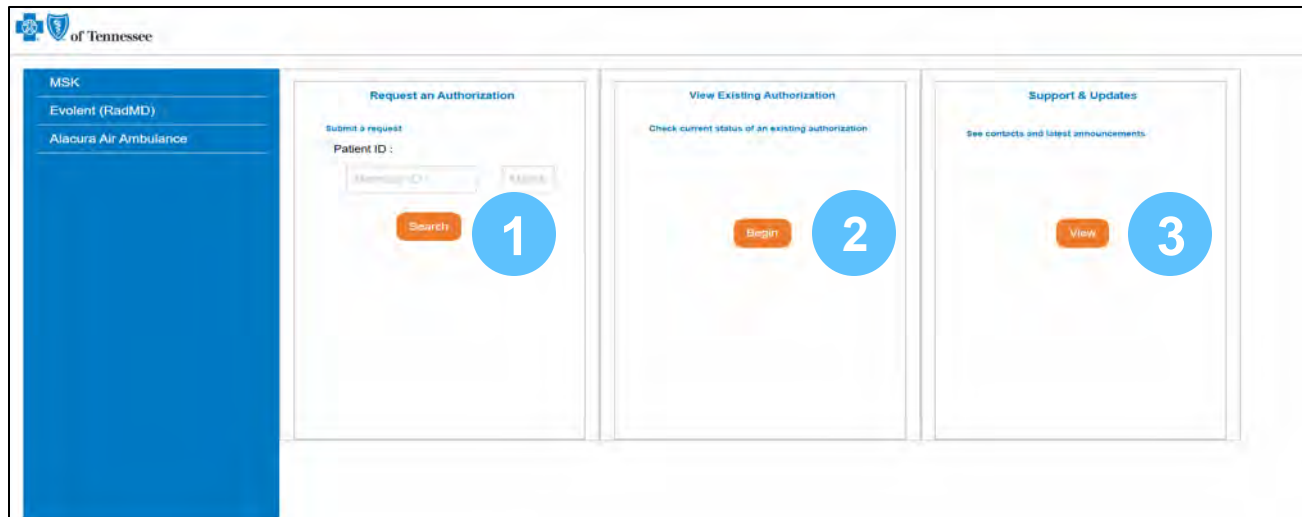


Cohere Health – Commercial Authorizations

Statewide Webinar Training Sessions:

- › **August 20th at 10:00 ET / 9:00 CT -**
<https://events.teams.microsoft.com/event/b30a8751-c318-4366-992e-2a6b9d208e0d@68503c37-a963-4410-afca-ecaad3d96f17>
- › **August 26th at 2:00 ET / 1:00 CT -**
<https://events.teams.microsoft.com/event/bbf54ebe-2b2a-417f-bd80-da57b70e5a11@68503c37-a963-4410-afca-ecaad3d96f17>
- › **August 28th at 11:00 ET / 10:00 C T -**
<https://events.teams.microsoft.com/event/97562dcd-a7ee-4051-8919-aacc94f2b5a1@68503c37-a963-4410-afca-ecaad3d96f17>

Authorization Submission / Review – New View



- 1 Request an Authorization
 - Patient Search — do not include prefix
- 2 View Existing Authorization
 - Check Authorization Status
 - View Letters
 - Update Authorization
- 3 Need Help?
 - Announcements

Requesting an Authorization — Commercial Member

1 Authorization Type

- Inpatient
- Outpatient
- Specialty Pharmacy

2 Procedure Codes

- Enter only 5-digit codes, no modifiers
- Magnifying glass to search

3 Requested Date of Service

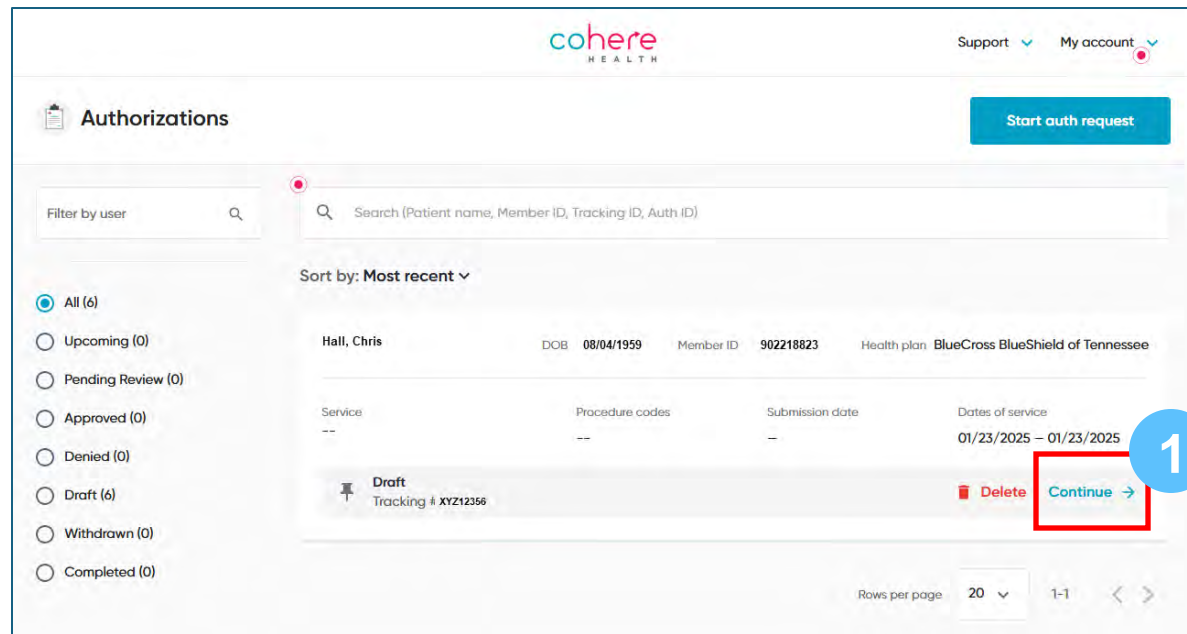
4 SSO to Cohere after clicking **Continue** button

The screenshot shows the 'Patient Information' section of the BlueCross of Tennessee authorization request form. The patient's details are as follows:

Name :	Chris Hall
Member ID :	902218823
Group ID :	100000
Birth Date :	08/06/1959
Age :	65
Address :	1 CAMERON HILL CIRCLE CHATTANOOGA, TN 37402
Phone :	4235353065
Eligible :	Yes

On the right side of the form, the 'Authorization Type' section includes radio buttons for Inpatient, Outpatient, and Specialty Pharmacy. Below this is the 'Procedure Codes' section, which instructs the user to 'Enter Only 5-digit procedure code; do not enter any modifiers'. It features a table with columns for 'Code' and 'Description', and a magnifying glass icon for searching. The 'Requested Date of Service' is set to 06/10/2025. At the bottom, there are 'Cancel' and 'Continue' buttons. Numbered callouts 1 through 4 highlight the following elements: 1. Authorization Type radio buttons, 2. Procedure Codes section, 3. Requested Date of Service field, and 4. The Continue button.

Commercial Authorizations



cohere HEALTH

Support My account

Authorizations

Start auth request

Filter by user

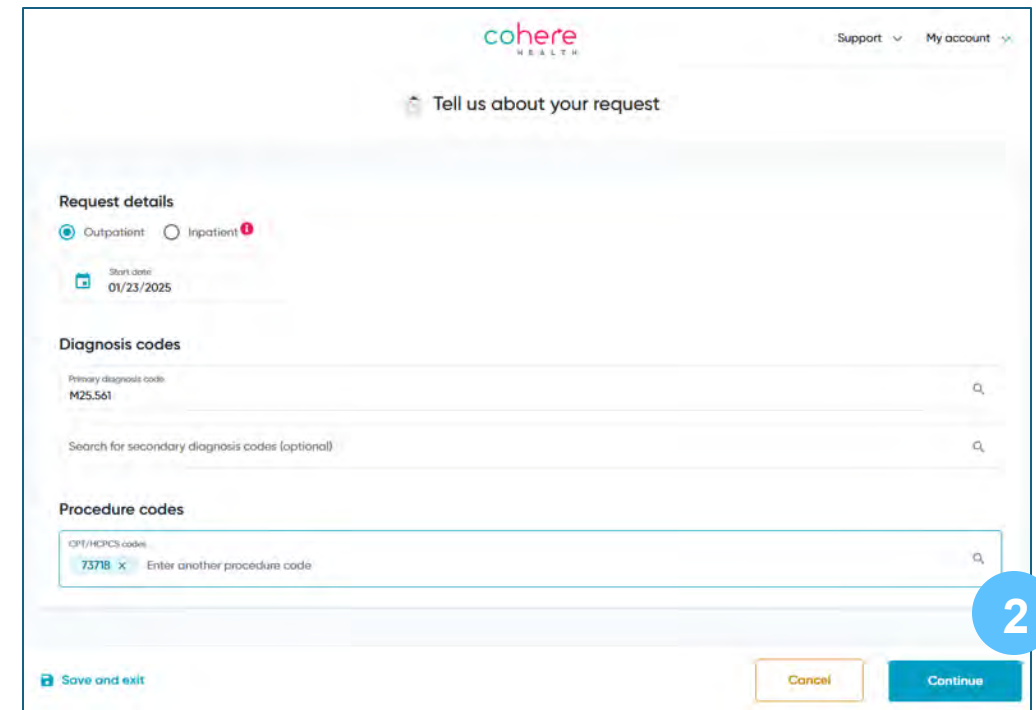
Search (Patient name, Member ID, Tracking ID, Auth ID)

Sort by: Most recent

☒ All (6)
☐ Upcoming (0)
☐ Pending Review (0)
☐ Approved (0)
☐ Denied (0)
☐ Draft (6)
☐ Withdrawn (0)
☐ Completed (0)

Service	Procedure codes	Submission date	Dates of service
Hall, Chris	DOB 08/04/1959 Member ID 902218823 Health plan BlueCross BlueShield of Tennessee		
--	--	--	01/23/2025 - 01/23/2025
Draft Tracking # XYZ12356		Delete	Continue →

Rows per page 20 1-1



cohere HEALTH

Support My account

Tell us about your request

Request details

☒ Outpatient ☐ Inpatient

Start date 01/23/2025

Diagnosis codes

Primary diagnosis code: M25.561

Search for secondary diagnosis codes (optional)

Procedure codes

CPT/HCPCS codes: 73718 Enter another procedure code

Save and exit Cancel Continue

Commercial Authorizations

The image displays two screenshots of the Cohere Health Commercial Authorizations workflow, illustrating the steps for selecting services and entering provider details.

Screenshot 1: Select services

At the top, the user's name is Jones, Ashley, DOB: 04/04/1977. The page title is "Select services". A message states: "For faster approval, let us know which services fit best. We found a few matches for the care you're requesting." Below this, a list of services is shown, with "MRI Left Knee" and "MRI Right Knee" highlighted. A "Continue" button is at the bottom right.

Screenshot 2: Enter provider details

At the top, the page title is "Enter provider details". The "Outpatient" radio button is selected. The "Place of service" is "Office". The "Ordering provider" is "Harry Potter, MD", with a "Network check complete" status. The "Performing or attending provider" is also "Harry Potter, MD", with a "Network check complete" status. The "Performing facility or agency" is "ABC Medical Group", with a "Network check complete" status. A "Save and exit" button is at the bottom left, and a "Continue" button is at the bottom right.

Commercial Authorizations

➤ **Very Important:** Be sure to attach clinical information shown in step 3

This screenshot shows the 'Enter provider details' step of the Cohere Health commercial authorization process. The interface includes a 'Back' button, a 'Support' link, and a 'My account' link. The main form area is titled 'Enter provider details' and contains several sections: 'Outpatient' (selected) and 'Inpatient' (unselected) radio buttons; a 'Place of service' dropdown menu set to 'Office'; an 'Ordering provider' section with a search bar containing 'Harry Potter, MD', a 'Network check complete' status, and an address field '1 Cameron Hill Circle, Chattanooga TN 37401'; a 'Performing or attending provider' section with a checked box 'Performing is the same as the ordering', a search bar containing 'Harry Potter, MD', a 'Network check complete' status, and address and TIN fields; and a 'Performing facility or agency' section with a search bar containing 'ABC Medical Group', a 'Network check complete' status, and address and TIN fields. At the bottom, there is a 'Save and exit' button and a 'Continue' button.

1

2

This screenshot shows the 'Add attachments' step of the Cohere Health commercial authorization process. The interface includes a 'Back' button, a 'Support' link, and a 'My account' link. The main form area is titled 'Add attachments' and contains a 'Choose files to upload' section with a message 'Please add clinical documentation to support this authorization and accelerate the review.' and an 'Add files' button. Below this, there is a list of uploaded files, including 'test.pdf' with a status 'Uploaded on 01/23/2025 at 12:30:08 PM (EST) by Faith Oancea'. At the bottom, there is a 'Save and exit' button and a 'Continue' button.

3

4

Commercial Authorizations

cohere
HEALTH

Support ▾ My account ▾

[< Back](#)

1

Review before submitting

Draft

Tracking #

Delete

Edit

Details

Primary diagnosis

M25.561 - Pain in right knee

Secondary diagnosis

--

Care setting

Outpatient

Place of service

Office

Ordering provider

Harry Potter, MD

[View info](#)

Performing or attending provider

Harry Potter, MD

[View info](#)

Performing facility or agency

ABC Medical Group

Facility state

Tennessee

Dates of service

01/23/2025 - 07/26/2025

Expedited

No

MRI Right Knee

Number of visits

1

Code

Status

Description

73718

Requested

Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)

MRI Left Knee

Save and exit

2

Submit

View Existing Authorizations

of Tennessee

MSK

Evoluti (RadMD)

Alacura Air Ambulance

Request an Authorization

Submit a request

Patient ID :

Member ID

Access

Search

View Existing Authorization

Check current status of an existing authorization

1

Begin

Support & Updates

of Tennessee

Authorizations

Find Authorizations by Provider, Member and Date Range:

Provider*

Harry Potter, Provider ID 1234567

Member*

Chris B Hall

From Date* - To Date *

03/12/2025

09/12/2025

Reset

Search

Find Authorizations by Case/Confirmation number

Confirmation number *

Case ID

Reset

Search

Home

Outpatient

Show 10 entries

Search:

Patient Name	Patient ID	Case ID	From - To Date	Service Description	Status	Requesting Provider	Servicing Provider
CHRIS HALL	902218823	412217493	05/10/2025 - 05/11/2025	OBS	Approved	Harry Potter	ABC Medical Center

PAYER SPACES

View / Print Letters

The screenshot displays the 'Inpatient Details' page with a 'Print' button in the top right corner. The page is divided into several sections:

- Inpatient Stay Information**
 - Patient Information**: Patient: Chris Hall, Member ID: MBCTEST00
 - Authorization**: Authorization ID: , Authorization Status: Fully Approved
 - Case Details**: Admitted: 02/05/2024, Expected Discharge: 02/13/2024, Actual Discharge: 02/10/2024, Requested LOS: 8, Approved LOS: 8
- Letter Details** (highlighted with a red box): Letter Date Time: 2024-02-06 12:24, [Chris Hall](#)
- Admitting Facility and Provider**
 - Admitting Facility**: Name: ABC Medical Center, ID: 1234567, Address: 1 Cameron Hill Circle, City: Chattanooga, State: TN, Zipcode: 37401, Country:
 - Requesting/Service Provider**: Name: Harry Potter, ID: 1234567, Address: 1 Cameron Hill Circle, City: Chattanooga, State: TN, Zipcode: 37401, Country:

Letter Details

- › Some lines of business display letters on different areas of the screen
- › View professional provider, facility and Member letters where applicable

PAYER SPACES

Update Existing Authorization

Please do not use this form for appeal and reconsideration status checks. Contact Customer Service to check the status.
Commercial: 1-800-924-7141
BlueCare Plus: 1-800-924-7141
Medicare Advantage: 1-800-924-7141
BlueCare: 800-468-9698
TennCare Select: 800-276-1978

Clinical Update Information

Please include all clinical information supportive of the request. LIST ALL PERTINENT INFORMATION SUCH AS: current medical status, activity, diet, medications with dosages, pain scale, physician orders, physician treatment plan, applicable office and/or inpatient progress notes, inpatient and/or outpatient treatment(s) including any special treatments such as alternative therapies or treatment, all pertinent lab values, and any other supportive information

Contact Information

Name:

Phone:

Fax:

Service Information

Note Type:

Clinical Notes:

Only PDF, TIFF, and JPEG files that total < 5,000 KB are allowed. Only alphanumeric characters and underscores are allowed in file names. Spaces are not allowed.

No file chosen

- 1 Clinical Update Information
- 2 Contact Information
- 3 Select Note Type
- 4 Enter Clinical Notes
- 5 Click Submit Notes

High Tech Imaging (HTI) Authorizations

Workflow Summary

Verify Member Benefits

- › Check **Prior Authorization Requirements** under **Eligibility & Benefits** to see if a prior authorization is required for HTI services.
- › If “Yes” is listed, an authorization is required.
- › If “No” is listed, an authorization isn’t required.

Verify Code List

- › Commercial Code List: [Commercial HTI Procedure Codes](#)
- › BlueCare Code List: [BlueCare HTI Procedure Code List](#)

Starting an Authorization

- › Start HTI Authorizations for TN Members on Availity Payer Spaces Application
- › Start BlueCard Authorizations under Patient Registration / Authorizations & Referrals

For the most streamlined process flow for submitting HTI Authorizations, these simple steps will be the most efficient, and effective way to obtain the Authorization.

High Tech Imaging Authorizations

Prior Authorization Requirements

Transaction: 7fae8565-1c8b-94dc-a3c8-170ba451141a
Date: Jan 23, 2025, 11:01 AM
Customer ID: 818201

Subscriber: CHRIS HALL
Member Id: QMI902218823
DOB: 1959-08-06
Gender: Male
Plan/Coverage Date: Jan 01, 2019

Advanced Radiological Imaging/High TechImaging

Prior Auth Required? Yes

Effective 9/1/2024: For Auth Request Call 1-800-924-7141 or request via the web

Prior to 9/1/2024: For Auth Request Call 1-888-693-3211

24/7 Nurseline benefit included?Yes- 1-800-818-8581

Case Management benefit included? Yes - 1-800-225-8698

Comprehensive Care Management for NICU? YES - 1-800-818-8581
Initial NICU authorization: Providers may fax clinical to 1-866-230-3424.

23 hour Observation for Tennessee In-Network Facilities ONLY
Prior Auth Required? Yes, except for 23 hour observation stays thru the Emergency Room thru 4/30/2024. Effective 5/1/2024 prior auth NOT required.

ClosePrint

Prior Authorization Requirements

Transaction: 7fae8565-1c8b-94dc-a3c8-170ba451141a
Date: Jan 23, 2025, 11:05 AM
Customer ID: 818201

Subscriber: CHRIS HALL
Member Id: QMI902218823
DOB: 1959-08-06
Gender: Male
Plan/Coverage Date: Jul 01, 2024

Gender Reassignment Surgery

Prior Auth Required? Yes

For Auth Request Call 1-800-924-7141 or request via the web

Genetic Testing

Prior Auth Required? No

High Tech Imaging

Auth Required? No

Case Management benefit included? Yes - 1-800-225-8698

Comprehensive Care Management for NICU? YES - 1-800-818-8581
Initial NICU authorization: Providers may fax clinical to 1-866-230-3424.

23 hour Observation for Tennessee In-Network Facilities ONLY
Prior Auth Required? Yes, except for 23 hour observation stays thru theEmergency Room thru 4/30/2024. Effective 5/1/2024 prior auth NOT required.
For Auth Request Call - 1-800-924-7141

ClosePrint

1 Prior authorization
is required for HTI

2 Prior authorization
is not required for HTI

Medicare Advantage Authorizations: LCD and NCD Guidelines

- When submitting Medicare Advantage authorizations, select the most appropriate LCD and/or NCD guideline.
- If the authorization meets the clinical criteria, you may receive instant approval.

The screenshot displays the 'Authorization Request' form in the mcg system. The form includes patient details (Patient: 1234567, Name: Chris Hall, DOB: 05/09/1945, Gender: Male) and authorization information (Authorization: 123456, Type: Procedure Pre-authorization, Status: Authorization Has NOT Been Submitted). It also shows 'Geographic Regions' set to 'All' and 'Procedure Code: E0430 (CPT/HCPCS)' with 'Requested Units: 1'. A blue circle with the number '1' highlights the 'Document Clinical' button. Below this, a table of guidelines is shown with a blue circle with the number '2' highlighting the 'Submit Request' button.

Guideline Title	Product	Code	Action
Oxygen Therapy, Continuous and Noncontinuous: Home	AC	A-0343-BC28	add
LCD Oxygen and Oxygen Equipment (L33797) Revision 11	MCR	L33797R011	add
NCD Home Use of Oxygen in Approved Clinical Trials (240.2.1) Version 1	MCR	N24021v1	add
No Guideline Applies			add

LCD/NCD Guidelines

Select all the appropriate criteria for the member and then click Save.

Procedure Code: E0430 (CPT/HCPCS)

Requested Units: 1

L33797R011 - LCD Oxygen and Oxygen Equipment (L33797) Revision 11 - (MCR)

This guideline is a Local Coverage Determination (LCD) that identifies circumstances under which services are considered reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). MCG Health may have made minor modifications in the language of the LCDs for clarity or to facilitate documentation in MCG software solutions.

1

The healthcare resource is/was needed for appropriate care of the patient because of ...

☒ Initial coverage for hypoxemia (Group I or II), as indicated by ...

☐ Treating practitioner has ordered and evaluated results of qualifying blood gas study performed at time of need. [🔗](#)

☒ Beneficiary's blood gas study (oximetry or ABG) meets ...

☐ Group I criteria, as indicated by ...

☒ Group II criteria, beneficiary with arterial PO2 of 56 mm Hg to 59 mm Hg or arterial blood oxygen saturation of 89 percent and ...

☐ Dependent edema suggesting congestive heart failure [🔗](#)

☒ Beneficiary with pulmonary hypertension or cor pulmonale, as indicated by ...

☒ Measurement of pulmonary artery pressure [🔗](#)

☒ Gated blood pool scan [🔗](#)

☒ Echocardiogram [🔗](#)

☐ Presence of "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVFL) [🔗](#)

☐ Erythrocythemia with hematocrit greater than 56 percent [🔗](#)

☐ Qualifying blood gas study (oximetry or ABG) was performed by treating practitioner or by qualified provider or supplier of laboratory services. [🔗](#)

☐ Provision of oxygen and oxygen equipment in home setting will improve beneficiary's condition. [🔗](#)

☐ Appropriate oxygen system, as indicated by ...

☐ Initial coverage for diagnosis not directly related to hypoxia (Group III), as indicated by ...

☐ Coverage for concurrent use of home oxygen therapy and oxygen equipment with positive airway pressure (PAP) device, as indicated by ...

The healthcare resource is/was not covered because of

☐ Beneficiary with ...

☐ Separately billed options, accessories, or supply items [🔗](#)

☐ Oxygen equipment and supplies for beneficiary who does not meet coverage requirements for home oxygen therapy [🔗](#)

☐ Emergency or stand-by oxygen system for beneficiary who is not regularly using oxygen [🔗](#)

☐ Topical hyperbaric oxygen chamber (A4575) [🔗](#)

☐ Topical oxygen delivery system (E0446) [🔗](#)

2

Save

Cancel

PAYER SPACES

Peer-to-Peer Review

- You can request a peer-to-peer review of a denied authorization online for Commercial and BlueCare Tennessee.
- Providers requesting a peer-to-peer will be contacted by a medical director at one of the dates and times provided on the form.
- Open existing authorization from Auth Inquiry / Clinical Update

Commercial

Clinical Update Information

Contact Information
Name: *
Phone: *
Fax: *

Provider Information
Provider Name: *
Provider Type: *
Provider Phone: *
First Available Date: *
From Time: * To Time: *
Second Available Date: *
From Time: * To Time: *
Third Available Date: *

Service Information
Note Type: * Peer to Peer Review

A Peer to Peer request allows a provider to speak directly with the Medical Director to dispute an adverse determination and to provide additional pertinent clinical information. The provider requesting the peer to peer will be contacted at one of the dates and times provided. If additional information is needed related to this request, the scheduler will reach out to the contact person listed above.
If your request is outside of normal business hours, your request will be reviewed the next business day. Peer to Peer requests will be scheduled Monday through Friday, 8 am to 5pm, EST, excluding holidays.

BlueCare

Clinical Update Information

Contact Information
Name: *
Phone: *
Fax: *

Provider Information
Provider Name: *
Provider Type: *
Provider Phone: *
First Available Date: *
From Time: * To Time: *
Second Available Date: *
From Time: * To Time: *
Third Available Date: *

Service Information
Note Type: * Peer to Peer Review

A Peer to Peer request allows a provider to speak directly with the Medical Director to dispute an adverse determination and to provide additional pertinent clinical information. The provider requesting the peer to peer will be contacted at one of the dates and times provided. If additional information is needed related to this request, the scheduler will reach out to the contact person listed above.
If your request is outside of normal business hours, your request will be reviewed the next business day. Peer to Peer requests will be scheduled Monday through Friday, 8 am to 5pm, EST, excluding holidays.

Behavioral Health Outpatient Authorizations: Treatment Types

BlueCare Treatment Types

Select

Psych PHP

Psych IOP

Respite

Ambulatory Detox

Substance Abuse IOP

Substance Abuse PHP

Psych Testing

Psych Consult (Medical Floor)

Routine Supported Housing

PACT/ACT

Home-based Treatment

Mental Health Care Coordination

Enhanced Supported Housing

Medically Fragile Supported Housing

Neuropsych Testing

ABA

Nursing Home Outpatient

TMS

FITT

CCFT H0037HA

CCFT H0037HB

CTT H0037HA

CTT H0037HB

CCFT H0036HA

CCFT H0036HB

CTT H0036HA

CTT H0036HB

CCFT T2022HA

CTT T2022HB

Commercial Treatment Types

Select

Select

Psych PHP

Psych IOP

Substance Abuse IOP

Substance Abuse PHP

Psych Testing

Neuropsych Testing

ABA

TMS

Behavioral Health Provider Initiated Notice (PIN)

- › Empowering provider workflow by new online process for PIN submissions.
- › Select the **Auth Inquiry / Clinical Update** form on the Availity Payer Spaces Authorization application.
- › The PIN Adverse Action form is found on this link: [Provider Initiated Notice Form](#)

Behavioral Health Provider Initiated Notice (PIN)

- › Submit only one PIN form per member. The PIN attachment can only be for the member chosen on the authorization inquiry.
- › Be sure to select the BH PINS note from the drop-down list, or the information won't route to the appropriate area.
- › Submitting the PIN using this method ensures the PIN notification is routed automatically and will be processed more quickly than a faxed PIN notification.

LTAC/SNF/Inpatient Rehab Authorizations

IMPORTANT

- › Authorization forms must be attached with any appropriate supporting clinical documentation.
- › Forms should be filled out completely and submitted to prevent approval delays.
- › Commercial Long Term Acute Care Hospitalization Services Authorization Form: [Long Term Acute Care Request Form](#)
- › Commercial/FEP, BlueCare, and Medicare Advantage SNF/Inpatient Rehab Authorization Request Form: [SNF_IP Rehab Request Form](#)

Hospice Authorizations – Commercial Members

- Select the Hospice form for Commercial Members.
Note: BlueCare does not require prior authorization for Hospice services.
- Be sure to attach the Certification of Terminal Illness and Election of Hospice Benefit forms to the authorization.

BlueCross of Tennessee

Submit Hospice

Select Patient Information

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided.

Home

Authorization / Advance Determination Submission

Inpatient Confinement

Inpatient Behavioral Health

Outpatient

Outpatient Behavioral Health

High Tech Imaging

Observation

Maternity Care Management

Hospice

Durable Medical Equipment

Specialty Pharmacy

Home Health Services

Outpatient Therapy

Auth Inquiry/Clinical Update

Evolution (RadMD)

Alacura Air Ambulance

ICD Code (No Decimals)

Description

Primary Diagnosis*

Enter

Add more codes...

Contact Information

Contact Name*

Contact Phone*

Requesting Provider Phone*

Hospice Phone*

Contact Fax*

Submitting From: ☐ Facility ☐ Physician's Office

Attach Clinical Information

Only PDF, TIFF, and JPEG files. Each file will be limited to 5 MB. Only alphanumeric and underscores are allowed. Spaces are not allowed. Please attach the Certificate of Terminal Illness and Clinical Information.

* Choose File No file chosen

Add more Attachments...

Reset

Back Cancel Continue

1

2

BlueCard – InterPlan Tool

InterPlan Medical Policy and Pre-Certification Application:

- › Providers can enter the member prefix into the application to determine specific Medical Policy and/or Pre-Certification (Prior Authorization) information for all BlueCard Plans. [BlueCard InterPlan Tool](#)
- › You can click either Medical Policy or General Pre-Certification / Pre-Authorization information.
 - Enter the member's three-character alpha-prefix and click **Submit**

BlueCard – InterPlan Tool

InterPlan Medical Policy and Pre-Certification Application:

- › Tool found on BCBST.com site as well as Availity Resources, where you can favorite the tool for easier use when inside Availity
- › **NOTE:** The information that displays is coming from each BlueCard Home Plan and may vary.

BlueCard Authorization – Tennessee Provider, Out-of-State Member

Authorization process for Tennessee provider treating an out-of-state member:

- Click Patient Registration, and then Authorizations & Referrals.
- Complete the form. The Member Prefix will single-sign on (SSO) to the member's home plan to complete the prior authorization.

The screenshot displays the 'Authorizations' portal for BlueCross Blue Shield of Michigan. The main heading is 'Pre-Service Review for Out-of-Area and Local Members'. A message states: 'IMPORTANT: You have been routed from BCBS TENNESSEE to BCBS MICHIGAN AND BLUE CARE NETWORK to complete your authorization request. You are now a BCBS MICHIGAN AND BLUE CARE NETWORK member.' Below this, users are prompted to choose from pre-authorization options: Inpatient Authorization, Outpatient Authorization, and Referral. A list of 'Authorization Vendors' is provided, including Carelon Provider Portal, e-referral, evoCore Provider Portal, naviiHealth Provider Portal, Novologix BCBSM, Novologix BCN/BCN Advantage, Novologix Medicare Plus Blue, TurningPoint Provider Portal, CareCentrix Provider Portal, and New Directions Provider Portal. A 'Back' button is at the bottom left. On the right, a 'Start an Authorization' form is shown, featuring fields for Transaction Type (Outpatient Authorization), Organization (BCBS of Tennessee), and Payer (BCBS TENNESSEE). It includes a 'Select a Patient' dropdown, a Member ID field (0401234567890), Service From Date (04/20/2023), and Service To Date (04/20/2023). The 'REQUESTING PROVIDER' section has a 'Select a Provider' dropdown (ABC Medical Center), a 'Requesting Provider Type' dropdown (Facility), a Name field (ABC Medical Center), an NPI field (1234567890), a Tax ID field (6700000000), and a Specialty / Taxonomy dropdown (202900050X - General Acute Care Hospital).

BlueCard Authorization – Provider is Out of State

Authorization process when the provider is out of state treating a BlueCross member:

- › Start the authorization from the local Blue Plan portal. If the Blue Plan uses their own portal for in-state authorizations, the BlueCard authorization should also start in that same portal.
- › After entering the member information, the electronic authorization process should take the provider to the authorization application.

BlueCare PCP Maintenance

Change Member PCP

- › Real time updates made with few data elements
- › No more WW3 claim issues by ensuring PCP change was made
- › Changes can be backdated 3 business days (21 business days for newborns)
- › FAQs: [myBluePCP | BlueCare Tennessee](#)

Review/Print My PCP Roster

- › Verify members assigned to each Provider in practice
- › Export to Excel or PDF



BlueCare PCP Maintenance

Review and update BlueCare, TennCare Select, & BlueCare Plus patient populations

Contact Preferences & Communication Viewer

Contact Preferences

- › Online updates for each contact type
 - Contracting, Credentialing, Network Operations, Network Updates, Quality & Clinical and Financial

View Communications

- › Online repository of communications



Contact Preferences & Communication Viewer

Update your contact information and view your important messages and documents.

Fee Schedule Viewer

- Provider Enrollment and Contracting User Role is needed
- Provider selection is optional, but often provides a better display inside view application



Fee Schedule Viewer

1

View your fee schedules for BlueCross contracts

of Tennessee

Fee Schedule Viewer

Home > BlueCross BlueShield of Tennessee > Provider Selection

Provider Selection

Please note that changes to fee schedules will be reflected in Availability the Monday following the effective date of the change.
Example: BCBST Base Fee Schedule for facilities are updated yearly on April 1st. If April 1, falls on a Monday, it will be available the following Monday.

Organization *

ABC Medical Group

Tax ID *

6200000000

Provider

Harry Potter

NPI

1234567890

Submit

2

PAYER SPACES

Fee Schedule Viewer

Fee Schedule Details

Harry Potter Contract ID : 1234567890

Address :
1 Cameron Hill Circle
Chattanooga, TN 37401

Select Fee Schedule

Network
BLUECARE

Agreement
Select an Agreement

I agree that the information in this fee schedule is considered confidential pursuant to my BlueCross BlueShield of Tennessee agreement. Unauthorized disclosure of this fee schedule is not permitted.

Submit

Provider Details

Search Fee Schedule Keywords / AND Search Effective Date (MM/DD/YYYY) From To Search Clear Search

Fee Schedule Details

Procedure Code	Rate	Indicator *	Site of Service	Age Range	Effective Date
90785	\$0.00		Non-Facility	All Ages	01/01/2014
90791	\$86.06		Non-Facility	All Ages	01/01/2014
90792	\$86.06		Non-Facility	All Ages	01/01/2014
90832	\$38.48		Non-Facility	All Ages	01/01/2014
90833	\$14.18		Non-Facility	All Ages	01/01/2014

Previous Page 1 of 154 10 rows Next

- › Select Network and Corresponding Agreement ID
- › If desired, export to Excel or PDF
- › If desired, search for specific CPT code

Enroll a Provider

- 1 Update CAQH [CAQH ProView](#)
- 2 Enter EFT/ERA information on [Change HealthCare](#)
- 3 Availity/Provider Enrollment Updates and Changes Application

Note: If Group is contracted in our Medicaid and/or Medicare Advantage Networks, the Providers being enrolled will need a Medicaid and/or Medicare Provider Number before beginning the enrollment process.

Provider Enrollment Updates and Changes

- Enrollment
- Change Request
- Network Verification
- Out-of-Network Provider Information
- Track a Request (Enrollment)



Provider Enrollment, Updates, and Changes

We are waiving EFT requirements
for provider enrollment. See News
and Updates

Helpful Hints and Pre-Requisites for Enrollment

- Before enrolling, individual providers should register for their CAQH ID at caqh.org/providers.
 - Please make sure all your addresses and supporting documents (licenses, certifications, etc.) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
 - Find out more about our Medicaid ID requirements at tn.gov/tenncare.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

BCBST will not differentiate or discriminate in the treatment of practitioners or organizations seeking credentialing on the basis of race, ethnic/racial identity, gender, age, sexual orientation, religion, patient type (e.g. Medicaid) in which the practitioner specializes.

PAYER SPACES

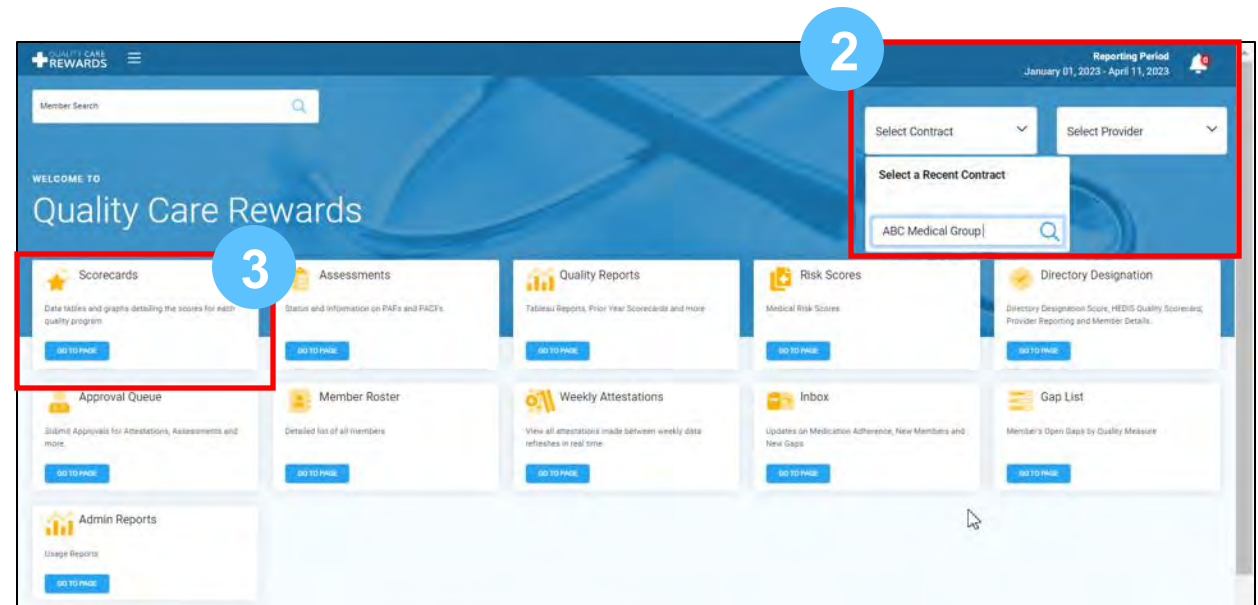
Quality Care Rewards (QCR)

- › Search Provider name in Contract Search Field
- › Select desired tile to view data or click horizontal lines in upper left corner for navigational menu

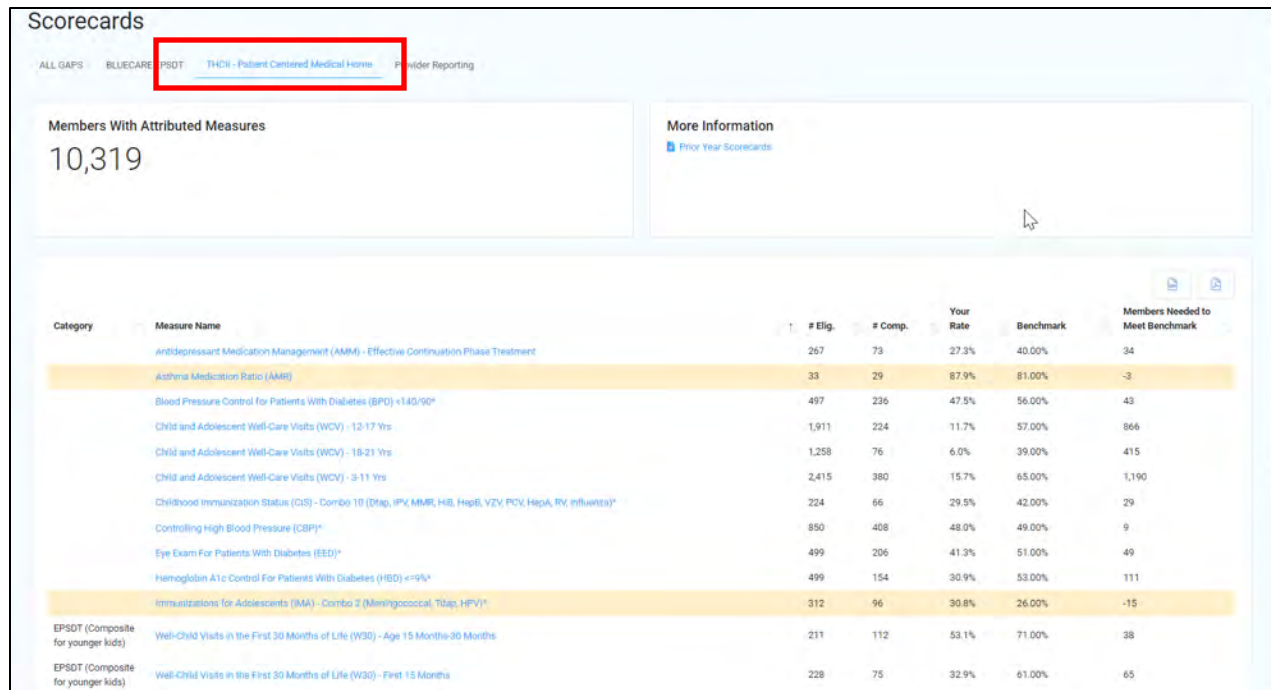


Quality Care Rewards (QCR Platform)

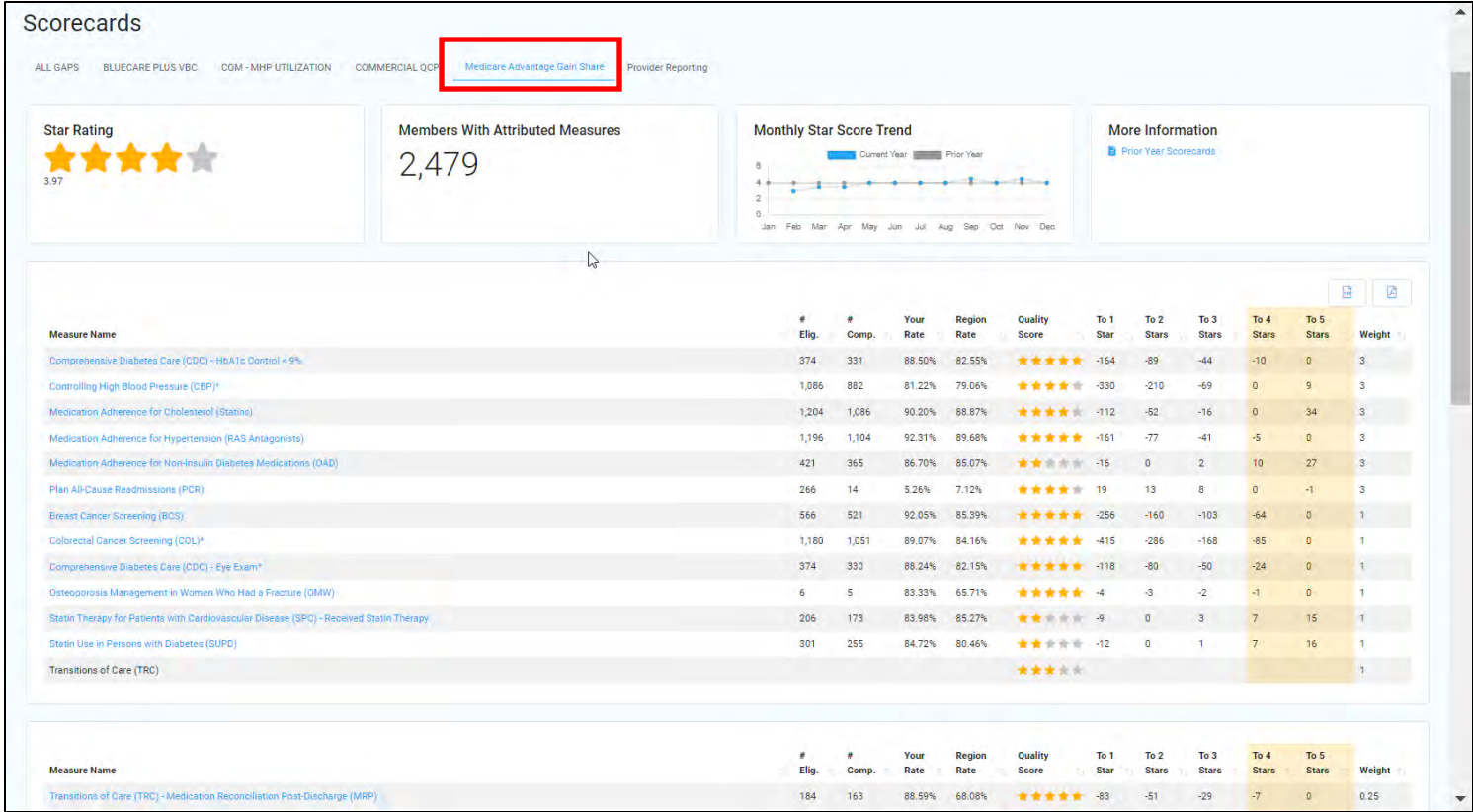
Review gaps and track incentives for providing quality care.



Scorecards: THCH – Patient Centered Medical Home



Scorecards: Medicare Advantage Gain Share



Tennessee HealthCare Innovation Initiative (THCII)

THCII Reporting Application

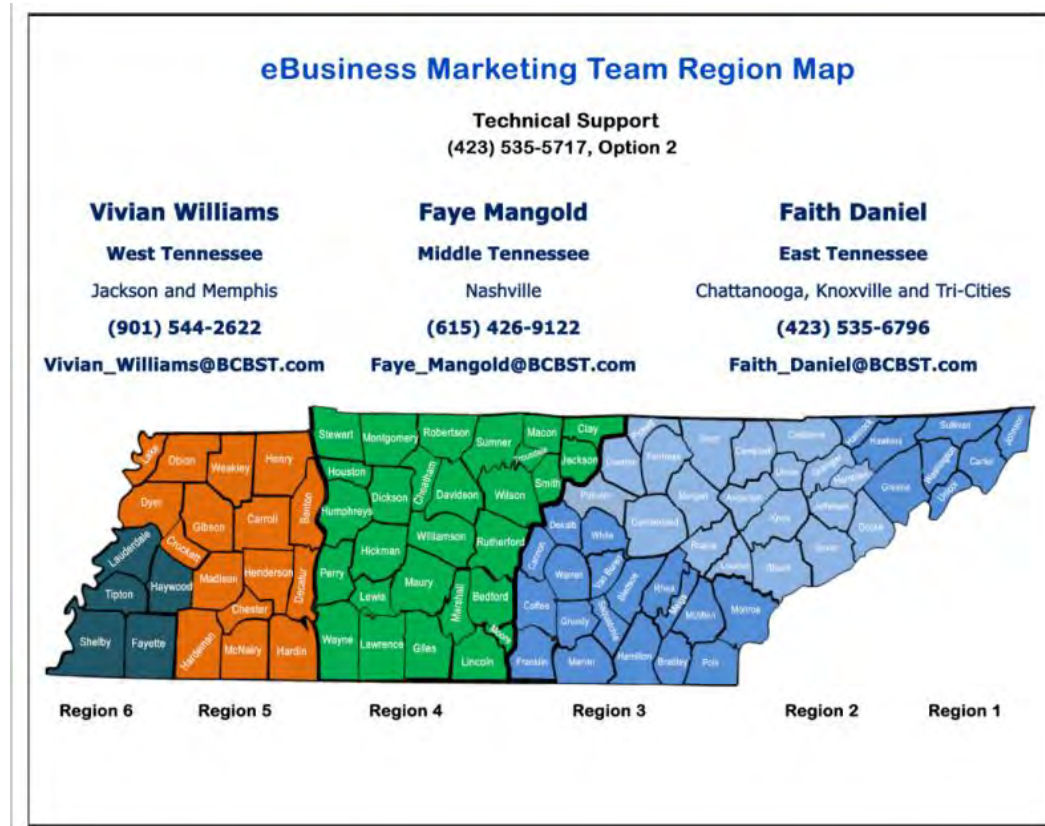
- 1 Episodes of Care
- 2 Patient Centered Medical Home
- 3 Tennessee Health Link (Behavioral Health)

Please select a program tab and provider to view reports. (if available)

Episodes of Care	Patient Centered Medical Home	Tennessee Health Link
<div>1</div> <div>2</div> <div>3</div> <div>ABC Medical Group</div> <div>2025<ul style="list-style-type: none">Q1<ul style="list-style-type: none">BlueCare<ul style="list-style-type: none">BlueCare Interim Performance DetailBlueCare Interim Performance Summary Wave 3, Wave 4, Wave 5, Wave 6202420232022</div>		

eBusiness Team Contact Information

› eBusiness Regional Map



Thank You

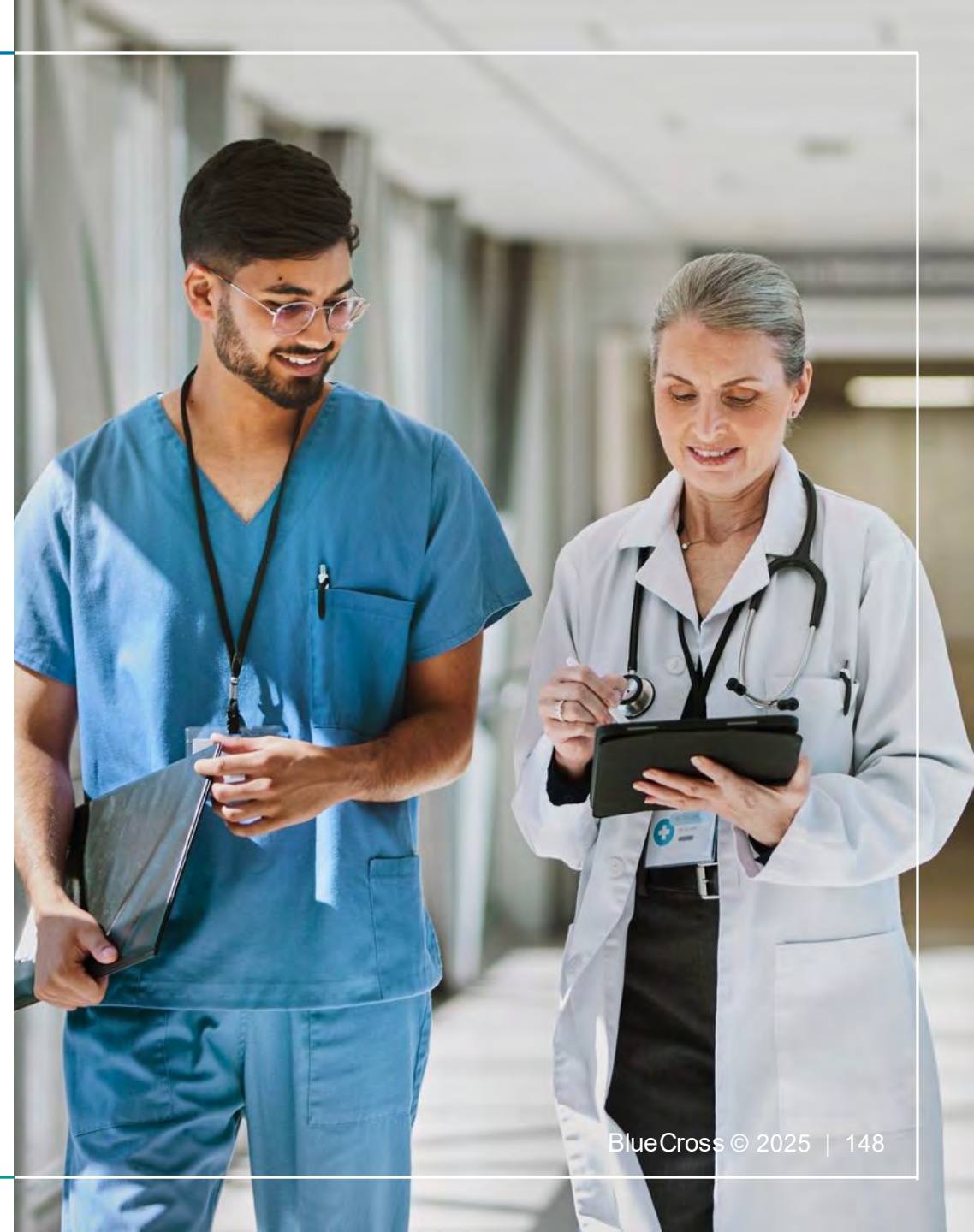


BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association

Provider Network Operations

Discussion Topics

- › CAQH / Provider Network Verification
- › Directory Suppression
- › Enrollment Process
- › Navigating the Persona Page and Accessibility
- › Enrollment Applications Suite and Contact Preference
- › Application Status Tracker
- › Reference Page



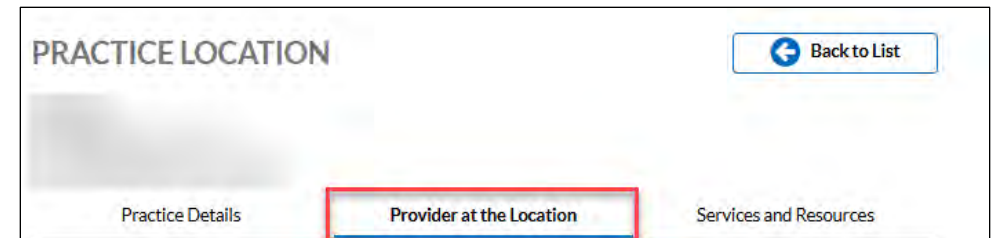


Directory Topics

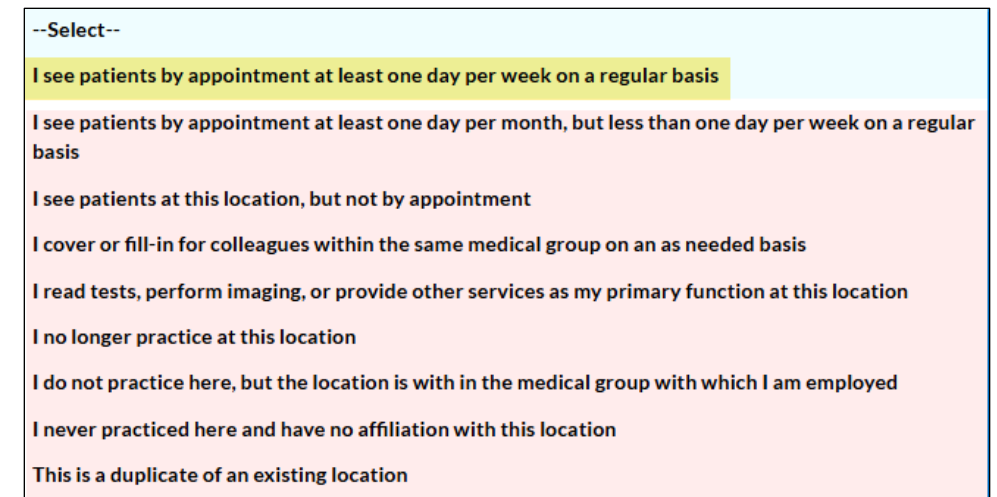
- › CAQH Practice Locations, Office Hours, and Hospital Affiliations
- › Network Verification
- › Consolidated Appropriation Act - Directory Suppression

Confirm Affiliation — Address

- › Review this each time you attest.
- › Notice which affiliations display in the directory.
- › Notice which affiliations do NOT display in the directory.
- › If a provider's address is displayed in the directory, a patient should be able to call that number and make an appointment with that provider at that location.



The screenshot shows the 'PRACTICE LOCATION' page. At the top right is a 'Back to List' button. Below the title is a blurred image of a practice location. At the bottom, there are three tabs: 'Practice Details', 'Provider at the Location' (which is highlighted with a red border), and 'Services and Resources'.



The screenshot shows a dropdown menu with the following options:

- Select--
- I see patients by appointment at least one day per week on a regular basis
- I see patients by appointment at least one day per month, but less than one day per week on a regular basis
- I see patients at this location, but not by appointment
- I cover or fill-in for colleagues within the same medical group on an as needed basis
- I read tests, perform imaging, or provide other services as my primary function at this location
- I no longer practice at this location
- I do not practice here, but the location is with in the medical group with which I am employed
- I never practiced here and have no affiliation with this location
- This is a duplicate of an existing location

Address Standardization

- › USPS Standard
- › Makes sure there's an accurate location to help your patients find your practice.
- › Allows all your providers to have the same address information for the same location.

The screenshot shows a web interface titled "Address Standardization" with a close button in the top right corner. Below the title, a message states: "The address you entered has been standardized. Please confirm that the suggested address is correct." The interface is divided into two main sections. The left section, titled "You entered", displays the input address: "2333 McCallie Avenue", "Suite 2", "Chattanooga, TN", and "37412". The right section, titled "Standardized Address", displays the suggested standardized address: "2333 McCallie Ave Ste 2", "Chattanooga, TN", and "37404-3258". At the bottom of the interface, there are two buttons: a red "Continue" button and a blue "Not now" button.

You entered	Standardized Address
2333 McCallie Avenue	2333 McCallie Ave Ste 2
Suite 2	Chattanooga, TN
Chattanooga, TN	37404-3258
37412	

Office Hours

- › Review this each time you attest.
- › If left blank in CAQH, patients will not see your office hours on our directory.

PRACTICE LOCATION [← Back to List](#)

Practice Details Provider at the Location Services and Resources

Practice Office Hours ⓘ

	Start Time	End Time	
Monday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours
Tuesday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours
Wednesday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours
Thursday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours
Friday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours
Saturday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours
Sunday	None ⓘ	None ⓘ	<input type="checkbox"/> Open 24-hours

Hospital Affiliation



Please Review

- › Review options for Hospital Affiliation and choose the appropriate State selection to drive the dropdown menu options for the accurate Hospital Name selection.
- › Hospital names shown in the drop down are as the hospital is registered with the American Hospital Association (AHA)

Admitting Privilege Record [Back to List](#)

* Required fields are indicated with a red asterisk. All other fields are optional.

Please enter the details of your Admitting Privilege Record. An admitting privilege means that you can admit patients on an unrestricted, limited or temporary basis.

*** State** **Country**

*** Hospital Name**

Ascension Saint Thomas Behavioral Health Hospital
Ascension Saint Thomas DeKalb
Ascension Saint Thomas Hickman
Ascension Saint Thomas Highlands
Ascension Saint Thomas Hospital
Pending

Start Date

*** Admitting Privilege Type**

☒ **Full and unrestricted**
You have privileges to admit patients with no limitations on number of patients or frequency of admit.

☐ **Temporary**
You have unrestricted access to admit patients but the privileges are temporary. These privileges are often granted prior to full medical staff membership or strictly as locum tenens.

☐ **Limited**
You can only admit under certain circumstances or for certain conditions. This type does not include limitations common to your specialty type.

Hospital Affiliation (cont.)



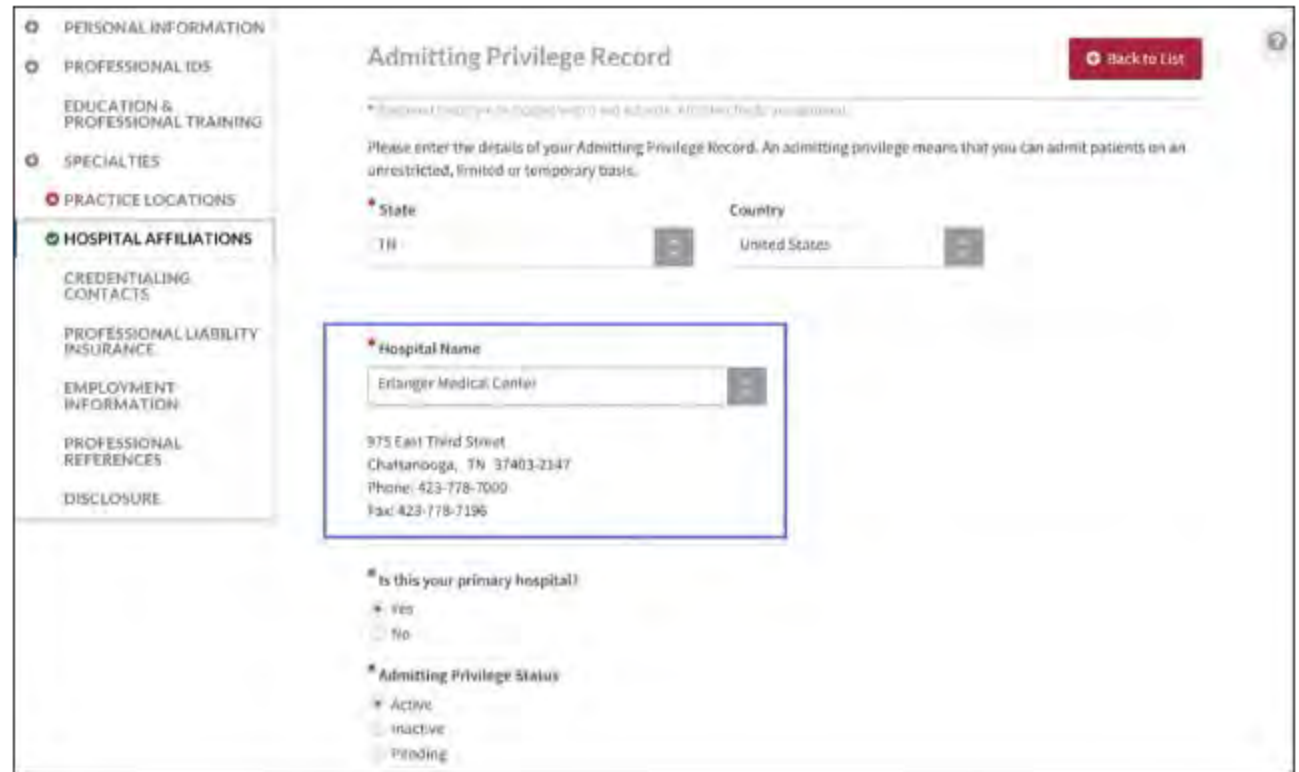
Please Review

- › If “**Other**” is selected, free form fields will be available but is not best practice.
- › This can cause inaccurate data to be loaded in our internal systems and display on the directory.

The screenshot shows the 'Admitting Privilege Record' form in the CAQH Provider Data Portal. The left sidebar lists various sections: PERSONAL INFORMATION, PROFESSIONAL IDS, EDUCATION & PROFESSIONAL TRAINING, SPECIALTIES, PRACTICE LOCATIONS, HOSPITAL AFFILIATIONS (selected), CREDENTIALING CONTACTS, PROFESSIONAL LIABILITY INSURANCE, EMPLOYMENT INFORMATION, PROFESSIONAL REFERENCES, and DISCLOSURE. The main form area is titled 'Admitting Privilege Record' and includes a 'Back to List' button. The form contains several fields: State (IL), Country (United States), Hospital Name (Other), Other Hospital Name (Drexler Med Center), Street 1 (123 East Third Street), Street 2 (Wing 100 Building), City (Ottumwa), Zip Code (52501), Phone Number (423-555-1234), and Fax Number. The 'Hospital Name' dropdown is highlighted with a blue box, and the 'Other' option is selected.

Best Practice

- › Standardized hospital name.
- › Standardized address.
- › Fewer keystrokes.



PERSONAL INFORMATION

PROFESSIONAL IDS

EDUCATION & PROFESSIONAL TRAINING

SPECIALTIES

PRACTICE LOCATIONS

HOSPITAL AFFILIATIONS

CREDENTIALING CONTACTS

PROFESSIONAL LIABILITY INSURANCE

EMPLOYMENT INFORMATION

PROFESSIONAL REFERENCES

DISCLOSURE

Admitting Privilege Record

[Back to List](#)

Please enter the details of your Admitting Privilege Record. An admitting privilege means that you can admit patients on an unrestricted, limited or temporary basis.

* State: TN Country: United States

* Hospital Name: Erlanger Medical Center

975 East Third Street
Chattanooga, TN 37403-2147
Phone: 423-778-7000
Fax: 423-778-7196

Is this your primary hospital?

☒ Yes
☐ No

* Admitting Privilege Status

☒ Active
☐ Inactive
☐ Pending

Network Verification

Home » BlueCross BlueShield of Tennessee » Provider Enrollment, Updates, and Changes » Provider Selection » Verification Details

Search Provider by Name:

Miller, Andrew C.
Provider ID: 3057668
Provider NPI: 1326046509

Verification Details

The information below is not a part of CAQH ProView® and we need you to verify for BlueCross BlueShield of Tennessee.

Basic Demographic

Changes to the Basic Demographic's section should be updated with the CAQH ProView® Profile.

Provider Name: Miller, Andrew C.	Gender: M	NPI Type 1: 1326046509
----------------------------------	-----------	------------------------

Provider Specifics

Submission of Provider Enrollment Form is needed for changes to the Tax ID or specialty.

Provider Number: 3057668	Tax ID: 620637725	NPI Type 2: 1326046509
Associated Group Name: Cherokee Health Systems		
Specialty: Psychiatric Clinical		

Network Information

Network Name	Accepting Patients (Yes/No)
Behavioral Health Comprehensive Network	> Yes / No
BlueAdvantage PPO	> Yes / No
Rendering - Value Options	> Yes / No

- › Information not collected or collected differently than from what BlueCross requires.
- › Accepting Patient Status-critical to patients seeking care.
- › Billing Address
- › New services within your group.
- › Quick and easy way to see what BlueCross has and update what's missing.
- › An easy way to let us know when a provider has left your group.

Consolidated Appropriation Act — Directory Suppression

Directory Suppression

- › Consolidated Appropriation Act (CAA) requires that you attest to your CAQH information every 90 days
- › Warning letter will be sent after you have not attested in over 90 days.
- › If we do not receive attested information from CAQH the suppression process will be initiated.
- › Your practice location will not be visible to members until you re-attest.



April 17, 2025

RE: Urgent Reminder to Update Your Provider Directory Information

Dear Provider:

Reference #: 1003351933

We're writing to remind you that you're required to verify and update your provider directory information at least every 90 days, as required under the Consolidated Appropriations Act, 2021. This requirement is included in the Provider Network section of our Commercial Provider Administration Manual.

As of today, we haven't received verification of your information in over 90 days, so please complete your verification. If an update and/or attestation isn't received timely, we may suppress your information from our provider directory (<https://bcbst.sapphirecareselect.com/>) until your information is validated.

Practitioners:

Review and attest to your information in [CAQH ProView](#) and complete the Network Verification Form in [Avality](#). This allows you to update your information and attest that it is accurate for each practitioner and location. When you have a change, you'll also need to update your information at [CAQH ProView](#) and [Avality](#).

Enrollment Process

Enrollment Process

Getting Started

There are a few requirements and steps you must take before we can begin the enrollment process.

- › You must have an NPI registered through NPPES, to begin.
- › Register with the Council for Affordable Healthcare, Inc. (CAQH) and get an ID number.
 - Give us access to your data and attest that it's correct no more than 90 days prior to giving us access.
- › You must have an account with Availity*. To register, access Availity and locate the BlueCross BlueShield payer space.
- › Set up an electronic funds transfer (EFT), as well as electronic claims and remittance, through our vendor, Change Healthcare.

To alter an existing contract, please contact your network manager before submitting an application.

Enrollment Process (cont.)

..... concurrent

1. INTAKE AUDIT

Our teams confirm we've received all your information and will contact you for additional documentation, if needed.

- › We may send a letter asking for additional information needed to complete the review of your application.*
- › You may receive a discontinuance letter if we aren't able to process your request.



2. CREDENTIALING

We verify all information received from providers applying to be in network with BlueCross.

- › We may send a letter asking for additional credentialing criteria we need to complete your application.*
- › We'll send a credentialing acceptance letter when our review is complete.**
- › If we're unable to credential a provider, we'll send a credentialing denied letter.



3. CONTRACTING

At this step, we approve or deny requests for participation in various BlueCross networks and send out the appropriate contracts.

- › We'll send a denial notice if the network applied for isn't available to the provider.
- › Approved contracts, amendments and other related communications will be sent through DocuSign or emailed from us.

*These communications require a response. Failure to respond will cause your application to be delayed or discontinued.

**The date listed is the credentialing approval date not your network participation date, which you'll receive during Provider Enrollment.

Enrollment Process (cont.)

4. ENROLLMENT AUDIT

Our teams review documentation to make sure all enrollment requirements are met, that you're credentialed or pre-approved, and that contracts are completed.



5. PROVIDER ENROLLMENT

We add the approved networks to your records and configure your information in our systems to make sure claims will be paid correctly and that all information displays correctly in our directory.

- › We'll send applicable acceptance letters with effective dates for all contracted networks.



6. ECOMMERCE

Our teams will set up your EFT, remittance advice and claims submission.

- › You'll receive a letter confirming that the provider has been approved to transmit claims through our vendor.
- › We'll send a letter letting you know that EFT is set up, and payments will be made electronically through the account you set up with Change Healthcare.

Enrollment Process (cont.)

- › Direct questions to Contracts_Reqs_GM@bcbst.com
- › To check an application status any time, visit the payer space in Availity
 - Provider Enrollment > Updates and Changes > Provider Type/Request Type/Track a Request

Navigating the Persona Page and Accessibility

Provider Portal Service Hub

Enrollment, Changes, and Updates

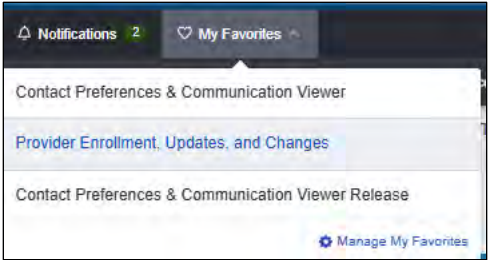
- › Navigating the Persona Profile Page and Accessibility
- › Enrollment Applications Suite
- › Contact Preference
- › Enrollment Application Status Tracker
- › Reference Page




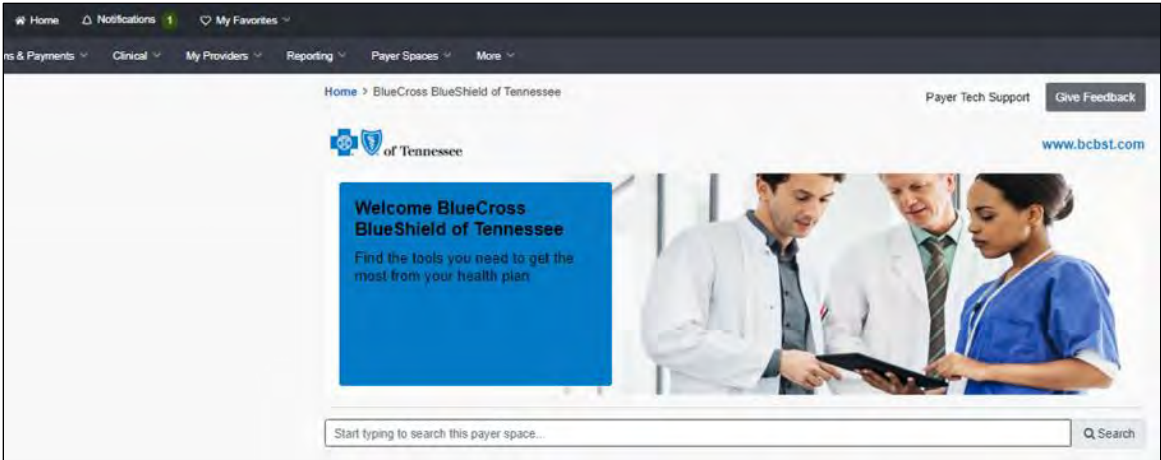
Digital Suite


Accessing the Digital Suite


Mark us as a favorite from our Payer Spaces for easy accessibility.




 **Provider Enrollment, Updates, and Changes**
Enroll or make changes to a Provider for BlueCross BlueShield of Tennessee



 **Provider Enrollment, Updates, and Changes**
Enroll or make changes to a Provider for BlueCross BlueShield of Tennessee

 **Contact Preferences & Communication Viewer**
Update your contact information and view your important messages and documents

 **Contact Preferences & Communication Viewer Release**
Release version

Persona Page

Messaging – Yellow Section

In this section you will find important messaging related to process changes, enhancements, and general details to help guide the submission experience.

Helpful Hints and Pre-Requisites for Enrollment

- Before enrolling, individual providers should register for their CAQH ID at caqh.org/providers.
 - Please make sure all your addresses and supporting documents (licenses, certifications, etc.) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
 - Find out more about our Medicaid ID requirements at tn.gov/tenncare.
- All enrolling providers must first register for EFT and make any changes to their Tax ID or NPI with Change Healthcare at payerenrolservices.com.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

BCBST will not differentiate or discriminate in the treatment of practitioners or organizations seeking credentialing on the basis of race, ethnic/racial identity, gender, age, sexual orientation, religion, patient type (e.g. Medicaid) in which the practitioner specializes.

Submit

Persona Page (cont.)

How to Navigate – Grey Section

The More Info section in grey will help guide your selection options when navigating the persona page. This self-directed section can help you direct your request to the appropriate application.

Helpful Hints and Pre-Requisites for Enrollment

- Before enrolling, individual providers should register for their CAQH ID at caqh.org/providers.
 - Please make sure all your addresses and supporting documents (licenses, certifications, etc.) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
 - Find out more about our Medicaid ID requirements at tn.gov/tenncare.
- All enrolling providers must first register for EFT and make any changes to their Tax ID or NPI with Change Healthcare at payerenrolservices.com.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

BCBST will not differentiate or discriminate in the treatment of practitioners or organizations seeking credentialing on the basis of race, ethnic/racial identity, gender, age, sexual orientation, religion, patient type (e.g. Medicaid) in which the practitioner specializes.

[Submit](#)

Persona Page (cont.)

Persona Navigations

By utilizing a persona, each user can navigate through different scenarios from a single page, accessing our library of applications simply by presenting a few generalized questions.

Helpful Hints and Pre-Requisites for Enrollment

- Before enrolling, individual providers should register for their CAQH ID at caqh.org/providers.
 - Please make sure all your addresses and supporting documents (licenses, certifications, etc.) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
 - Find out more about our Medicaid ID requirements at tn.gov/tenncare.
- All enrolling providers must first register for EFT and make any changes to their Tax ID or NPI with Change Healthcare at payerenrolservices.com.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

BCBST will not differentiate or discriminate in the treatment of practitioners or organizations seeking credentialing on the basis of race, ethnic/racial identity, gender, age, sexual orientation, religion, patient type (e.g. Medicaid) in which the practitioner specializes.

Persona Page — Yellow Section

Messaging – Helpful tips for enrolling.

Think of this section as vital news and tips related to having a successful enrollment experience including pre-requisites.

Helpful Hints and Pre-Requisites for Enrollment

- Before enrolling, individual providers should register for their CAQH ID at caqh.org/providers.
 - Please make sure all your addresses and supporting documents (licenses, certifications, etc.) are updated in CAQH.
- Providers joining a group already contracted with our BlueCare Tennessee networks must have a Medicaid ID.
 - Find out more about our Medicaid ID requirements at tn.gov/tenncare.
- All enrolling providers must first register for EFT and make any changes to their Tax ID or NPI with Change Healthcare at payerenrollservices.com.

Persona Page — Options

Individual Practitioner

Enroll a new provider who will **not be associated with a provider group entity**. Update an existing provider with Type 1 NPI Specialty or Tax ID.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

Persona Page — Options (cont.)

Group

Enroll a new group or add providers to an existing group. Up to 15 providers may be added on a single submission. Type 2 NPI is required for this selection. Individuals with a Type 2 NPI are accepted as well.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

Persona Page — Options (cont.)

Ancillary and Facility

These options are available and can update network verifications, enroll for out of network, and request changes. Enrollment options are not available at this time.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

Accessing Providers

Accessing Your Organization

Improved navigation using the Tax ID(s) associated to the Organization in Availity.

The image displays two screenshots of the 'Provider Selection' form. The top screenshot shows an error message: 'You must have authorization to add practitioners to a group. If your group does not appear in the dropdown please contact your group administrator'. Below this is a dropdown menu for 'Organization (Tax ID)*' with the text 'Select an organization' and a red error message 'Please select an organization'. The bottom screenshot shows the full form with fields for 'Organization (Tax ID)*', 'Tax ID*', 'Provider (Populated by Manage My Organization)', and 'Organizational NPI (Type 2)*', along with a 'Submit' button.

Persona Page — Options (cont.)

Individual Practitioner

Enroll a new provider who will **not be associated with a provider group entity**. Update an existing provider with Type 1 NPI Specialty or Tax ID.

By continuing this individual provider request, you will only be considered for individual provider enrollment. You must use our [Group Enrollment](#) request to associate a practitioner to a group with a Group NPI (Type 2).

The screenshot shows a web form for enrolling an individual practitioner. At the top, a yellow banner contains a warning icon and text: "By continuing this individual provider request, you will only be considered for individual provider enrollment. You must use our [Group Enrollment](#) request to associate a practitioner to a group with a Group NPI (Type 2)." Below the banner, the form includes several fields: "Organization (Tax ID)*" with a dropdown menu showing "Select an organization" and a red error message "Please select an organization"; "Tax ID*" with a dropdown menu showing "Select a TaxID"; "Provider (Populated by Manage My Organization)" with a dropdown menu showing "Select a provider"; and "Individual NPI (Type 1)*" with a text input field. An "OR" label is positioned between the "Provider" and "Individual NPI" sections. A blue "Submit" button is located at the bottom left of the form.

Persona Page — Options (cont.)

Group

Enroll a new group or add providers to an existing group. Up to 15 providers may be added on a single submission. Type 2 NPI is required for this selection. Individuals with a Type 2 NPI are accepted as well.

You must have authorization to add practitioners to a group. If your group does not appear in the drop down, please contact your group administrator.

This screenshot shows a form for adding practitioners to a group. At the top, a yellow banner contains a warning: "You must have authorization to add practitioners to a group. If your group does not appear in the dropdown please contact your group administrator". The form includes three dropdown menus: "Organization (Tax ID)*" with the placeholder "Select an organization", "Tax ID*" with the placeholder "Select a TaxID", and "Provider (Populated by Manage My Organization)" with the placeholder "Select a provider". Below these is an "OR" separator and a text input field for "Organizational NPI (Type 2)*". A blue "Submit" button is located at the bottom left of the form area.

This screenshot shows the "BCBST Org Provider Enrollment Bus 1" page. The header includes "Customer ID", "Administrator", and "OAA Current? N/A". Below the header, there are tabs for "View Issues", "View Identifiers", and "Maintain Identifiers". The main content area displays a table with columns for "Tax ID(s)", "NPI", "Region", "Primary Taxonomy", and "Primary Service Address". The "Region" column shows "TN" and a link "Add Payer Region". The "Primary Taxonomy" column shows "N/A". The "Primary Service Address" column shows "1 Cameron Hill Ct, Chattanooga, Tennessee 37402". At the bottom, there is a "Providers" section with a search bar and a "Manage Providers" button.

Persona Page — Options (cont.)

Ancillary and Facility

These options are available and can update network verifications, enroll for out of network, and request changes. Enrollment options are not available at this time.

Please select one option for the Provider Type and one option for Request type below:

Provider Type (Select One):

- ☐ **Individual Practitioner** if you want to:
 - Enroll or update a provider who is **NOT** associated with a provider group.
- ☐ **Group** if you want to:
 - Enroll a new group or add new practitioners joining an established group.
 - Update network verifications for your rostered practitioners.
 - Update information about your brick-and-mortar facility or remove a practitioner from your group.
- ☐ **Facility** for Updates if you file claims with a UB-04.
- ☐ **Ancillary** for updates if you file claims with a CMS-1500 or UB-04.

AND

Request Type (Select One):

- ☐ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
- ☐ **Change Request** if you are updating existing provider information, removing a practitioner from your group, updating an address, making changes to supervising or covering physicians.
- ☐ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ☐ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ☐ **Track A Request**

Digital Application — Options

Individual Practitioner — Existing

The following options are available:

- › Update Provider Network Information
 - Provider Change Request
- › Update Out-of-Network Provider
 - Out-of-Network Enrollment
- › Add or Update Tax ID or Specialty
 - Individual Enrollment Request
- › Update Network Verification
 - Network Verify Request
- › Join a Group
 - Group Enrollment Request

The image displays two overlapping screenshots of the BlueCross BlueShield of Tennessee digital application suite. The top screenshot shows the 'Change Request Details' page, which includes an 'Introduction' section and a list of update options: 'Update Provider Network Information', 'Update Out-of-Network Provider', 'Add or Update Tax ID or Specialty', 'Update Network Verification', and 'Join a Group'. The bottom screenshot shows the 'Enrollment Details' page, which includes an 'Introduction' section and a list of update options: 'Update Provider Network Information', 'Update Out-of-Network Provider', 'Add or Update Tax ID or Specialty', 'Update Network Verification', and 'Join a Group'. Both screenshots show a blue header bar with the title of the page and a blue 'Acknowledge' button at the bottom right.

Digital Application — Options (cont.)

Group — Existing

The following options are available:

› Add or Remove Networks

- Contact Network Manager or Email:
Contracts_Reqs_GM@bcbst.com

› Enroll Additional Providers

- Group Enrollment

The image displays two overlapping screenshots of the BlueCross digital application suite. The top screenshot shows the 'Change Request Details' page, which includes an 'Introduction' section with text about partner information and a list of updates. The bottom screenshot shows the 'Enrollment Details' page, which includes an 'Introduction' section with text about enrollment and a sidebar with links to 'Networks', 'Provider Information', and 'Contact Details'.

Digital Application – Options (cont.)

Group — Existing

The following options are available:

- › Update Out-of-Network Enrollment
 - Out-of-Network Enrollment
- › Add or Update Tax ID or Specialty
 - Contact Network Manager or Email:
Contracts_Reqs_GM@bcbst.com
- › Update Network Verification
 - Network Verify Request

The image displays two overlapping screenshots of the BlueCross BlueShield of Tennessee digital application suite. The top screenshot shows the 'Change Request Details' page, which includes an 'Introduction' section and a list of updates. The bottom screenshot shows the 'Enrollment Details' page, which includes an 'Introduction' section and a list of existing providers.

Change Request Details

Introduction

We have partnered with CAQH Proview® to ensure information on practitioner locations, demographics, and hospital affiliations. Even if your location information is updated below for your group, you will need to still review and attest your CAQH Proview® for any practitioners associated with your group so we can receive the most updated information for the Provider Directory.

Below always verify us for relative updates specific to your provider:

- Location Information, ADA Limitations, and Patient Discharge Information at the Practice Level ONLY
- Contact Preference Address Updates
- Removing a Practitioner from the Group
- POC/Patient Level Updates and Reassignments
- Covering & Supervising Physician Updates
- eConsent / Change/Phone Updates

Please contact us at 1-800-924-7343 and follow the prompt for Network Contracts or Crossbilling, or email Contracts_Reqs_GM@bcbst.com

Enrollment Details

Introduction

Completion and acceptance of this enrollment request by BlueCross BlueShield of Tennessee is not a guarantee of network participation. BlueCross BlueShield of Tennessee policies and procedures will govern appeals related to this Enrollment Request. This enrollment request must be completed in its entirety to begin the contracting and onboarding process.

CAQH Provider ID

BlueCross BlueShield of Tennessee partners with CAQH Proview, which offers providers a single point of entry for information. By applying for Network Participation via this request you agree to be included in our roster with CAQH.

Existing CAQH Providers

If you are already registered and have a CAQH Provider ID, please verify that:

- your information is current and matches the information submitted on this enrollment request;
- you have completed a CAQH Proview online application; and
- all supporting documents are current and attached to your CAQH profile.

If you have "authorized" BlueCross BlueShield of Tennessee to access your credentialing information (if you selected "Global authorization," then BlueCross already has access to your data).

If you have not authorized BlueCross to access your credentialing information, you can complete your authorization by using the four steps below:

To allow BlueCross BlueShield of Tennessee access to your data:

1. Go to MyBlueCross and enter your username and password.
2. Select the "Authorization" link located under the CAQH logo.
3. Scroll down and select BlueCross BlueShield of Tennessee or you may select Global Authorization.
4. Select Save to submit your changes.

If you have questions about the CAQH Provider ID, please contact:

CAQH Support: 1-855-399-5771 | CAQH Email: providerhelp@proview-caqh.org | Website: <https://proview-caqh.org>

Networks

Provider Information

Contact Details

Contact Preferences

NAVIGATING & ACCESSIBILITY – CONTACT PREFERENCES

Contact Preferences



Contact Preferences & Communication Viewer

Update your contact information and view your important messages and documents

Contact Preferences

I want to:

[Update Contact Preferences](#)

[View Communications](#)

Contact Type *

Select a Contact Type

Organization *

Select an organization

Tax ID *

Select a Tax ID

Provider

Select a provider

NPI

[Submit](#)

Contact Type Descriptions:

Contracting - Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies and annual updates to Commercial BlueCross Performance Ratings.

Credentialing - Information about your credentialing status or credentialing appeals inquiries.

Network Operations - Updates about network enrollment and your listing in the BlueCross Provider Directory.

Network Updates - General business announcements, newsletter updates and surveys.

Quality & Clinical - Notifications about Quality Care Quarterly newsletter, available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application.

Financial - Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items.

Contact Type Descriptions:

Contracting - Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies and annual updates to Commercial BlueCross Performance Ratings.

Credentialing - Information about your credentialing status or credentialing appeals inquiries.

Network Operations - Updates about network enrollment and your listing in the BlueCross Provider Directory.

Network Updates - General business announcements, newsletter updates and surveys.


Quality & Clinical - Notifications about Quality Care Quarterly newsletter, available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application.

Financial - Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items.

Application Status Tracker

Enrollment Tracker

Self-Service Tracker — Track a Request



Provider Enrollment Tracker

Data Refresh Date (EST) :

Today's Date:

Tax ID :

Group NPI

Provider NPI

PEF/GEF ID

Status

Tax ID	Group NPI	Provider NPI	PEF/GEF ID	Line of Business	Provider Name	Start Date	Latest Status Date	Status	Percentage Complete		
			PEF-78618	Discontinued		5/23/2023	5/25/2023	Discontinued	<div>Discontinued</div>		
			PEF-88082	Discontinued		7/25/2023	7/31/2023	Discontinued	<div>Discontinued</div>		
			PEF-66024	Group Contracts		3/6/2023	5/17/2023	Complete	<div>100%</div>		
1			GEF-78333	Group Contracts		5/21/2023	6/22/2023	Complete	<div>100%</div>		
			GEF-89533	TBD		8/2/2023	8/2/2023	In Process	<div>5%</div>		
			GEF-78333	Group Contracts		5/21/2023	6/20/2023	Complete	<div>100%</div>		
			GEF-78333	Group Contracts		5/21/2023	6/8/2023	Complete	<div>100%</div>		
			GEF-72822	Group Contracts		4/19/2023	5/10/2023	Complete	<div>100%</div>		
			GEF-79466	Group Contracts		5/30/2023	6/22/2023	Complete	<div>100%</div>		
			GEF-81084	Group Contracts		6/8/2023	7/10/2023	Complete	<div>100%</div>		
			GEF-83674	TBD		6/22/2023	7/7/2023	Pended, ple..	<div>Pended to provider for more info</div>		
			GEF-88993	TBD		7/31/2023	7/31/2023	In Process	<div>5%</div>		
			GEF-86154	TBD		7/12/2023	7/13/2023	In Process	<div>15%</div>		
			GEF-78333	Group Contracts		5/21/2023	6/8/2023	Complete	<div>100%</div>		
			GEF-82844	TBD		6/20/2023	8/1/2023	Pended, ple..	<div>Pended to provider for more info</div>		
			GEF-85333	Group Contracts		7/6/2023	7/21/2023	In Process	<div>60%</div>		
			GEF-78618	Group Contracts		5/23/2023	6/20/2023	Complete	<div>100%</div>		
			GEF-87054	Group Contracts		7/18/2023	7/21/2023	In Process	<div>60%</div>		
			GEF-86154	Group Contracts		7/12/2023	8/1/2023	In Process	<div>60%</div>		
			GEF-89533	TBD		8/2/2023	8/2/2023	In Process	<div>5%</div>		

Why the New Enhancement

To better serve our customers, we are developing a self-service tracker for Group and Individual enrollment applications. This new capability lets you see the status and progress of any active enrollments submitted.

Real-time updates will be available directly from our Persona Page.

REFERENCES

Provider Network Operations

Provider Network Services

Questions or concerns regarding enrollment status, contracts, or credentialing

Phone: **1-800-924-7141** Credentialing and Contracting Option

Email: Contracts_Reqs_GM@bcbst.com

Provider Operations Process Support

Submission of provider enrollment supporting documentation

Email: ProviderSupport@bcbst.com

REFERENCES

Provider Network Operations (cont.)

Provider Maintenance

Questions or concerns regarding provider changes, data verifications, or correspondence

Email: PNS_GM@bcbst.com

Provider Directory

If you see something incorrect in our online Directory, you can report it with one click by choosing

See something incorrect? Let us know.

REFERENCES

Provider Network Operations (cont.)

Steps to enroll or make changes in our network

Here's where you'll start to enroll as a new provider or add a provider to your group contract.

- 1 Enter/update your information in [CAQH ProView](#).
- 2 All enrolling providers must first register for EFT and make any changes to their Tax ID or NPI with Change Healthcare at payerenrollservices.com
- 3 Register with [Availity](#) & complete your enrollment application or change form.

REFERENCES

Provider Network Operations (cont.)

Important Links

- › [Provider News and BlueAlerts](#)
- › [Provider Quick Reference Guide](#)
- › [Availity](#)
- › [CAQH Proview](#)
- › [Find My BlueCross Contact](#)

Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association

Medicare Advantage

2025 Quality Program Measure Changes

› Diabetes

- The **Hemoglobin A1c Control for Patients With Diabetes (HBD)** measure will be replaced with the **Glycemic Status Assessment for Patients With Diabetes (GSD)** measure.

› Pharmacy

- The **Polypharmacy - Multiple Anticholinergic Medications (Poly-ACH)** measure will move from the monitoring section into the scored section of the program as a single-weighted measure.

› Transitions of Care

- The **Notification of Inpatient Admission (NIA)** and **Receipt of Discharge Information (RDI)** components will be removed from the scoring of the **Transitions of Care (TRC)** measure.

› Member Experience

- The **Member Experience – CAHPS** measure weight reduces from 4 to 2

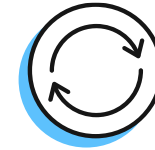
› Monitoring Status

- Concurrent Use of Opioids and Benzodiazepines (COB)
- Member Experience – HOS: Improving or Maintaining Mental Health
- Member Experience – HOS: Improving or Maintaining Physical Health

Medical Management

Prior Authorization Initiatives

- › Authorizations for Durable Medical Equipment is now code based. This reduced the number of DME items needing authorizations by approximately 1,000.
- › Radiation therapy planning codes were removed. Now only the procedure needs prior authorization.
- › A Master List of codes that have been removed from the Prior Authorization requirements can be found on our website.



Continuous Enhancements

We continue to review other services to see if there are opportunities in which some of the authorizations can be “auto-approved” based on the clinical information submitted.

These modifications are expected to decrease the provider administrative burden and improve the timing in which the member receives the services.



MEDICARE ADVANTAGE

QUALITY+
PARTNERSHIPS

PAF Updates

Provider Assessment Forms (PAF)

› Updated/Redesigned PAF in QCR

- Preferred method of completion
- Complete in or export from QCR in Availity®
- \$225 reimbursement (CPT® 96161)
- Main method of submission in 2024 and forward
- Keep a copy in the member's medical record

› Non-Standard PAF and Blank Form

- Retired and no longer accepted

Case Management

Internal

- › Utilization Management
- › Customer Service
- › Medical Directors
- › Appeals
- › Member Outreach
- › Health Navigation
- › Behavioral Health
- › Long Term Support Services

External

- › Primary Care Providers
- › Specialists
- › Members
- › Member Family / Friend
- › Facilities
- › Vendors

Case Management (cont.)

Support Available

> Community Resources

- Connect with local resources to help with things your benefits may not cover. You can get help with eating healthy, transportation, housing and more.

> AbleTo

- Offers mental health programs at no extra cost. You can work one on one with a motivational coach, licensed therapist or both. Visit ableto.com/BCBST to enroll.

> Home Meal Delivery

- You can potentially get 14 meals delivered to your home after a qualifying inpatient stay. We work with **Mom's Meals** and **Senior Solutions** to provide these meals.

Case Management (cont.)

Support Available (cont.)

> CareTN

- Connect digitally with your care team through the free CareTN mobile app. You can choose a program based on your health needs. Download the app from your smartphone's app store and use access code **medhelpwell** to get started.

> TeleHealth Services

- Get care anytime with **Teladoc Health**. Call **1-800-835-2362**, TTY **711** 24/7 or go to **bcbst.com/Teladoc**. You can also call **Nurseline** to get help with symptoms or where to get care. Call **1-888-747-8951**, TTY **711** anytime to talk with a registered nurse.

**We're right here
when you need us.**



bcbstmedicare.com



1-800-611-3489, TTY 711

MONDAY THROUGH FRIDAY
FROM 9 A.M. TO 6 P.M. ET.



My HealthPath

Incentive Activity	2025
Annual Wellness Visit (AWV)	\$20
Health Needs Assessment (HNA)	\$20
Breast Cancer Screening (BCS)	\$25
Colorectal Cancer Screening (Colonoscopy)	\$50
Colorectal Cancer Screening (Sigmoidoscopy)	\$50
Colorectal Cancer Screening (CT Colonography)	\$50
Colorectal Cancer Screening (FIT DNA)	\$30
Colorectal Cancer Screening (In-home FOBT)	\$20
Diabetic Retinal Eye Exam (CDC-Eye)	\$40



- › Screenings must have a 2025 Date of Service (DOS)
- › Claims based redemption for all members (no action required)

Enrollment Options

- › Online: bcbstmyhealthpath.com
- › Phone: Customer Service

Resources and Services

We're here to support your hard work and performance in the Quality+ Partnerships program with the following resources including, but not limited to:

- › Regionally based consultants
- › Quality metric and financial reporting
- › Risk adjustment education and support
- › Integrated quality pharmacist
- › In-home screening partners and in-office health screening events
- › Provider education opportunities
- › Supplemental data collection

MA_ProviderOutreach@bcbst.com

Pharmacy

Pharmacy Updates

- › IRA changes that impact Part D
- › M3P
- › 100-day supplies for Tier 1 and Tier 2 medications
- › Star Measure Changes for 2025
- › Trends in the industry
- › Partnerships / Initiatives



Pharmacy

Medication Adherence Tips

- › New therapies
- › Established maintenance medications
- › Dose changes
- › 100-day supply benefit
- › Prescription directions
- › Drug cost discussion
- › Set expectations
- › Medication adherence packaging
- › Medication adherence opportunity report



Part D Measures

- › Medication Adherence for Cholesterol (Statins)
- › Medication Adherence for Hypertension (RASA)
- › Medication Adherence for Diabetes Medications (OAD)
- › Statin use in Persons with Diabetes (SUPD)
- › Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)
- › Concurrent Use of Opioids and Benzodiazepines (COB)

Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association



ANCILLARY ALL BLUE WORKSHOP

Ancillary Network Managers

Shawanna Mason and Starla Scruggs

Ancillary Topics of Discussion



Ancillary

- › Complex Rehab Technology (CRT) Legislation
- › Taxonomy Guidelines
- › Compression Garments
- › Hearing Aids
- › Place of Service
- › Invoice/Waiver
- › DME Issues
- › Home Health Billing Guidelines
- › Change of Ownership
- › BlueCare Electronic Visit Verification Upcoming Changes

CRT Legislation

NEW

CRT Legislation

- 1 Coverage for Complex Rehab Technology (CRT) Maintenance Effective July 1, 2024.
- 2 The repairs must be provided by an authorized CRT equipment supplier. CRT providers are required to complete the Tennessee Department of Commerce and Insurance's CRT Attestation Form and submit with the claim.
- 3 All paid claims are subject to provider audit and recoupment if no attestation form is on file.
- 4 Please note that we will require the primary carrier's EOB. The primary carrier's EOB does not have to include the MS modifier, but the claim submitted to us will require the MS modifier.
- 5 BlueCare, TennCare*Select* and CoverKids cover and reimburse medically necessary repairs on CRT annually for at least one preventive maintenance visit.
- 6 No authorization is needed.

ANCILLARY - CRT

For questions about billing for CRT maintenance, please refer to this grid

Approach to Identify Wheelchair Device	Use Wheelchair code + M5 modifier for Data Reporting/Segmentation of device (No payment)
Approach to Identify and Reimburse for Maintenance Service Only	Line 1 Billed on Claim – Wheelchair code + M5 modifier (No payment)
	Line 2 Billed on Claim – K0739M5 (Indicates Maintenance; Results in Payment)
Approach to Identify and Reimburse for a Combined Visit of Repair and Preventative Maintenance Services	Line 1 Billed on Claim – Wheelchair code + M5 modifier (No payment)
	Line 2 Billed on Claim – K0739 + M5 modifier (Indicates Maintenance; Results in Payment)
	Line 3 Billed on Claim – K0739 (without modifier) (Indicates Repair; Results in Payment)
Approach to Identify and Reimburse for a Repair Service Only.	Line 1 Billed on Claim – Wheelchair code + M5 Modifier (No payment)
	Line 2 Billed on Claim – K0739 (without modifier) (Indicates Repair; Results in Payment)

Taxonomy

Billing Provider Taxonomy

We follow CMS guidelines for filing the National Provider Identifier (NPI) number. Professional claims require a taxonomy code to be submitted for the billing and rendering providers.

If you don't submit the appropriate taxonomy code, claims may be rejected, denied or result in incorrect reimbursement.

Specialty Types

This will apply to the following specialties only: Home Infusion (HITS), Pharmacy (PHARM), Specialty Pharmacy SPRX, or any DME (Durable Medical Equipment) specialty.

If the provider is in network, then the provider should be filing with the taxonomy you were credentialed with. If you have questions of how you're credentialed, please reach out to your Network Manager or Provider Services.

Provider Administration Manual

"We follow CMS guidelines for filing the National Provider Identifier (NPI) number. However, professional claims need a taxonomy code to be submitted for the billing and rendering providers. A taxonomy code is a unique 10-character code that designates your classification and specialization. It's important that both the billing and rendering provider taxonomy codes match the contracted provider."

Compression Garments

Lymphedema Compression Treatment Items

- › As of January 2024, we cover the gradient compression garments.
- › Previously we didn't view some codes as compression, they were considered surgical dressings.
- › According to CMS "surgical" was removed from certain codes and now those codes are considered for lymphedema.
- › There are only certain codes for lymphedema that we'll cover. They should be filed with the correct code and diagnosis code.
- › If the code is not on your fee schedule, you must follow our guidelines located in the PAM. Reimbursement Guidelines for Codes Classified as DME, Medical Supplies, Orthotics and Prosthetics Without an Established Maximum Allowable.

Hearing Aids

Hearing Aid Guidelines

- › Hearing aids covered under the members DME Benefit.
- › Pricing for hearing aids without a fee will be priced using Invoices.
- › The Provider Administration Manual references “Codes without a published Medicare fee – BlueCross BlueShield of Tennessee reserves the right to request the name of the manufacturer, product name, product number, and quantity provided”.
- › All services rendered should be billed to us on the same date of service.
- › As covered in our bi-annual site visits, please refer members to in-network providers for their maximum benefit or if the members benefit include out of network benefits. Only if the member has out of networks benefits may they be referred to an OON provider.

Hearing Aid Guidelines (cont.)

- Hearing exams, screenings, fittings/orientations/hearing aid checks, ear impressions, non disposable ear molds/inserts and conformity evaluations will be reimbursed based on the lesser of line level covered charges or the network maximum allowable fee schedule.
- Hearing aid batteries, accessories, assisted listening devices, disposable ear molds, dispensing fees, shipping/handling and sales tax won't be reimbursed separately except when the member's benefit has specific group coverage.
- Hearing related services and equipment should be billed using the most appropriate V code and number of units as defined by HCPCS.

Place of Service

Place of Service (POS)

- › The POS should represent where the item is being used, not where it's dispensed. For DME provider types this could include POS codes: 04, 09, 12, 13, 14, 16, 27, 32, 33, 34, 54, 55, 56, and 99 as possible member residence.
- › For all lines of business, DME providers must use “99” as the place of service code when submitting a claim for an item purchased by and delivered to a member at a retail store/place of business.
- › DME and medical supplies must be billed on a professional CMS-1500 claim form.

Invoices/Waivers

Invoices/Waiver

- › We reserve the exclusive right to determine the manufacturers visibly published and date of service appropriate list price.
- › We've used sources to determine the manufacturer's published list price that include but aren't limited to: Information visibly published by the manufacturer (e.g., product catalogs, product price listings and manufacturer order forms).
- › The coding and reimbursement team does not review quotes.
- › Please make sure you are following these guidelines to ensure easy review and processing.
- › In order for a waiver to be used for BlueCare, the Provider must document that the member was informed that a service was "non-covered."

DME ISSUES

DME Supply Issues

- › BCBST follows CMS and NCCI Guidelines for Diabetic Supplies,
- › Lines of business BlueCare and Commercial will follow the 30 day supply guidelines.
- › MedAdvantage and DSNP are the only line of business that allows providers to bill a 90 day supply order.
- › According to the BlueCare and Commercial Manuals there are only 5 items that require a date span.
- › Please make sure at all times, the correct codes are being utilized.
- › Please be mindful of changes, yearly for BlueCare and Commercial lines of business Addition/Deletion/Revision HCPCS and CPT Codes.

Commercial Home Health Agency Billing Guidelines



Home Health Agencies and Private Duty Nursing

- › Commercial claims for Home Health Services and Private Duty Nursing don't require a procedure code.
- › T1000 shouldn't be billed on Commercial Home Health Services.
- › T1000 is designed for use by Medicaid State Agencies only.
- › Commercial claims inaccurately billed with T1000 will result in the claim being denied and require a corrected claim.

Home Health Billing Reminders

- › Providers should use Type of Bill 032X for home health services.
- › A separate line item must be billed for each date of service.
- › Supplies not billed with the appropriate revenue and HCPCS code will be rejected or denied.



Home Health Billing Reminders (cont.)

- › Billing of supplies by a third-party vendor that are used in conjunction with a home health or private duty nursing visit are the responsibility of the home health agency.



Change of Ownership or Control (CHOW)

Change of Ownership or Control

1

Direct or **Indirect** sale or other disposition of all or a majority of the assets of a provider. This may involve a change of name, NPI or Tax ID.

2

Consolidation – The combination/ joint transactions resulting in a change in the beneficial owner, directly or indirectly, or more than 25% of the then-outstanding number of units, interests or shares of the provider's voting stock (or membership interests or other equity).

3

Conversion – Changing from one legal entity type to another (i.e., conversion from partnership to corporation or conversion from corporation to a limited liability company).

4

Corporation – Acquisition/Merger - The purchase of a provider or another organization, the acquisition/merger of the provider corporation with another corporation, or

5

Leasing - The lease of all or part of the providers facility or any other transaction that results in a change to the NPI or Tax ID of a provider. The lease agreement should be presented as documentation.

6

Partnership – The removal, addition or substitution of a partner may constitute a change of ownership.

CHANGE OF OWNERSHIP OR CONTROL

Things To Know

1

Providers considering a **CHOW** should notify **us** at least **60** prior to the effective date of the **CHOW** and a Consent to Assignment has been executed for the network effective dates to mirror the **CHOW** effective date.

2

The new provider must complete a Facility Credentialing Application and enroll in Electronic Funds Transfer (**EFT**) to receive payment.

3

If the buyer assumes the existing provider agreement, **we**, both the new and old owners, must complete a Consent to Assignment agreement to legally transfer existing provider to the new owner.

4

If **we**, the new and old owners do not agree to assume the existing agreements, the existing agreement will be terminated with the effective date of the **CHOW**, New owner will be required to sign a new agreement.

5

If a **Consent of Assignment is executed**, the buyer/new owner should submit claims for dates of service on or after the CHOW using the new owner NPI or Tax ID.

6

If a **Consent of Assignment is NOT executed**, claims for dates of service prior to the CHOW should be submitted the existing providers NPI and Tax ID. Claims for dates of service on or after the CHOW effective date should be submitted with the new owners NPI and Tax ID.

BlueCare

Electronic Visit Verification (EVV) Changes

BlueCare Tennessee and **CareBridge** are excited to partner on the Electronic Visit Verification (EVV) Model for Home Health Services providers in Tennessee.

Over the coming weeks and months, we'll share information about the upcoming transition to **CareBridge** as the EVV vendor for BlueCare Tennessee.

BlueCare Tennessee and CareBridge

- › Providers may choose to use **CareBridge** at **no cost** to your agency.
- › Providers may choose to contract with a third-party EVV solution, and will be responsible for any costs associated with the EVV solution.
- › Starting Aug. 1, 2025, providers will be able to access the **CareBridge** Provider Setup and Access Request Form to notify **CareBridge** of your EVV vendor selection.

CareBridge Integration

- › Providers that intent using or continue to use a third-party EVV solution should complete the **CareBridge** Third-Party EVV Vendor Intake Form.
- › **CareBridge** will contact your EVV vendor to begin the integration process.
- › Please contact your Provider Network Manager if you identify any barriers to your agency's successful transition.

Updated Reconsideration and Appeals Forms

Available 07/01/2025

Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association



EPISODES OF CARE

Agenda

1

TennCare's Recent Annual Feedback Session

2

Risk Adjustment Review

3

How Episode Risk Adjustment Affects Episode Spend

4

Episodes of Care Risk Factor Examples

5

Best Practices in Risk Adjustment

6

Risk Adjustment Reminders

7

Questions

TennCare's Annual Feedback Session

The 2025 Episode of Care Feedback Session was held virtually on Thursday, May 1, 2025.

TennCare shared a brief presentation about the Episodes of Care program and stakeholders were able to share their questions and concerns.

100 Attendees/170 RSVPs and 11 feedback items addressed live at the event.

The [Slide Deck from the 2025 Episodes of Care Feedback Session](#) is now available on TennCare's website.

TennCare's Annual Feedback Session

This session is a great resource for all stakeholders to better understand:

- › The make-up of TennCare's Episodes of Care team
- › Historical achievements in cost savings and quality improvement
- › The role of provider feedback in the Episodes of Care Program
- › How to engage with TennCare and your MCO representatives

TennCare's Next Steps:

- › Working through individual feedback items
- › Consolidating items that need MCO input/research
- › Prioritizing changes that may impact thresholds

Risk Adjustment Review

- Risk adjustment is one of the tools we use to achieve a fair comparison in episode spend across all Quarterbacks (QBs).
 - Note: Each payer runs its own risk adjustment model based on cost and there are variations in the population covered by each payer. Risk factors may vary across payers.
- Risk scores are derived from internally developed regression models at the episode of care level.
 - A regression model is a tool that describes the relationship between one or more independent variables (ICD-10 codes) and a response, dependent, or target variable (risk as it relates to episode cost).

Risk Adjustment Review (cont.)

- Risk models estimate the expected cost of a particular episode of care given:
 - Member demographics (age and gender)
 - Clinical information for the 12 months prior to the beginning date of the episode of care
- Quarterbacks are compared based on their performance on quality metrics and the average spend for their episodes.



Risk Adjustment Affects Episodes Spend

- Risk adjustment is used to fairly compare episode spend across all QBs.
- Based on the number of identified factors in a valid episode, a member risk score is derived.
- A risk score less than 1.0 is considered to have less-than-average risk and adjusts the cost of your episode up; a score greater than 1.0 is considered to have higher-than-average risk and adjusts your episode cost down.

Breast Biopsy Risk Factors

CCS Code	Factor	Weight
—	Female	0.843
—	Male	0.815
2.5	Cancer of breast	0.532
2.12	Secondary malignancies	0.638
5.14	Screening and history of mental health and substance abuse codes	0.009

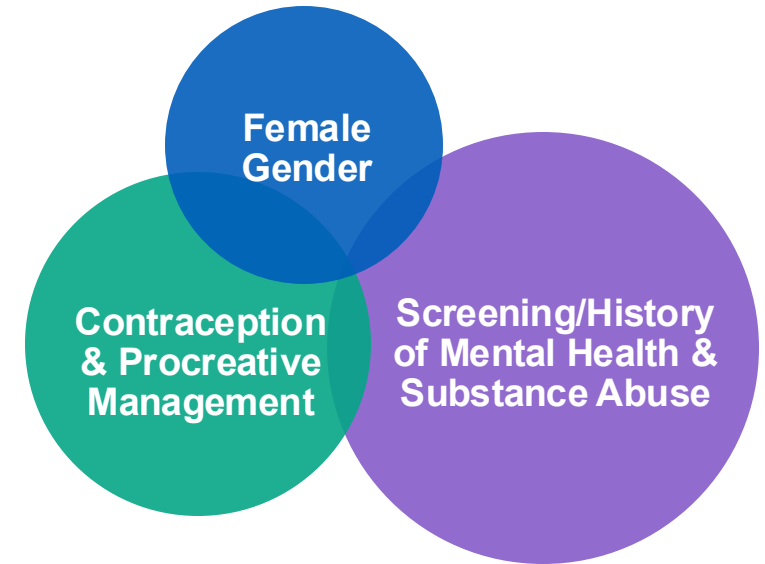


EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Breast Biopsy Risk Factors

This member's unadjusted episode cost = **\$1,676**

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.



<div>Female Gender 0.843</div>	+	<div>Procreative Management 0.042</div>	+	<div>Hx MH/SA 0.009</div>	=	<div>Episode Risk Score 0.894</div>
---	---	--	---	--------------------------------------	---	---

The member's risk adjusted episode cost is **\$1,676/0.894 =**

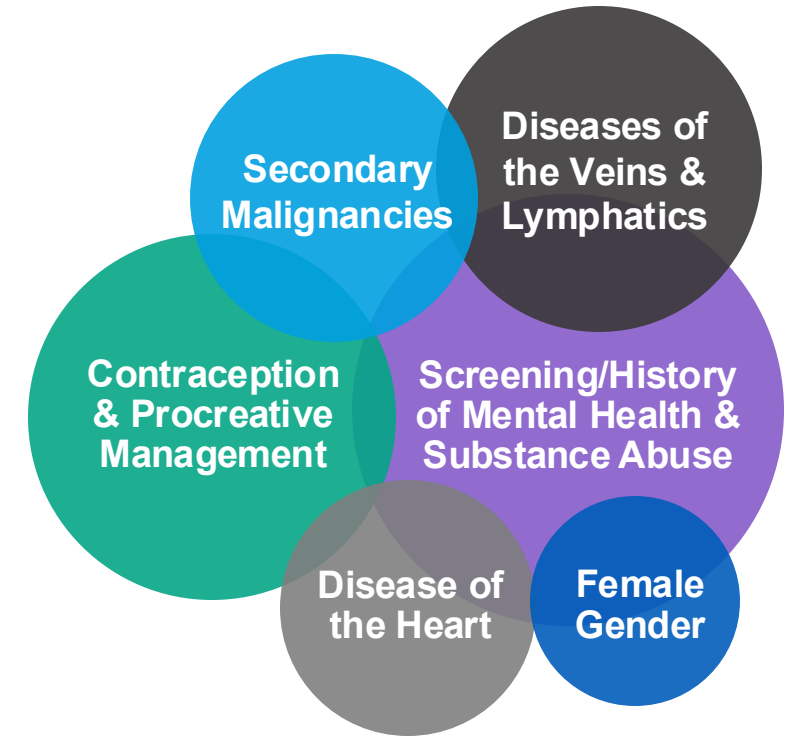
\$1,875

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Breast Biopsy Risk Factors

This member's unadjusted episode cost = **\$1,676**

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.



<div>Female Gender 0.842</div>	+	<div>Procreative Management 0.003</div>	+	<div>Hx MH/SA 0.009</div>	+	
		<div>Disease of Veins/lymphatics 0.029</div>	+	<div>Secondary Malignancies 0.638</div>	+	<div>Disease of the Heart 0.040</div>
					=	<div>Episode Risk Score 1.562</div>

The member's risk adjusted episode cost is **\$1,676/1.562 =**

\$1,073

*Cost difference of \$603

Back & Neck Pain Risk Factors

CCS Code	Factor	Weight
—	Female	0.538
—	Male	0.571
3.1	Thyroid Disorders	0.044
3.2	Diabetes mellitus without complication	0.010
6.5	Headache; including migraine	0.059
6.9	Other nervous system disorders	0.166
7.2	Diseases of the heart	0.064
7.5	Diseases of veins and lymphatics	0.059
9.8	Liver disease	0.051
13.2	Non-traumatic joint disorders	0.110

Back & Neck Pain Risk Factors (cont.)

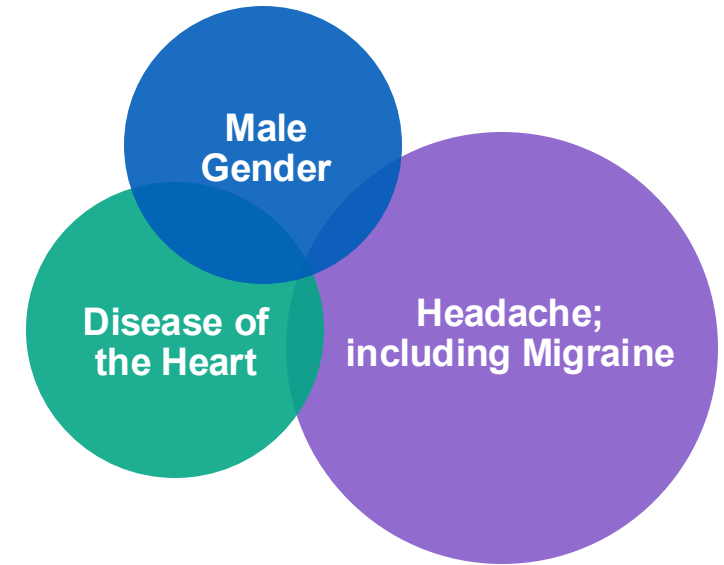
CCS Code	Factor	Weight
13.6	Acquired deformities	0.218
13.8	Other connective tissue disease	0.159
13.9	Other bone disease and musculoskeletal deformities	0.149
16.1	Joint disorders and dislocations, trauma related	0.061
16.7	Sprains and strains	0.168
16.10	Complications	0.118
16.12	Other injuries and conditions due to external causes	0.185

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Back & Neck Pain Risk Factors

This member's unadjusted episode cost = **\$1,113**

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.



<div>Male Gender 0.476</div>	+	<div>Disease of the Heart 0.100</div>	+	<div>Headache; including Migraine 0.145</div>	=	<div>Episode Risk Score 0.721</div>
--------------------------------------	---	---	---	---	---	--

The member's risk adjusted episode cost is **\$1,113/0.721 =**

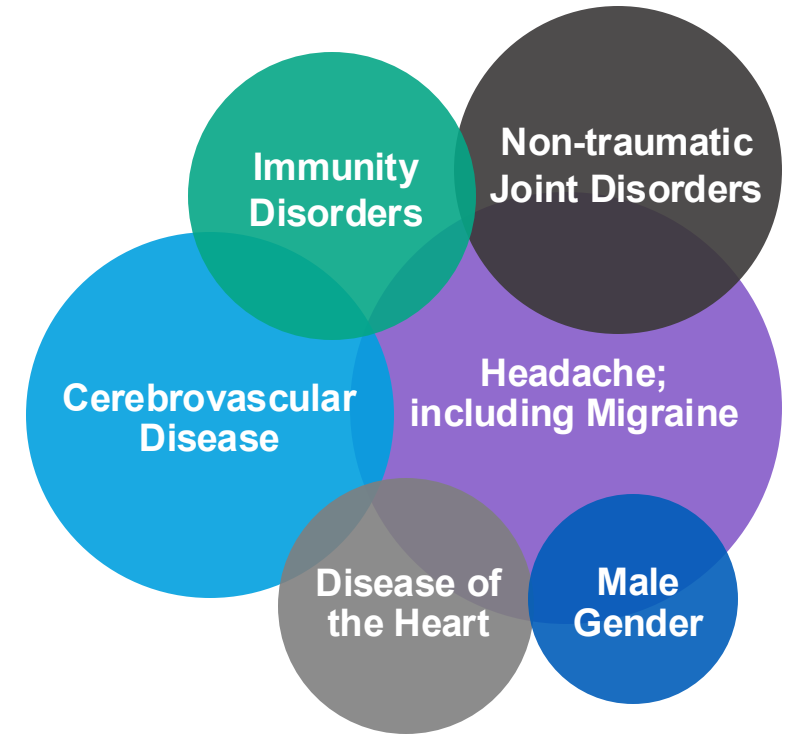
\$1,544

EXAMPLES OF RISK FACTORS IMPACTING EPISODE RISK SCORE

Back & Neck Pain Risk Factors

This member's unadjusted episode cost = **\$1,113**

The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.



<div>Male Gender 0.476</div>	+	<div>Headache; including Migraine 0.145</div>	+	<div>Immunity Disorders 0.134</div>	+		
		<div>Non-traumatic Joint Disorders 0.140</div>	+	<div>Cerebrovascular Disease 0.067</div>	+	<div>Disease of the Heart 0.100</div>	
						=	<div>Episode Risk Score 1.062</div>

The member's risk adjusted episode cost is **\$1,113/1.062 =**

\$1,048

*Cost difference of \$496

EXAMPLE

Back/Neck Pain Risk Assessment Questionnaire

Date: _____ Name: _____ DOB: _____		Office Use Only <input type="checkbox"/> Systems Reviewed <input type="checkbox"/> Conditions Classified Initials: _____
Personal Health Assessment Check only those conditions that apply to you.		
Cardiovascular System <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Arrhythmias <input type="checkbox"/> History of Cardiac Arrest <input type="checkbox"/> Prior Heart Surgery <input type="checkbox"/> Other _____	Digestive System <input type="checkbox"/> Liver Disease <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> GERD <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Other _____	Endocrine System <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cushing Syndrome <input type="checkbox"/> Other _____
Musculoskeletal System <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Scoliosis <input type="checkbox"/> Kyphosis <input type="checkbox"/> History of Muscle Tendon or Ligament Issues <input type="checkbox"/> History of Bone Spurs <input type="checkbox"/> Osteoporosis <input type="checkbox"/> History of Osteonecrosis <input type="checkbox"/> History of Traumatic Joint or Bone Injury _____ <input type="checkbox"/> History of Sprain or Strain in Arms/Legs/Back/Jaw <input type="checkbox"/> Complications from a Previous Surgery _____ <input type="checkbox"/> Other _____	Nervous System <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Tension Headaches <input type="checkbox"/> Other Headache Syndrome _____ <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Other _____	Vascular System <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Chronic Venous Insufficiency <input type="checkbox"/> History of Blood Clots in Arms/Legs <input type="checkbox"/> Peripheral Artery Disease <input type="checkbox"/> Raynaud's Disease <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Other _____
Other: Please Explain 		

Risk Adjustment Reminders

› Be as accurate as possible with every patient encounter.

- You are telling us a story using diagnostic and procedure codes. If you don't document it, we only get half the story.
- This could be the difference between a risk share OR a gain share payment!

› Utilize THCI documents for risk adjustment.

- Knowing what risk factors impact your episodes will help ensure risk accuracy.
- [508C 2024 Episodes of Care Risk Adjustment \(bcbst.com\)](https://www.bcbst.com/508C-2024-Episodes-of-Care-Risk-Adjustment)

Risk Adjustment Reminders (cont.)

› Review your quarterly reports.

- Taking the time to review your reports each quarter will ensure they are accurate and reflect the intensity of each patient encounter.

› Reach out with questions.

- We want you to succeed in the Episodes of Care program!
- Contact: Darlene_Smith@bcbst.com

› Notice inconsistencies? No worries!

- If you notice that a patient's risk score is inaccurate, you have until **June 30th** to file a corrected claims form to adjust the risk score to accurately reflect that patient's risk intensity before final reports are populated.

Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association

Commercial Quality Improvement

Healthcare Effectiveness Data and Information Set (HEDIS®)

What is HEDIS?

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in patient health. HEDIS reporting is mandated by NCQA for compliance and accreditation.

Wellness and Preventive Care



Breast Cancer Screening (BCS-E)

Goal of the Measure

Patients, 40-74 years of age, who are recommended for a mammogram, should have this screening for breast cancer every two years.

Patients recommended for routine mammogram screening are those who have:

- Administrative Gender of Female (Administrative Gender code F) any time in the member's history.
- Sex Assigned at Birth (LOINC code 76689-9)



Helpful Tips

- › An order alone isn't acceptable to close the gap in care. Documentation must include that a procedure was done (date and result).
- › All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance.
- › A patient's refusal doesn't exclude them from the measure.



Unacceptable Documentation

- › Date ranges, i.e., "mammogram 1-2 years ago"
- › Documentation of date due, ordered, scheduled, etc. without documentation of completion
- › Documentation alone that screening is "up to date"
- › Documentation of "patient reported"
- › Documentation of only "mastectomy" for exclusion

Helpful Tips

- › Breast MRI, ultrasounds and biopsies don't count for numerator compliance of the measure.
- › If a patient only had a unilateral mastectomy, they aren't exempt from the measure. Documentation must show "bilateral" mastectomy to be excluded from the measure.

Cervical Cancer Screening (CCS-E)



Goal of the Measure

Patients, 21-64 years of age, recommended for a routine cervical cancer screening should be screened using either of the following criteria:

- 21-64 years of age who had cervical cytology every three years
- 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing every five years
- 30-64 years of age who had cervical cytology/hrHPV co-testing every five years



Helpful Tips

- › Documentation of hysterectomy alone doesn't exclude a patient from this measure.
- › The documentation must show total hysterectomy, complete hysterectomy, vaginal hysterectomy, or that the cervix is surgically absent to show evidence that the cervix was removed, and screening isn't needed.
- › Documentation of the pap test result and date in the chart is needed to close this gap through medical record review. Biopsies don't count because they're diagnostic and not valid for primary cervical cancer screening.

Helpful Tips

- › An order alone isn't acceptable to close the gap in care. There must be documentation that the procedure was performed (date and result).
- › A patient's refusal doesn't exclude them from the measure.
- › Patients with Sex Assigned at Birth of Male are excluded from the measure.



Chlamydia Screening (CHL)

CHLAMYDIA SCREENING (CHL)

Goal of the Measure

Patients ages 16-24, with continuous enrollment, who were identified as sexually active during the measurement year should have at least one test for chlamydia during the measurement year, Jan. 1-Dec. 31 (each year).



- › Patients with Sex Assigned at Birth of Male are excluded from the measure.

Helpful Tips

- › A gap in care will still open for CHL even if a patient is taking contraceptives for a reason other than birth control, such as acne.
- › “Sexually active” for this HEDIS measure is defined by:
 - Pharmacy data (contraceptives, diaphragm, spermicide)
 - OR
 - Claims data
- › An order alone isn’t acceptable to close the gap in care. There must be documentation that the procedure was done (date and result).
- › A patient’s refusal doesn’t exclude them from the measure.

Colorectal Screenings (COL-E)



COLORECTAL SCREENINGS (COL-E)

Goal of the Measure

Patients 45-75 years should have appropriate screening for colorectal cancer.



Helpful Tips

Any **one** of these will meet the criteria of the measure:

- Quaiac-based fecal occult blood test (gFOBT) yearly
- Fecal immunochemical (FIT) yearly
- Multitargeted stool DNA with FIT test (sDNA Fit) every three years
- CT colonography every five years
- Flexible sigmoidoscopy every five years
- Colonoscopy every 10 years (Gold Standard)



Remember, the screening frequency depends on the method of testing the patient had in the past. (Colonoscopy screening is only every 10 years).

Helpful Tips

NCQA **doesn't allow** the following to close this measure:

- › Digital rectal exam as evidence of colorectal screening
 - Not specific
 - Not comprehensive
- › FOBT documented as being performed in an office setting or on a sample collected via digital rectal exam (Same date of service as the office visit)



Unacceptable Documentation

- › Date ranges, i.e., “colonoscopy about nine years ago”
- › Documentation of date due, ordered, scheduled, etc. without documentation of completion
- › Documentation alone that screening is “up to date”
- › Documentation of “patient reported”

Helpful Tips

- › Partial colectomy exclusions **aren't acceptable**; Colectomy must be total and documented as such
- › Documentation that says “reported by patient” or “per patient”
- › An order alone **isn't acceptable** to close the gap in care, there must be documentation that the procedure was done (date and result)
- › A patient's refusal **doesn't exclude** them from the measure



Well-Child Visits in the First 30 Months of Life (W30)

Goal of the Measure

- › Patients 0-30 months of age must complete six or more well child visits with a Primary Care Provider (PCP) on different dates of service on or before the child turns 15 months;
AND
- › Patients must complete two or more well child visits with a PCP on different dates of service, after the child turns 15 months and before they turn 30 months.



Exclusions

Patients in hospice and patients who die during the measurement year

Child and Adolescent Well-Care Visits (WCV)



Goal of the Measure

- › Patients 3 to 21 years old should have one or more comprehensive well-visits with a PCP or obstetrician-gynecologist (OB/GYN) every year.
- › **Exclusions:** Patients in hospice and patients who die during the measurement year.



Helpful Tips

- › The well-child forms available on the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) website (tnaap.org) address all components of the well-child measures, if properly and fully completed. We highly encourage using those forms.
- › The gaps for well visits should be closed through claims submissions.



Don't Forget!

Services specific to the assessment or treatment of an acute or chronic condition don't count toward the measure.



Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BMI)

Goal of the Measure

- › Patients must complete at least one outpatient visit with a PCP or an OB/GYN during the measurement year and have documentation of Body Mass Index (BMI) percentile.
- › Ages: Children turning 3-17 years of age as of Dec. 31 of the measurement year

› Exclusions:

- Patients in hospice and patients who die during the measurement year
- Patients with a diagnosis of pregnancy during the same measurement year

Helpful Tips

- › This is a yearly measure (Jan. 1 to Dec. 31).
- › Height, weight, and BMI are used to calculate a BMI percentile
- › The information must be recorded, dated and maintained in the patient's legal health record.
- › A specific BMI percentile can be documented on an age-growth chart.

HEDIS Tips and Best Practices

Tips and Best Practices

- 1 Closing measures with coding through claims or data exchange feeds, if applicable, is best.
- 2 Accurate coding is key to ensuring providers get credit for their quality work and patient gaps are closed.
- 3 It's important to make sure all diagnosis codes, procedure codes and applicable modifiers have been listed on the claim form.
- 4 You can find a list of the most common sample codes for gap closure in our 2025 Commercial Measures Guide.

TIPS AND BETS PRACTICES

General documentation errors that won't close gaps in care include:

- 1 Documentation of a patient's refusal of a test or screening
- 2 Documentation of "ordered" or "scheduled" test/screening
- 3 Documentation of patient "up-to-date" or "current"
- 4 Documentation that the patient was asked about immunizations
- 5 Documentation of where the test was done but no date or result
- 6 Documentation of results out of range for the measure
- 7 Re-entering the same attestation repeatedly

Keys for Attestation

Submitting attestations within our Quality Care Rewards (QCR) application is another great option to close gaps in care. Please make sure to follow these guidelines when using the QCR:

- › Never attest to a screening, visit or gap closure that hasn't occurred yet.
- › Attestations should only be done after completing the care/screening or if an exclusion is met based on the patient's medical documentation.
- › Include (upload) documented proof from the chart that what you're attesting to has already taken place.

Provider Resources

RESOURCES

Keeping you Informed

We Value Your Commitment to Quality Care

We know you're already providing high-quality care to your patients, and we want to ensure your practice gets the recognition it deserves. You're helping our members get important preventive screenings, providing effective, timely treatment, and improving medication adherence so they can be as healthy as possible. This quality care is central to our mission of delivering peace of mind through better health to the members we serve.

RESOURCES

Quality Resources for You and Your Patients



Provider Resources

To keep you informed of changes and best practices, the Commercial Quality Improvement team provides monthly, quarterly and annual publications. We offer a range of services and events, as well as on-site visits, to support your success in closing HEDIS measures for your patients. Our team can also share digital educational materials for you and your patients, as well as assist with health screenings and events.



Member Education

We believe quality care involves the promotion of care management for health and wellness measures as they relate to members' chronic conditions, age, gender and behavioral health.

Our goal is to empower our members to focus on preventive care and chronic condition management so they can make informed decisions and have an active voice in their health.

RESOURCES

Quality Care Measure Guide

2025 Quality Care Measures & Comprehensive Program Information Guide

- This guide is published annually and available in digital format:
 - New HEDIS specifications for the year
 - Measure descriptions, what service is needed and what to report
 - Measure-specific inclusion and exclusion criteria
 - Sample diagnoses, CPT® and HCPCS codes related to gap closure
 - Helpful tips and best practices
 - For digital copy, contact Commercial Quality Improvement at:
GM_Commercial_Quality_Improvement@bcbst.com



RESOURCES

Provider Tool Kits

Within the 2025 Quality Care Measures & Comprehensive Program Information Guide, you'll also find tool kits on these topics:

- Quality Measures Quick Reference
- Adolescents Immunizations Tool Kit
 - Additional resources, including a parent's reminder letter and tips for vaccination success and safety
- Support Guide for the Kidney Health Evaluation Measure (KED)
 - Helpful information for understanding the measure, including codes and best practices

RESOURCES

Provider Tool Kits (cont.)

- › Guide to Statin Measures (SPC and SPD)
 - Helpful information for understanding these measures, including sample codes, exclusions and a statin medication list
- › Antibiotic Stewardship Tool Kit and Pocket Guide
 - Details on the Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) and Upper Respiratory Infection (URI) measures, including CDC updates, exclusions and patient resources
- › Low Back Pain Pocket Guide and Low Back Pain Coding Guide
 - Includes a coding tool and exclusion pocket guide

RESOURCES

Provider Tool Kits (cont.)

- › Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
 - Contains sample questions and helpful tips
- › Cultural Competency in Health Care
 - Culture shapes how people experience their health care. Learn more about what it means to deliver culturally competent care and related resources.
- › Guide to Advanced Illness and Frailty Exclusions
 - See how advanced illness and frailty impact HEDIS measures, including exclusion codes and tips

RESOURCES

Provider Newsletter

> Monthly BlueAlertSM Newsletter

- The BlueAlert newsletter gives you timely information on forms and process changes, coding tips, drug coverage and more. View the newsletter at provider.bcbst.com.



RESOURCES

On-Site Health Screenings – Wellness

Each year, we hold wellness events in communities across the state to help support your efforts to deliver quality care. Our goal is to make it easy for your patients to get the preventive care they need by bringing these events to their communities.

Our Quality teams often host screening events that can be held in your office, in our mobile unit or in the local community. We can customize these on-site events to meet your needs or preferences.

During these events, your patients are often able to close multiple gaps in care and get important educational material.

RESOURCES

On-Site Health Screenings (cont.)

Wellness Event Campaigns

We identify members who could benefit from these screenings and schedule a convenient time for them. Our on-site events can also include community outreach and member education.

Our team will be on site at your event to assist our vendor partners, answer questions and help educate your patients about the importance of preventive care and screening tests.

To schedule an event, email

GM_Commercial_Quality_Improvement@bcbst.com.

RESOURCES

On-Site Health Screenings (cont.)

We offer on-site health screening events at your location tailored to best fit the needs of your office. Services we can offer include:

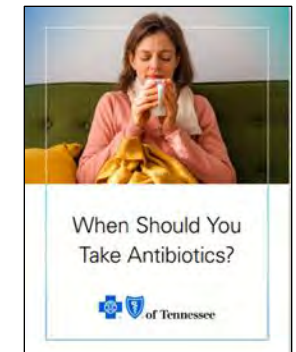
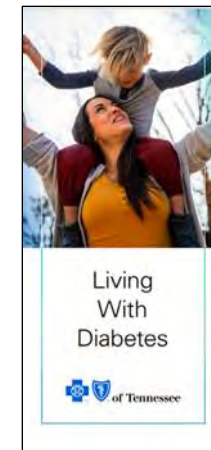
- › Breast cancer screenings
- › Colorectal cancer screenings
- › Diabetic retinal eye exams
and other diabetic screenings
- › Drive-through vaccine clinics

RESOURCES

Digital Patient Educational Material: Health Planners, Brochures and Magnets

Educating patients on preventive care and chronic care management empowers them to:

- › Remain in control of their health care
- › Stay up to date on recommendations
- › Make informed decisions
- › Be as healthy as they can be



RESOURCES

Provider HEDIS Education for Quality Measures

We offer free customized virtual training on HEDIS quality measures. Learn best practice tips for closing gaps in care, keys to coding, yearly specification changes and more.

We cover as many measures as you'd like to know about.

Contact your Quality Improvement Clinical Consultants to schedule a time that's convenient for you and your staff.

GM_Commercial_Quality_Improvement@bcbst.com



To get credit for attending today, please email
your name, group/provider and Tax ID to
ABW_QA_feedback@bcbst.com



Thank You



BlueCross BlueShield of Tennessee, an Independent Licensee of Blue Cross Blue Shield Association