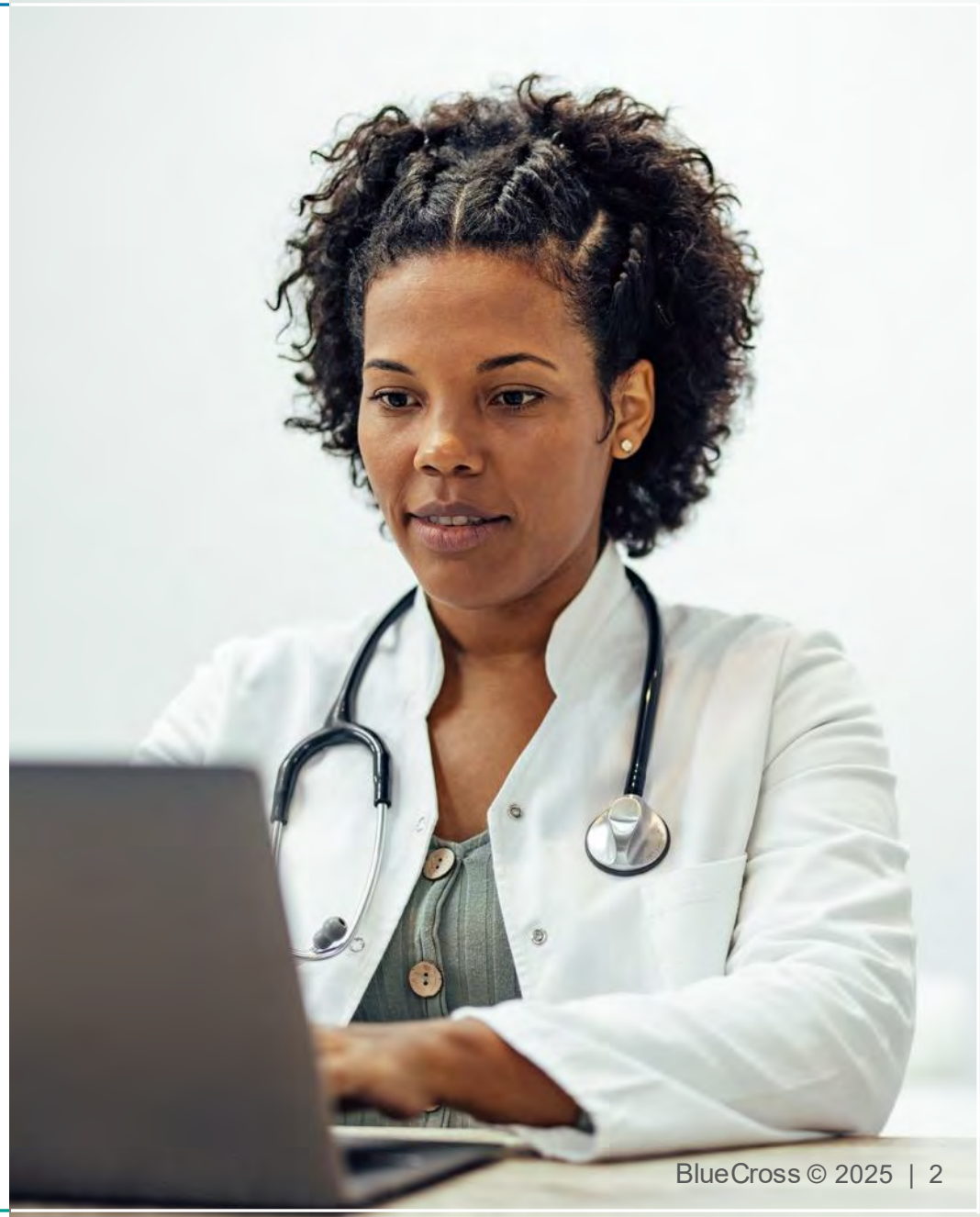
Welcome
2025 All Blue Workshop℠

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



BLUECARE TENNESSEE

of Tennessee

ALL Blue 2025

BlueCare Tennessee

TENNCARE KIDS GOALS

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.

TENNCARE KIDS RESOURCES

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**

TENNCARE KIDS RESOURCES

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

TENNCARE KIDS RESOURCES

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

What's Covered?

BlueCare℠ 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.

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**.

TennCare*Select*

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**.

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

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	Bill the visit using category II code 0500F, and please remember to: • Include the appropriate Evaluation & Management (E&M) Code (99202-99205 or 99211-99215) confirming pregnancy.* *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. • 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.	Bill the visit using category II code 0503F, and please remember to: • Include the postpartum code 59430. • Bill the $75 fee associated with 0503F. **Note:** We'll allow for reimbursement of two claims for code 0503F during the 84-day postpartum period.	Bill CPT® 96160 with a TH modifier to show you completed the service, and please remember to: • Bill the $28.35 payment for performing this screening. **Note:** No specific diagnosis code is required for payment.
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*Select*, 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 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

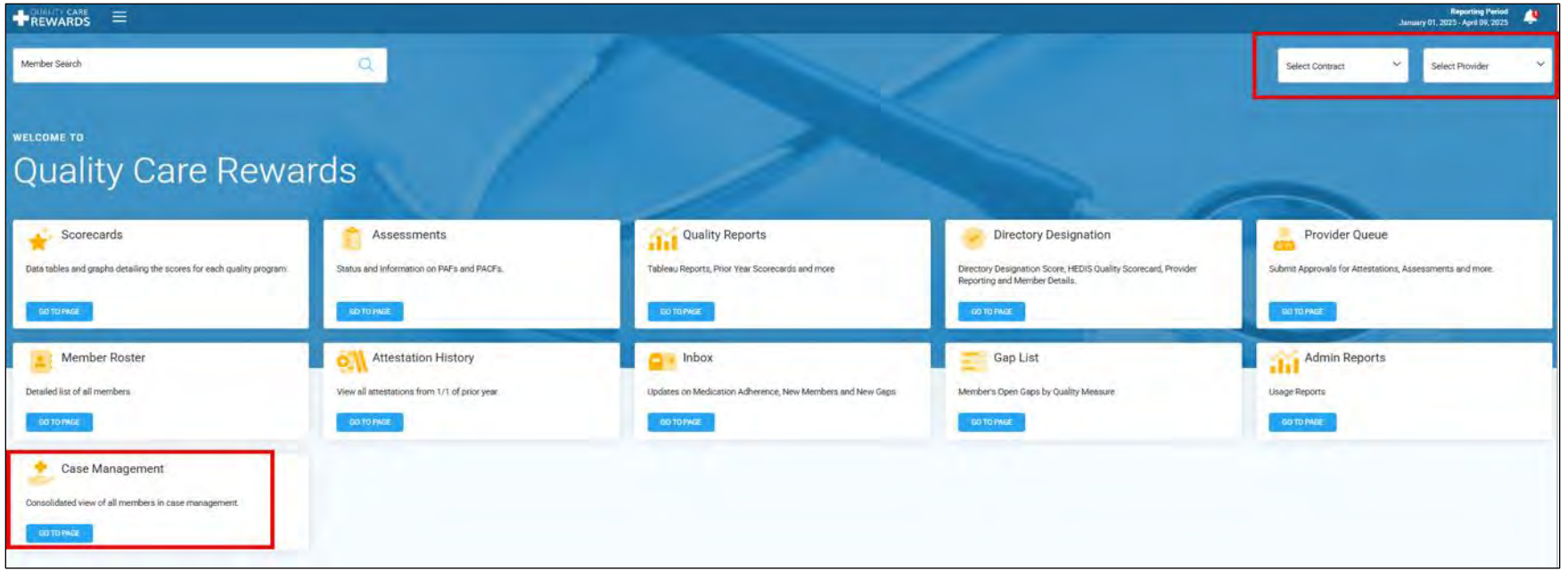
Primary care providers can leverage the Quality Care Rewards (QCR) application in Availity to refer patients enrolled in BlueCare Tennessee and CoverKids for care management services.

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.

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

West TN
Vivian Williams
Vivian_Williams@bcbst.com
(901) 544-2622

East TN
Faith Daniel
Faith_Daniel@bcbst.com
(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)

BEHAVIORAL HEALTH

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.

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

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

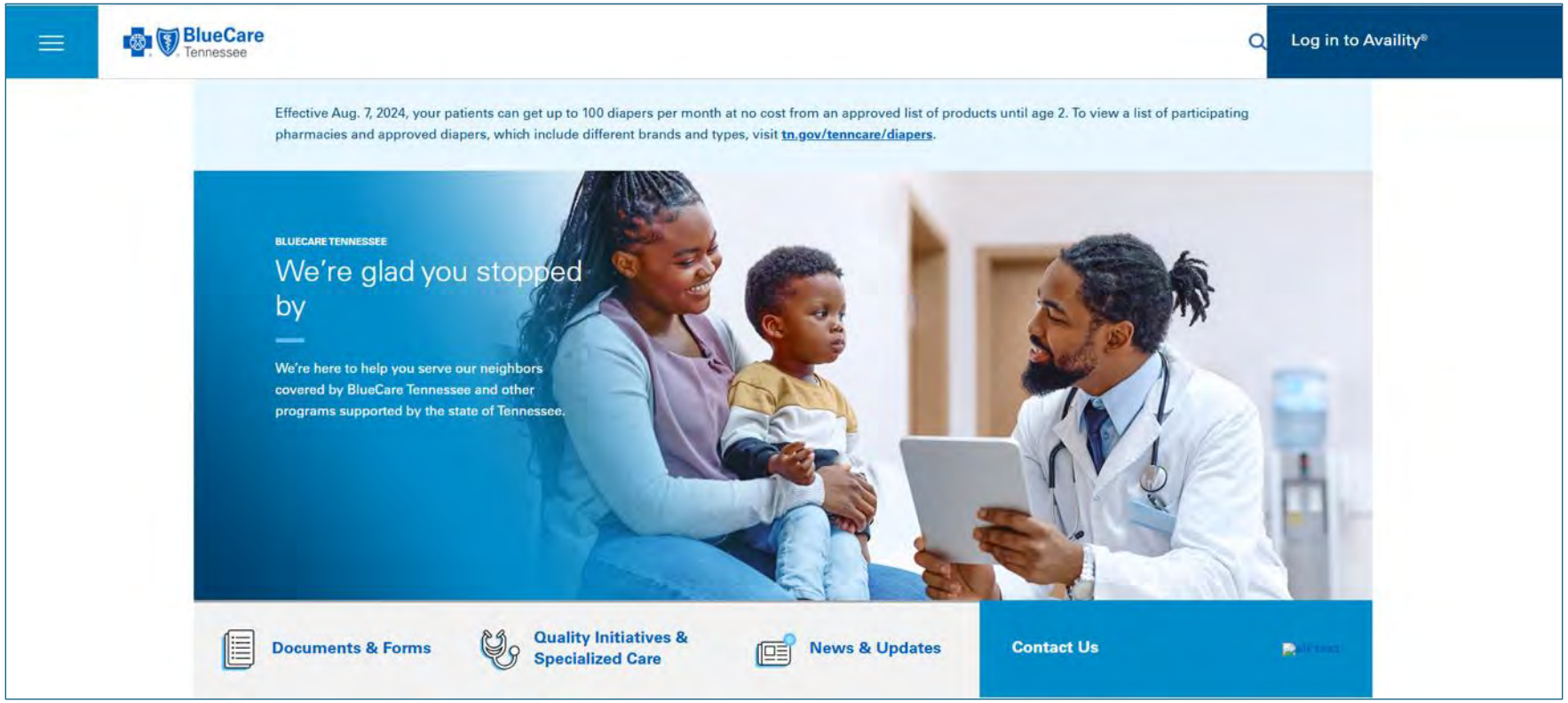
Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES):

1-833-281-5020

BlueCare Website: Provider Administration Manual (PAM)

BLUECARE WEBSITE

BlueCare Tennessee for Providers



BLUECARE WEBSITE

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)

PROVIDER ADMINISTRATION MANUAL (PAM)

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 6th 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.

2025 BlueCare Tennessee Required Training

G. Subcontracting

Prior Approval

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. 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

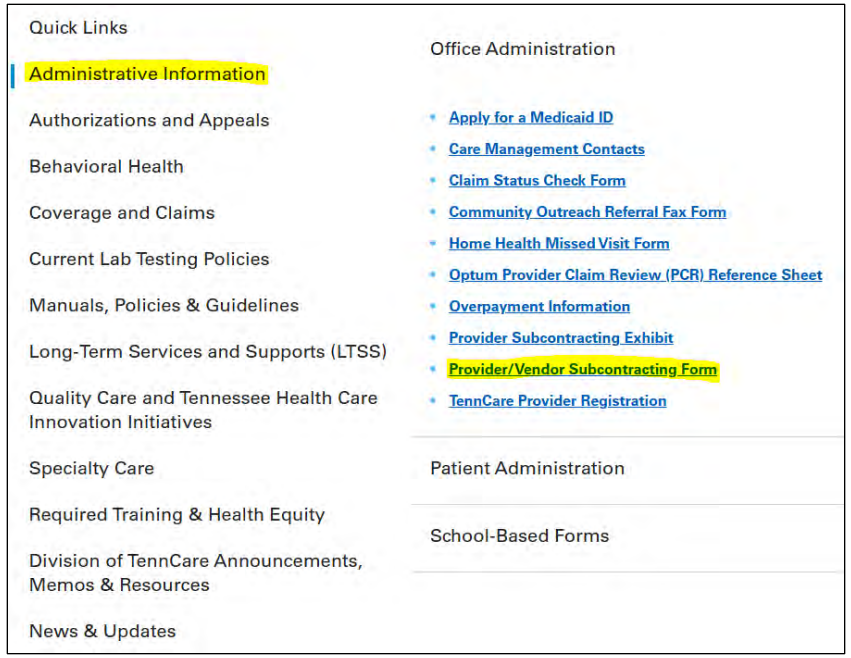
In addition, Deficit Reduction Act/Fraud Waste and Abuse training shall be provided to the employees of subcontractors supporting the BlueCare Tennessee contract. The date the training was provided as well as the attendees should be documented.

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

2025 BlueCare Tennessee Required Training (cont.)



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 Availity

AVAILITY PCP CHANGE MAINTENANCE APPLICATION

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.

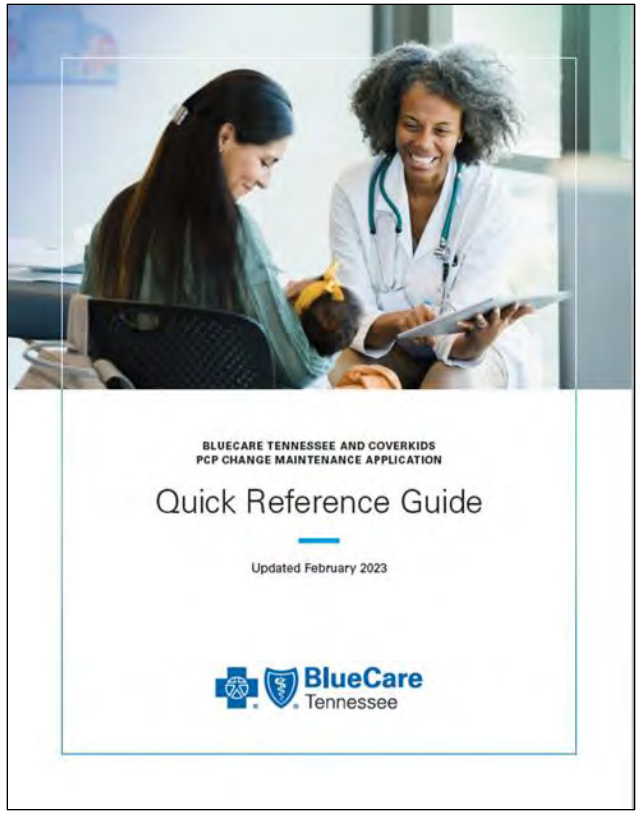
Using the application:

- 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 BCBSTN℠ 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

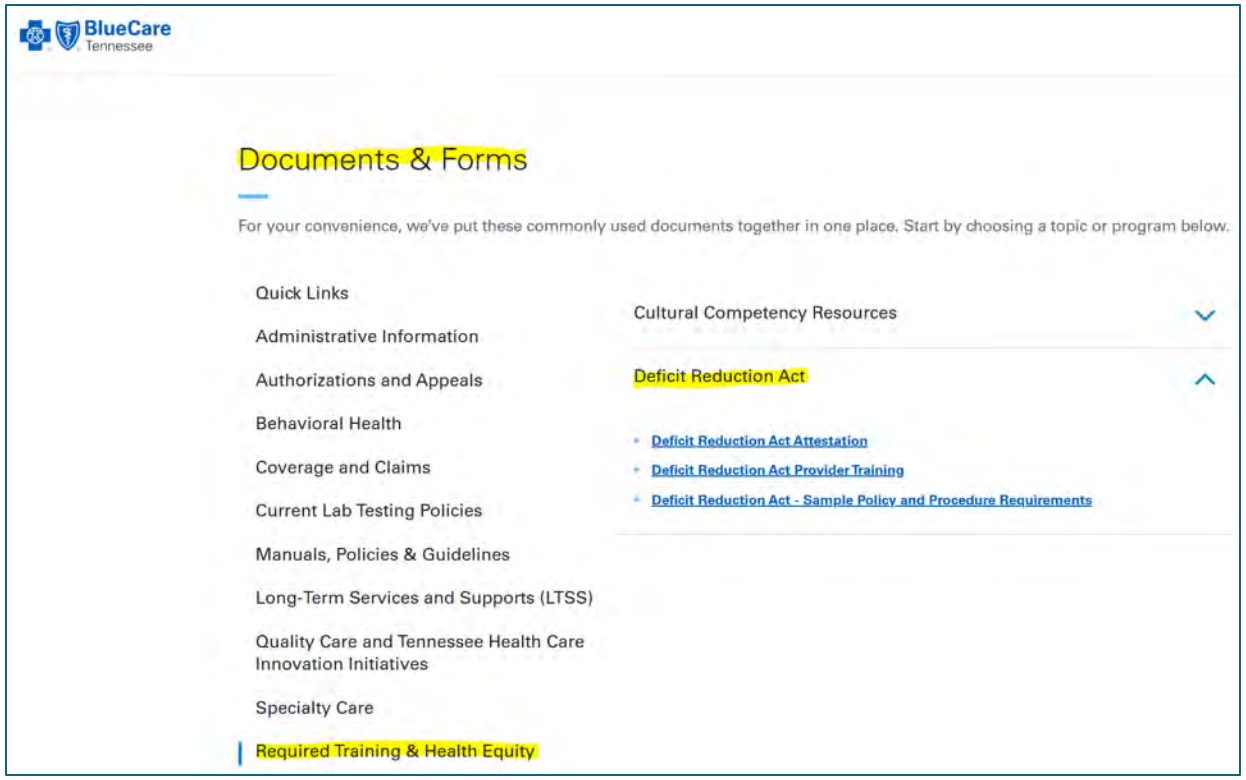
CAQH

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



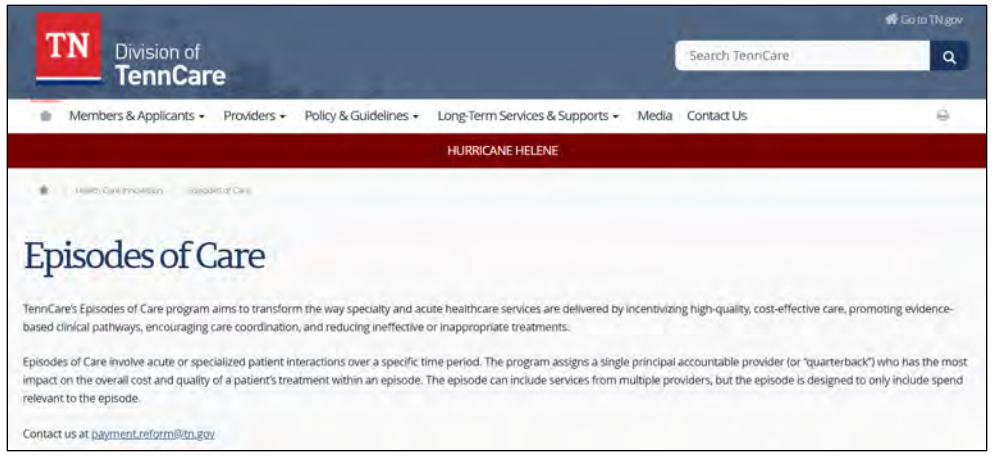
https://bluecare.bcbst.com/providers/tools-resources/documents-forms

- 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.

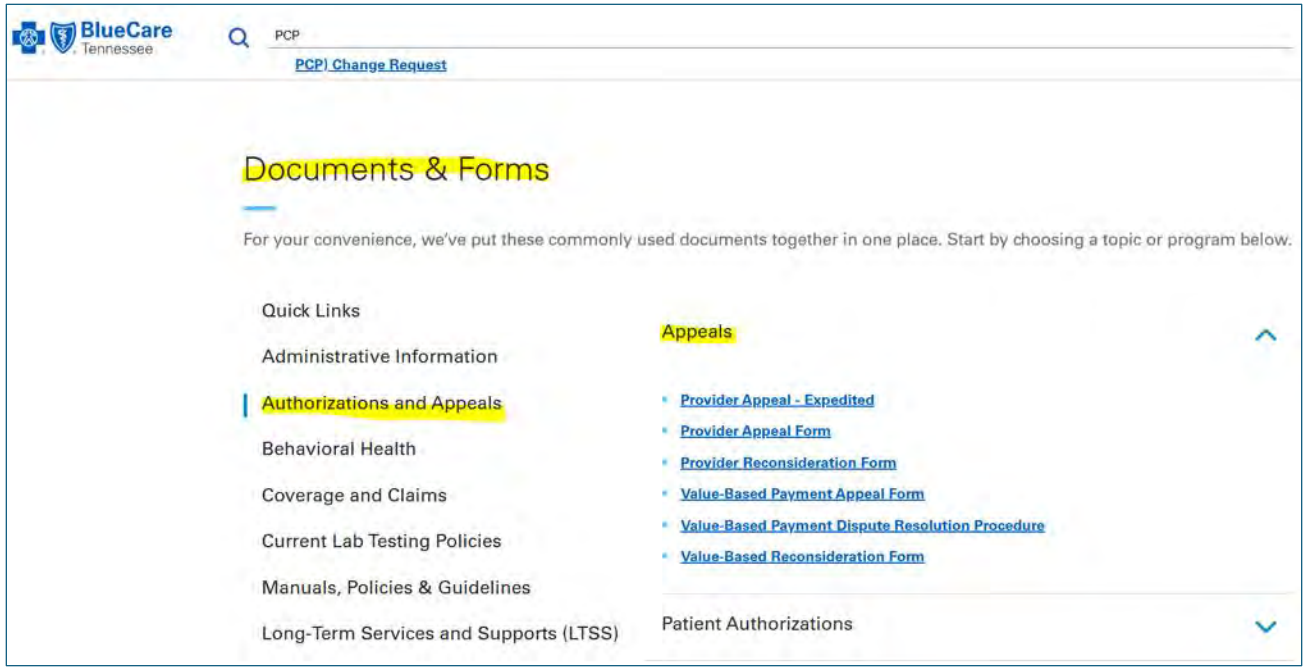
2025 BlueCare Required Training (cont.)

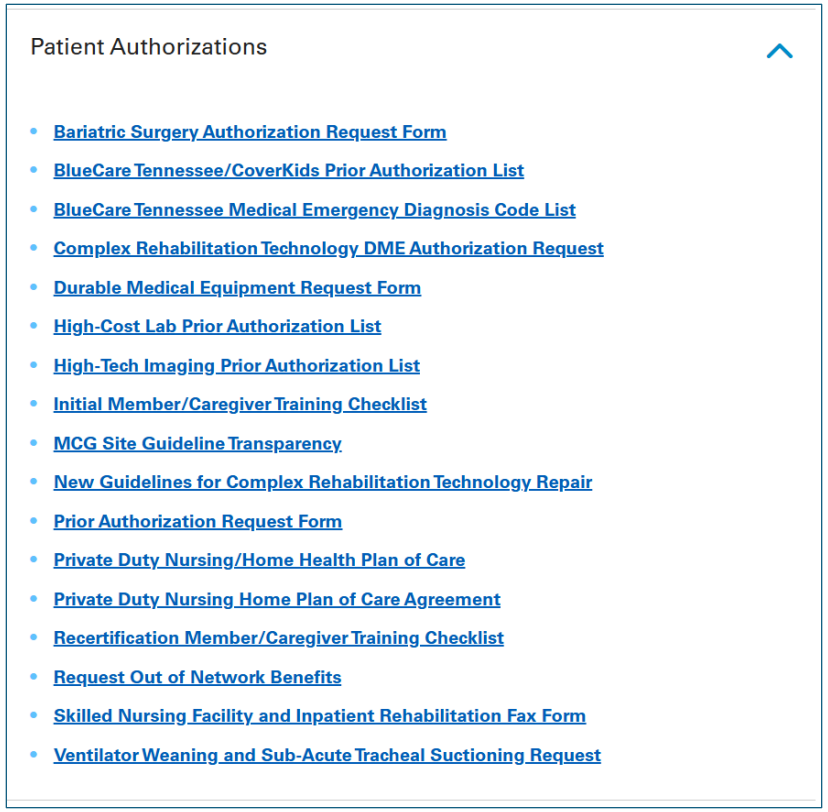
- Episodes of Care reports are available on Availity, BlueCare Tennessee's secure web portal. Just log on and scroll to the link "Tennessee Health Care Innovation Initiative." Select the reporting period and line of business to review. Providers can also find more information on the State of Tennessee's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

Authorizations and Appeals

BLUECARE TENNESSEE

Authorizations & Appeals





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

Claims Reconsiderations and Appeals (PDRP)

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)

BLUECARE PLUS TENNESSEE

Member Benefits

2025 Changes			
Benefit	**BlueCare Plus**	**BlueCare Plus Choice**	**BlueCare Plus Select**
Transportation	**150** suppplemental 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 TENNESSEE

2025 Member Incentives

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

Service	Codes	Coverage Notes	Amount
PACF	96160 96161	• Submitted once **per calendar year** • Completed with the “Welcome to Medicare” Exam or AWV	$155.00
ICT	99366 - 99368	• 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**
- 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

BLUECARE PLUS TENNESSEE

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

BLUECARE PLUS TENNESSEE

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

BLUECARE PLUS TENNESSEE

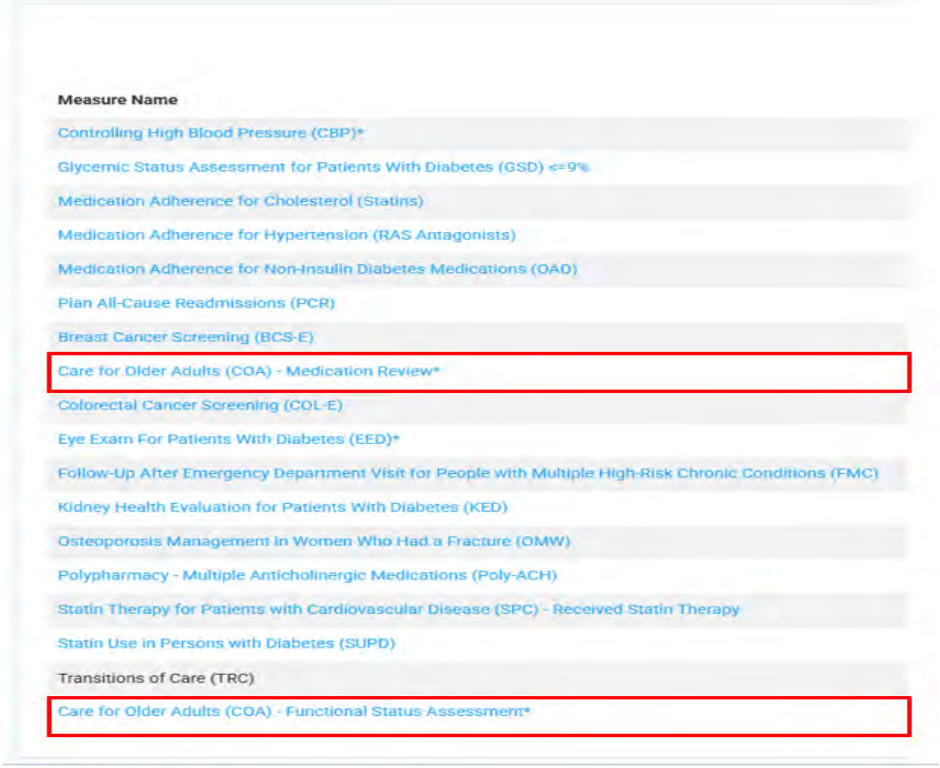
2025 Quality Program Measures - COA

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.



BLUECARE PLUS TENNESSEE

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

BLUECARE TENNESSEE

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

eBusiness

Availity®

EMPOWERING YOUR DIGITAL WORLD

of Tennessee

ALL Blue 2025

AVAILITY®

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

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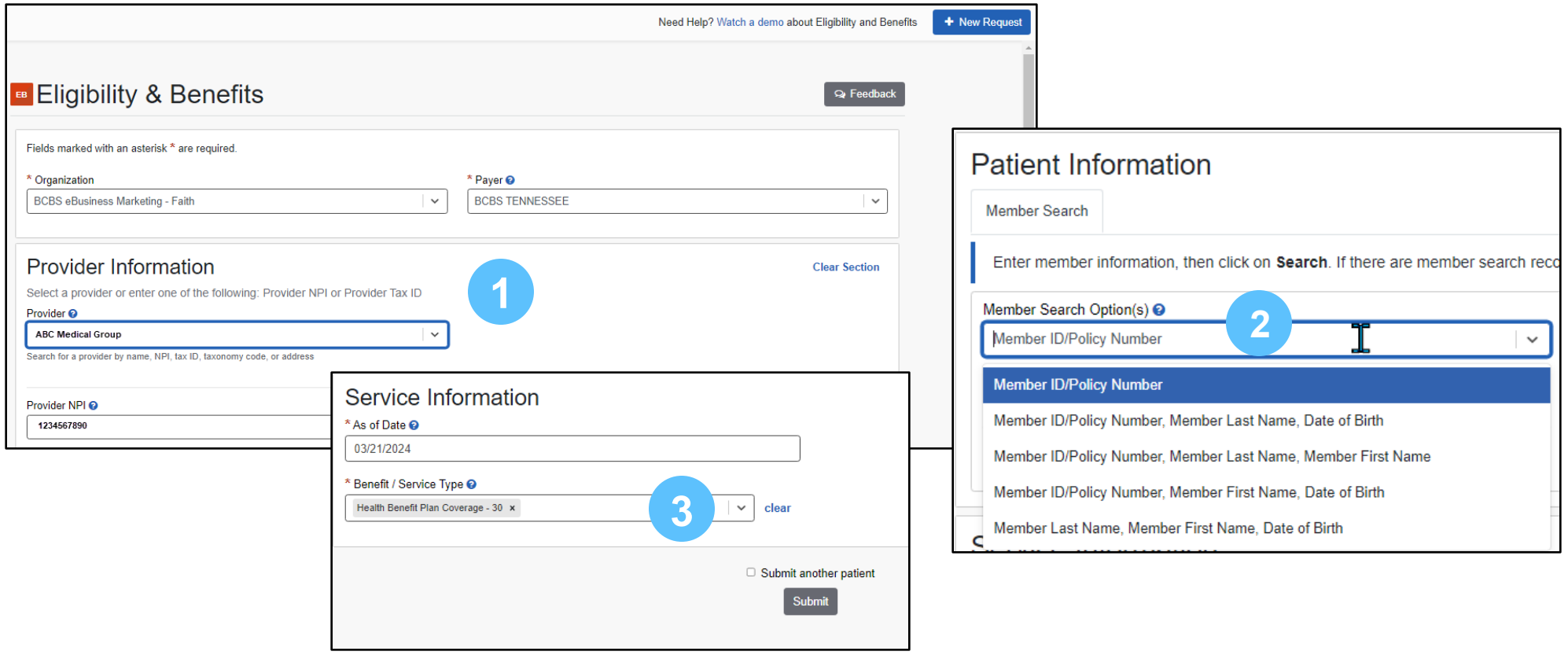
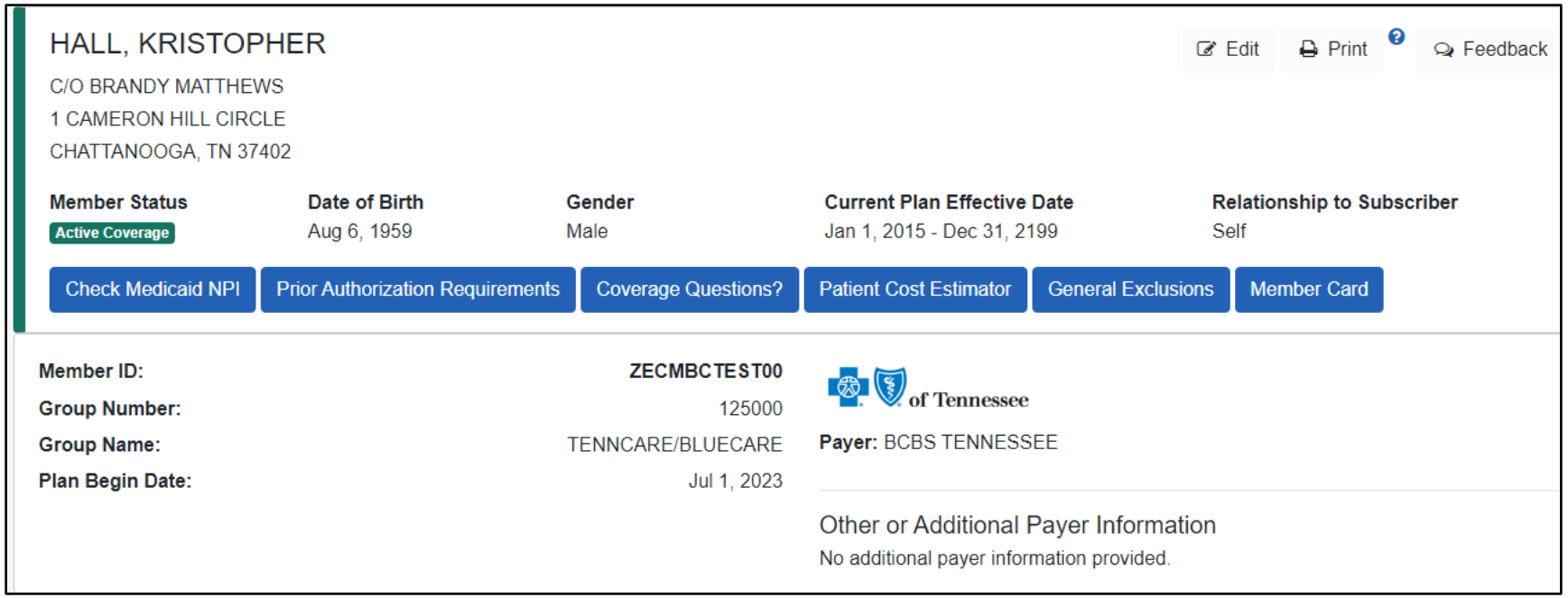
Eligibility & Benefits



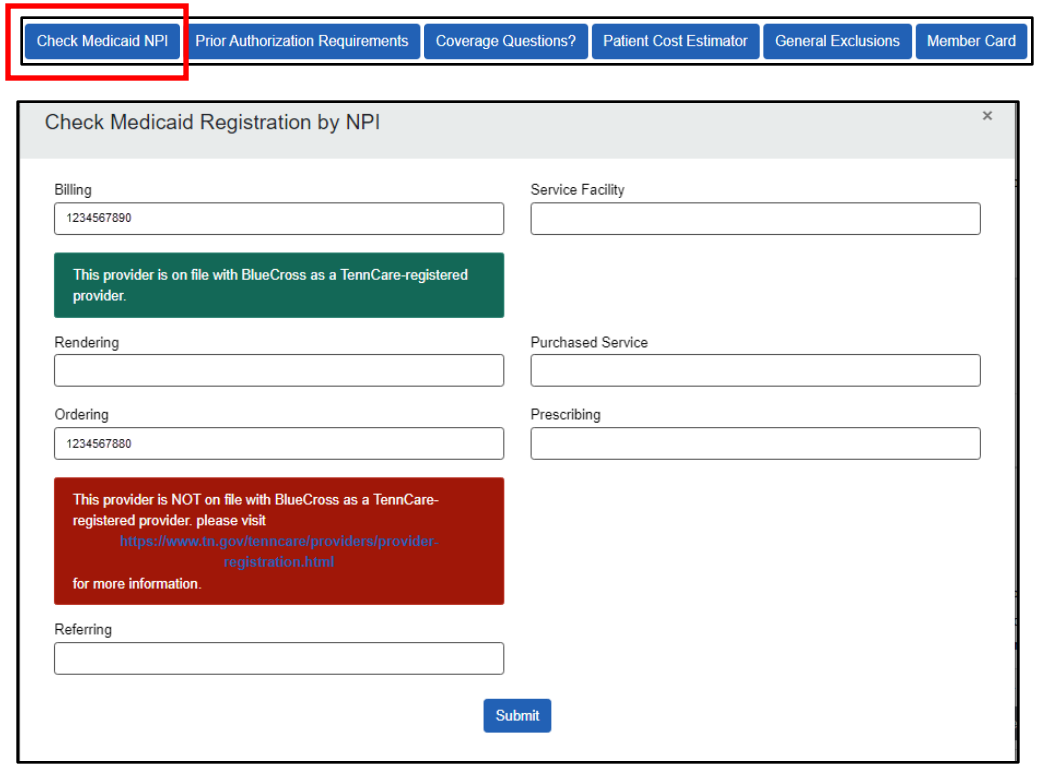
AVAILITY MULTI-PAYER

BlueCare℠ Tennessee Member Eligibility & Benefits



Check Medicaid Registration by NPI

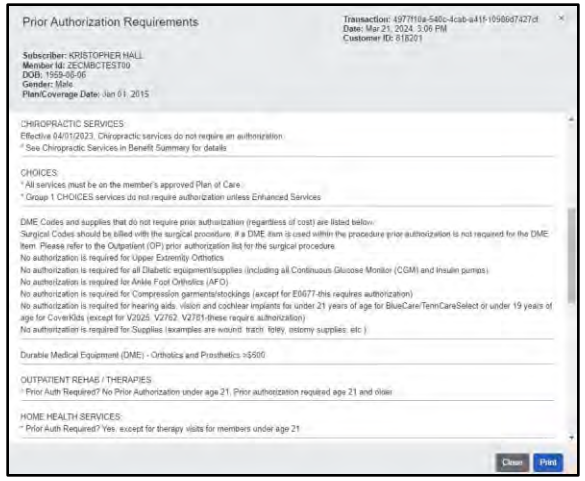
- All NPIs billed on a claim must be on file with TennCare.
- NPIs not on file will result in a rejected claim.



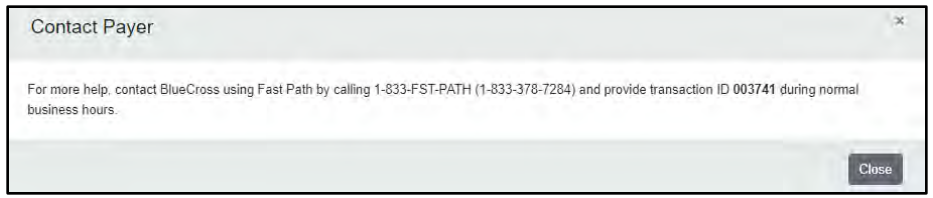
Prior Authorization Requirements & Coverage Questions

Check Medicaid NPI | Prior Authorization Requirements | Coverage Questions? | Patient Cost Estimator | General Exclusions | Member Card

Prior Authorization Requirements

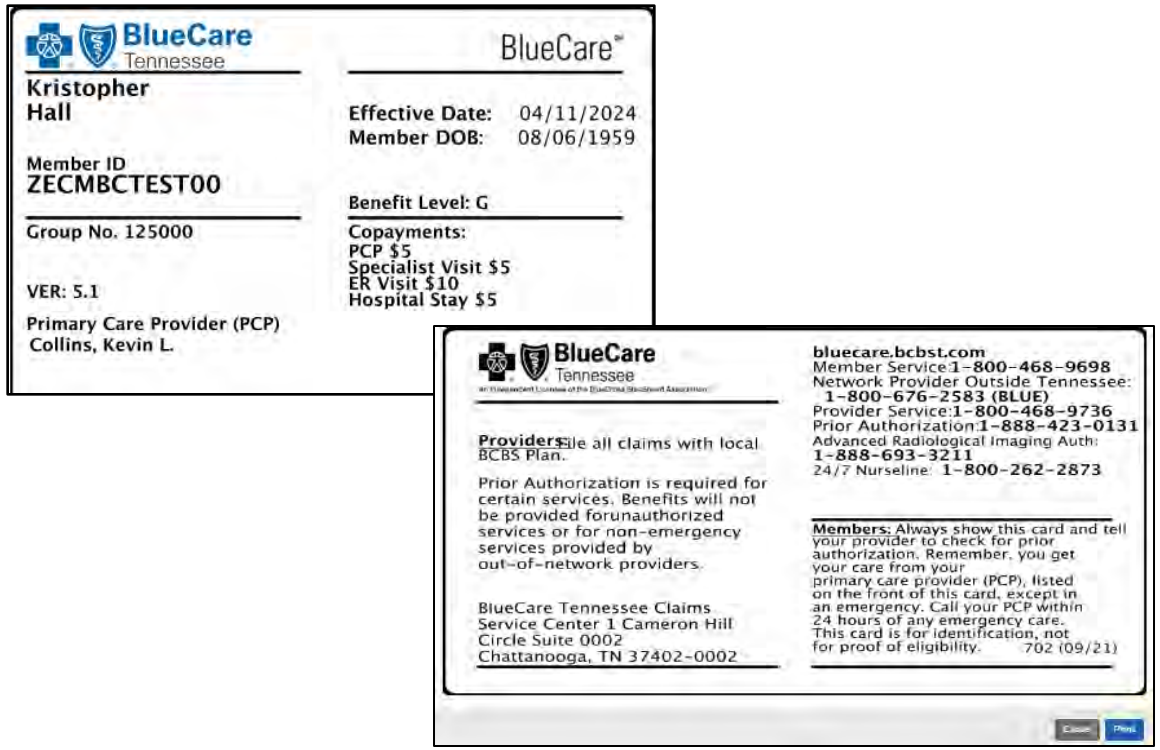


Coverage Questions? “Fast Path”



Member Card

Check Medicaid NPI | Prior Authorization Requirements | Coverage Questions? | Patient Cost Estimator | General Exclusions | Member Card

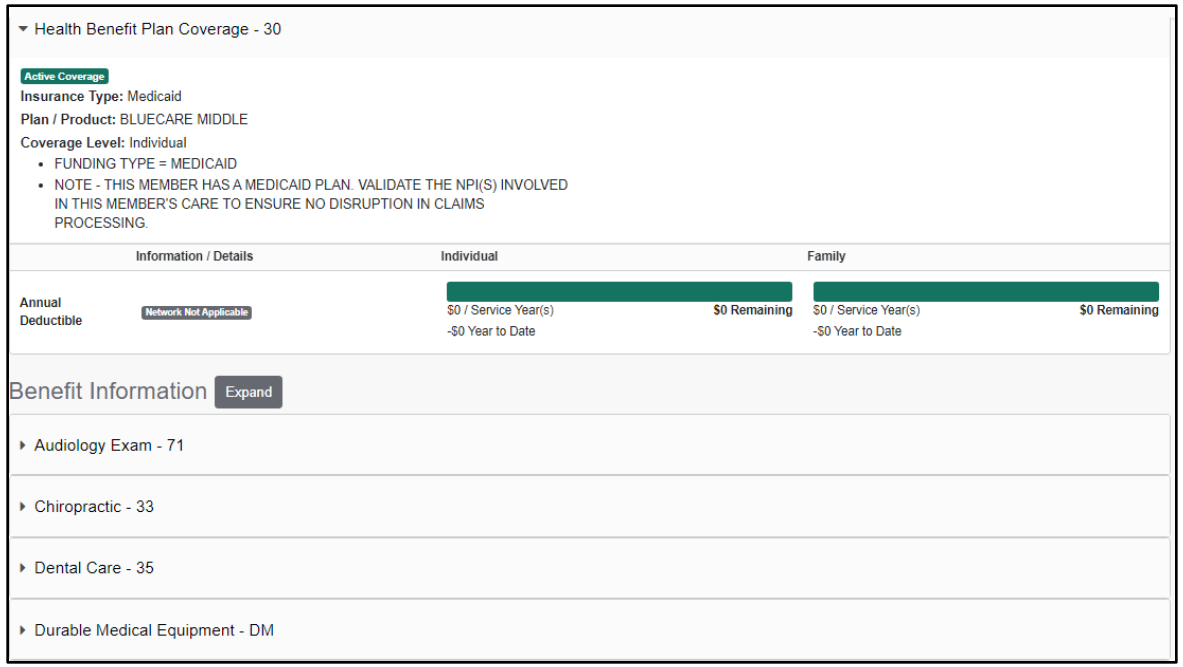


Additional Information

- Patient Cost Estimator
  - Real Time Claim Adjudication on Payer Spaces (RTCA)
- General Exclusions

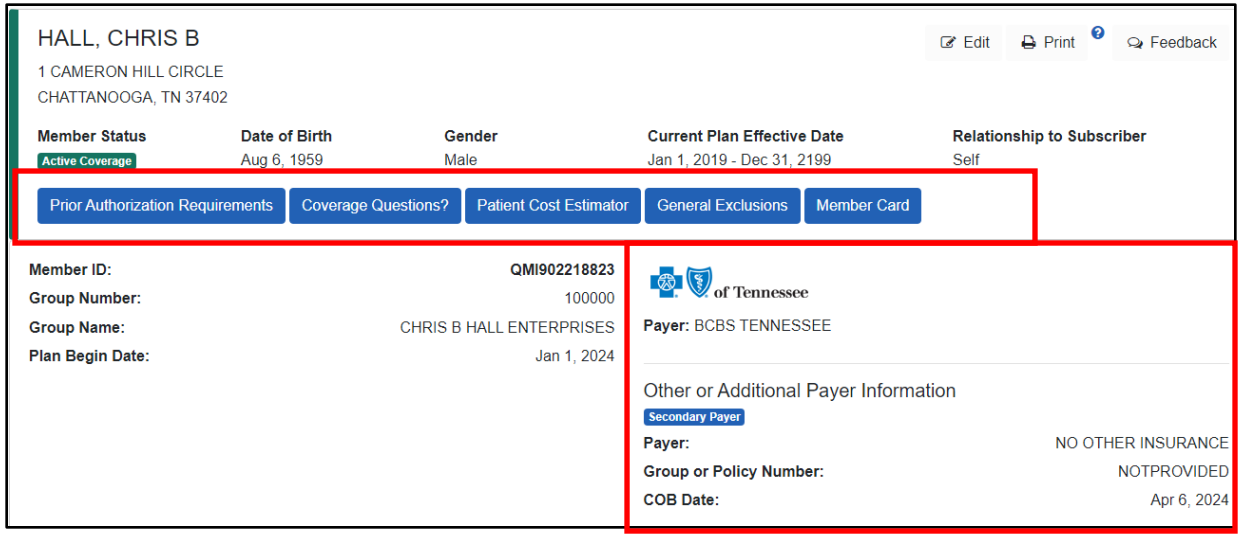
BlueCare Member Benefits

- Coverage Level
  - Funding Type = Medicaid
  - Note: Validate the NPIs involved
    - Check Medicaid NPI button on previous slide
- Annual Deductible
- Benefit Information

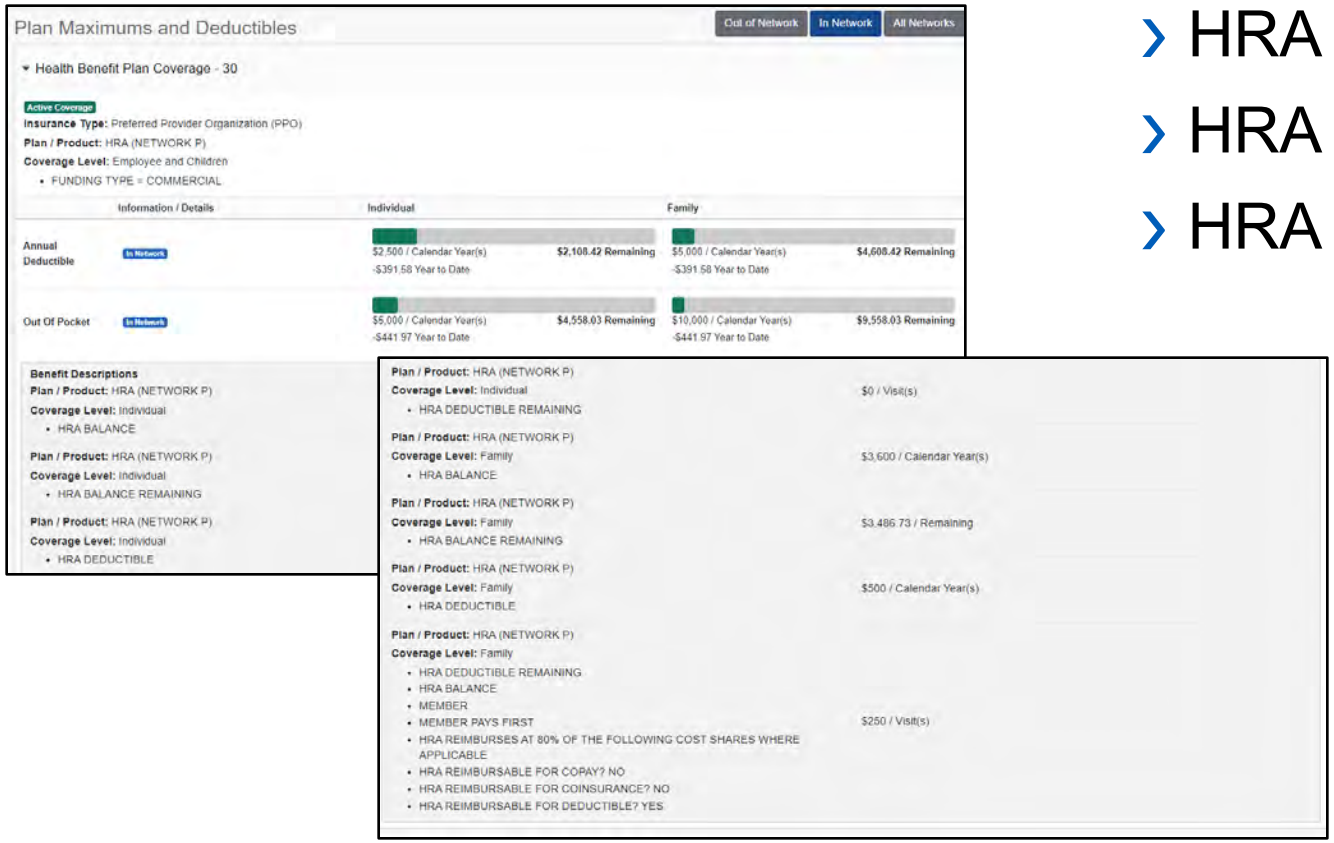


Commercial Member Eligibility & Benefits

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



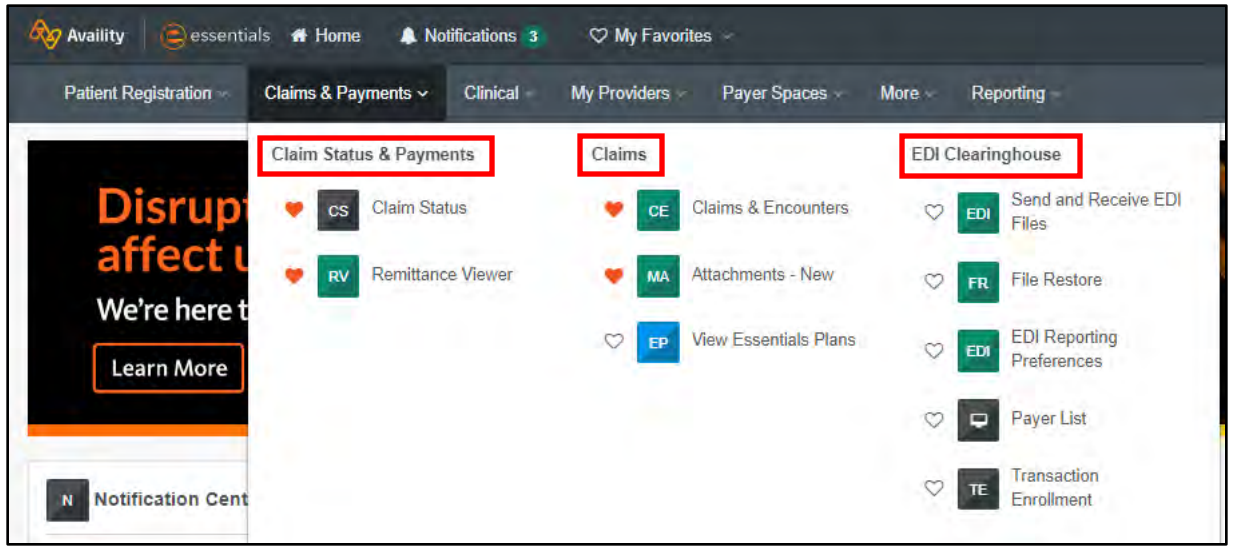
Health Reimbursement Account (HRA)



- 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



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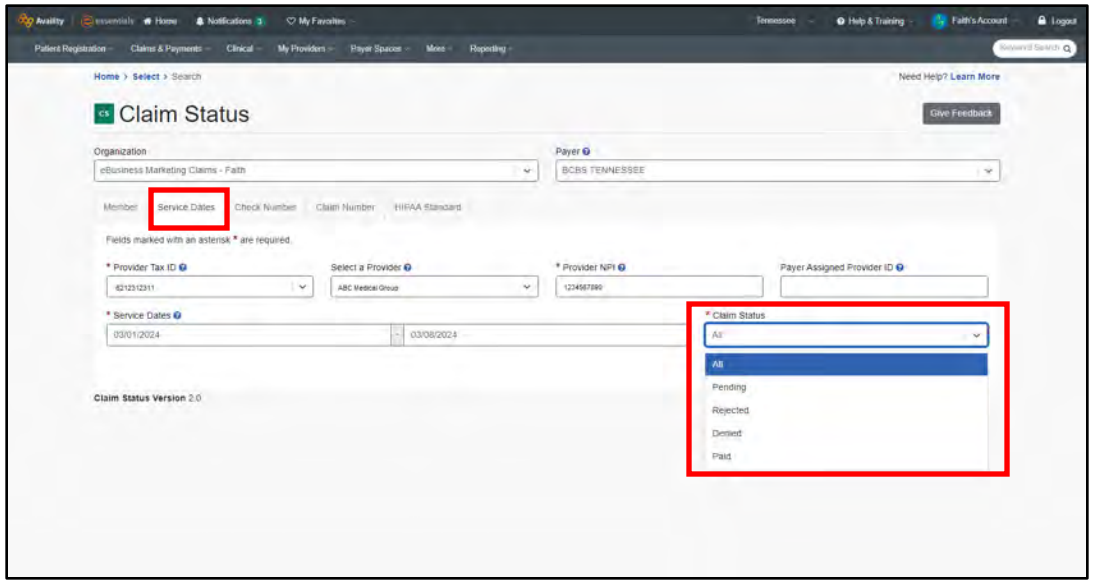
Claim Status

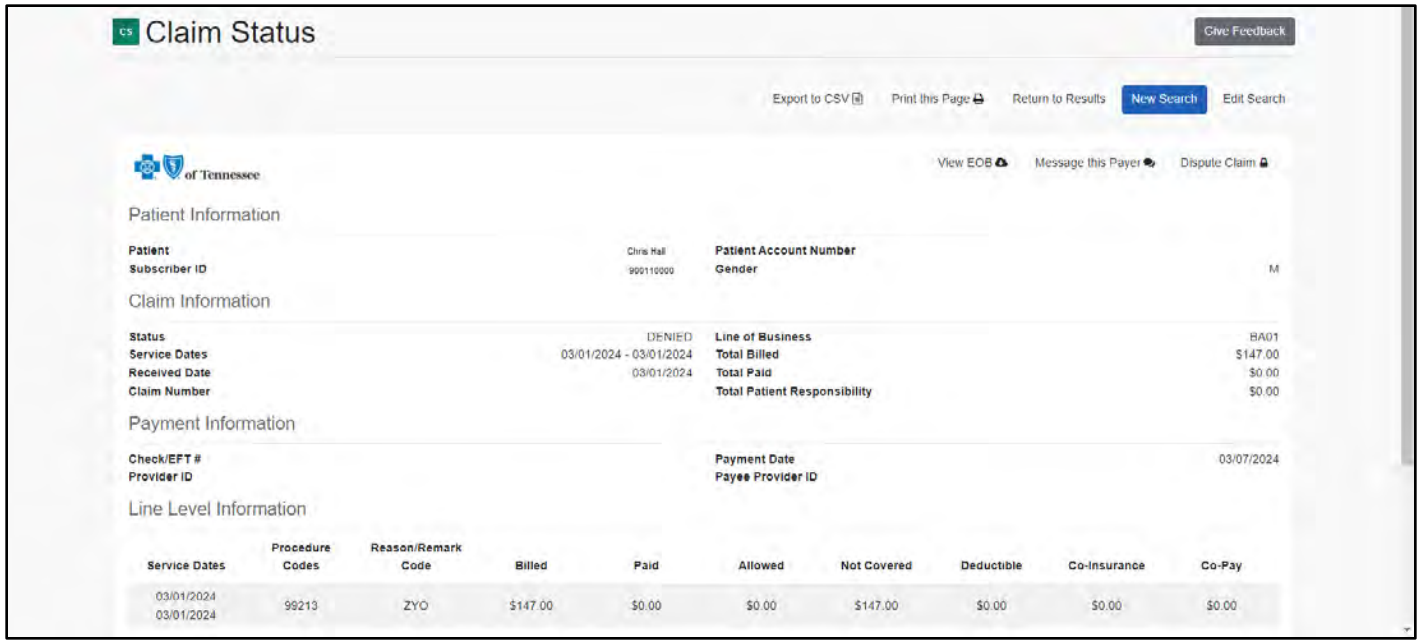


Search by:

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

AVAILITY MULTI-PAYER

Claim Status



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

AVAILITY MULTI-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:

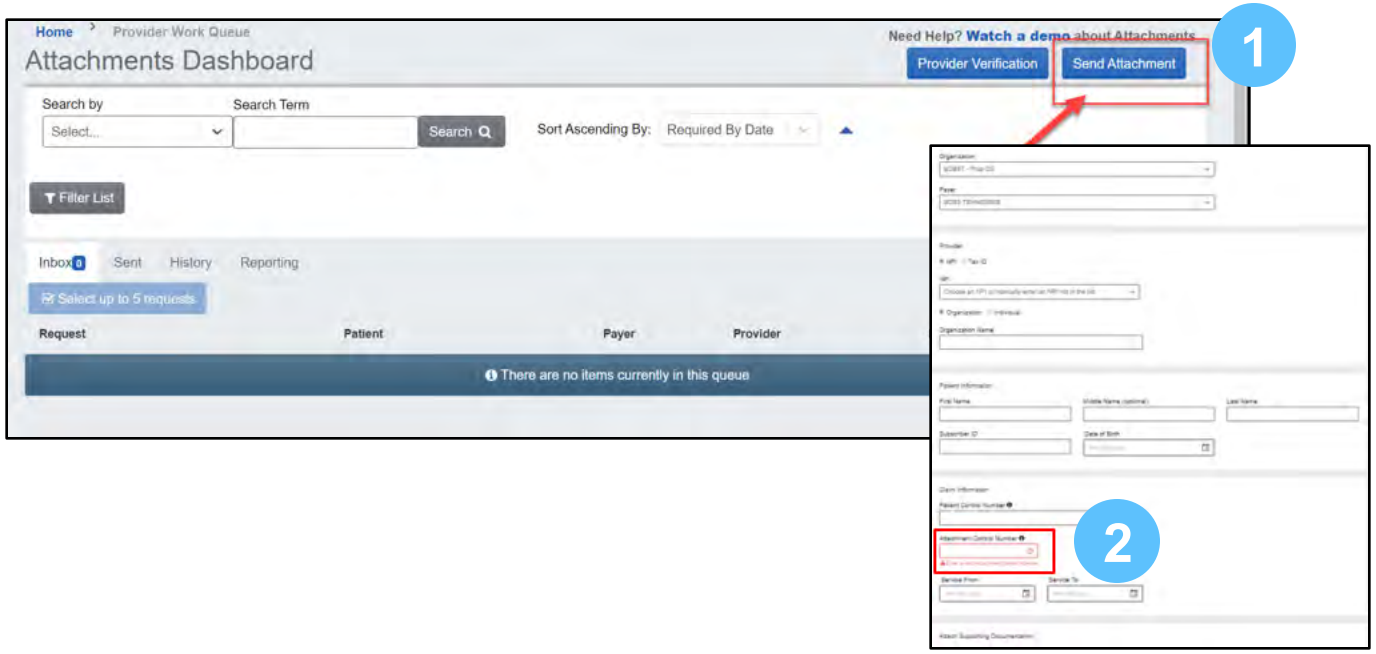
- Provider Dispute Resolution Procedure (PDRP): PDRP Form
- Reconsideration Form: Reconsideration Form
- Appeal Form: Appeal Form

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

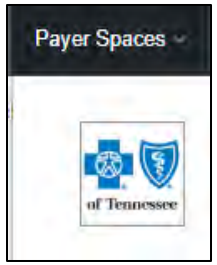


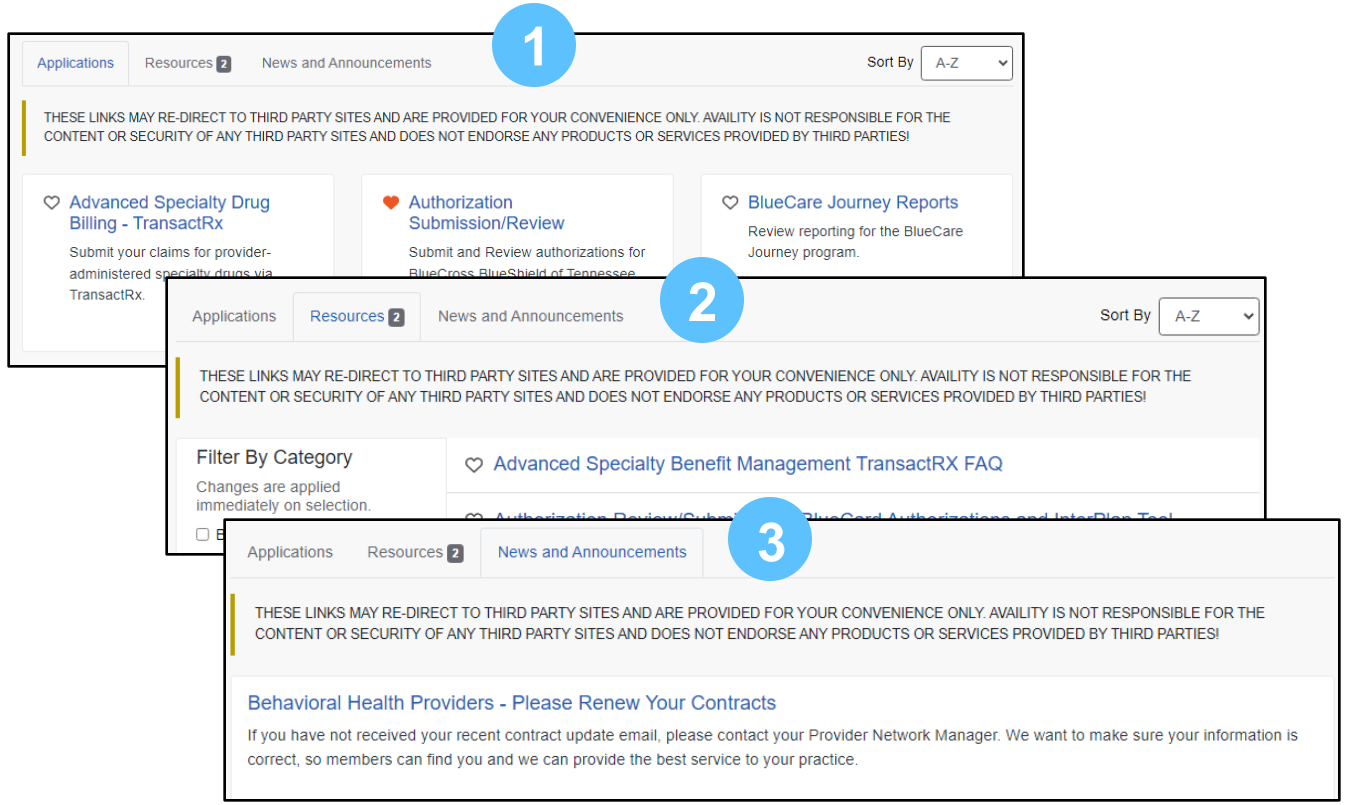
- This is not for claims that have been previously processed. **PWK is for new claims only.**

PAYER SPACES

Introduction to Payer Spaces

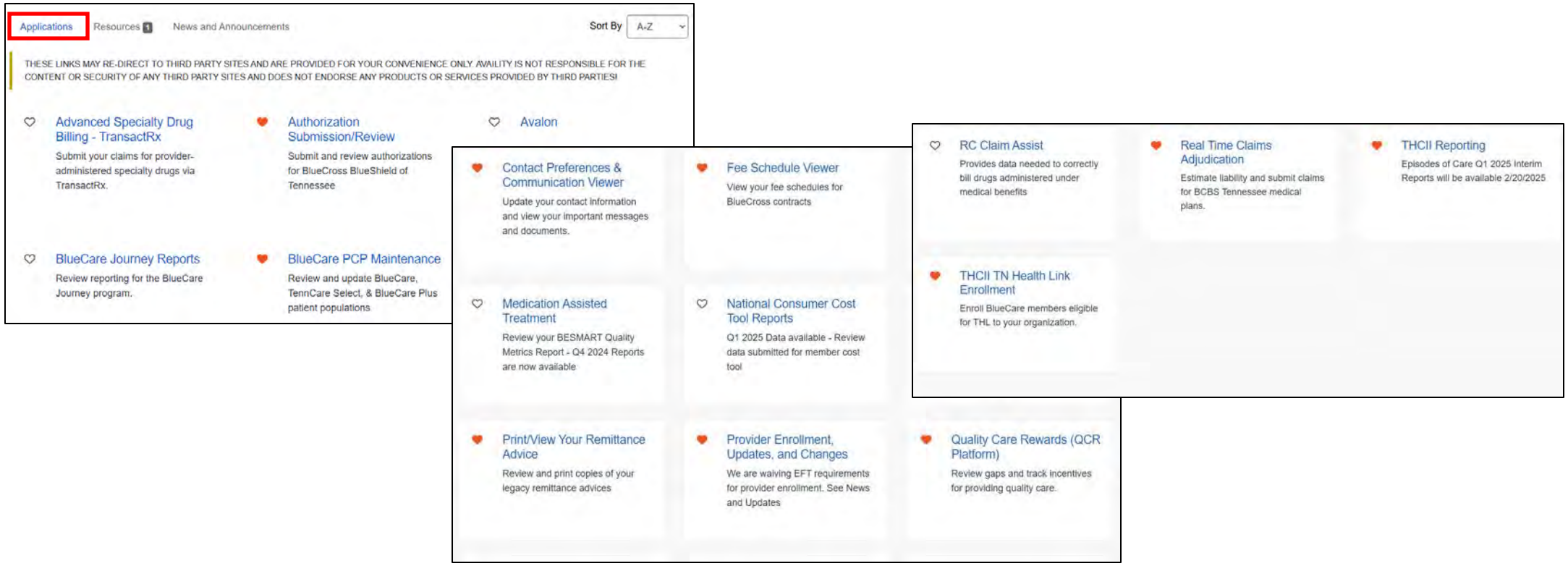
1. Applications
2. Resources
3. News and Announcements





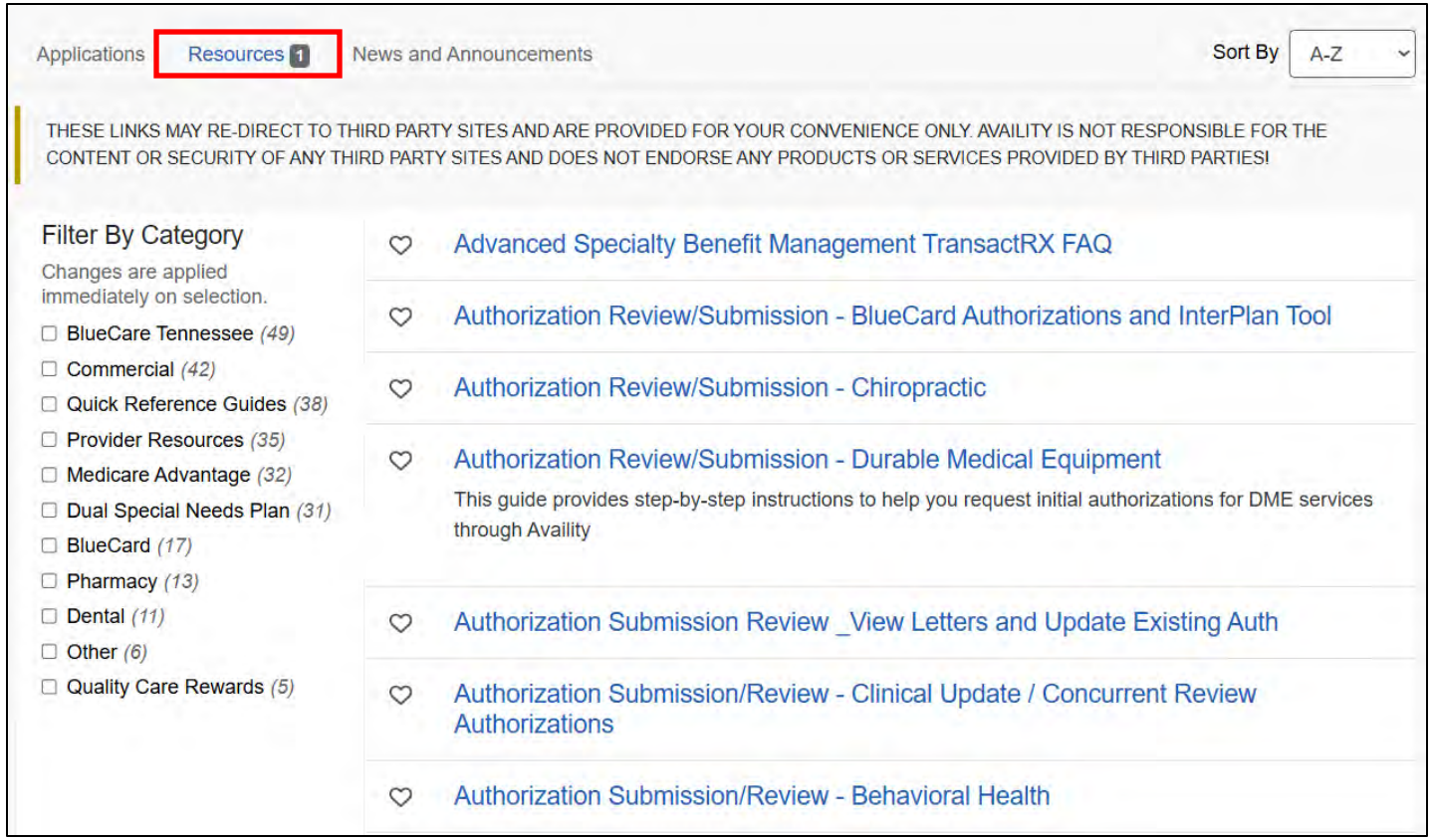
PAYER SPACES

Applications



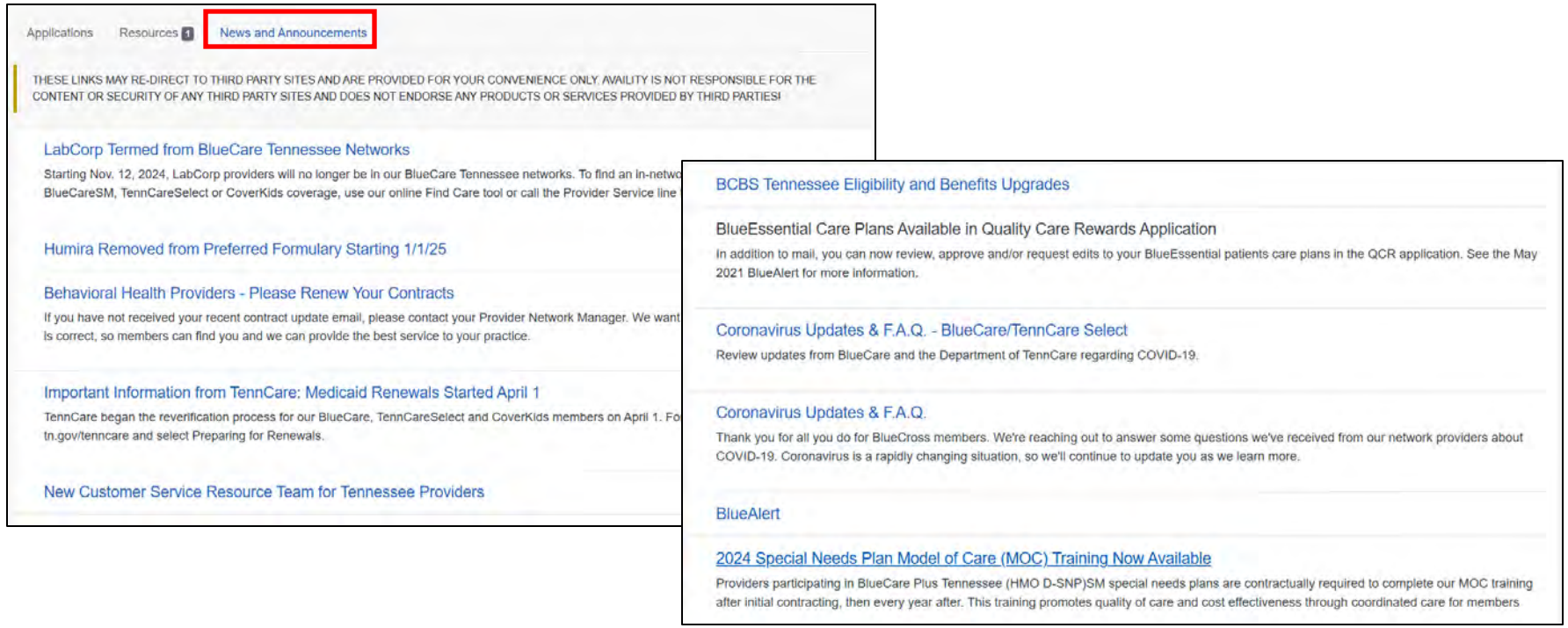
PAYER SPACES

Resources



PAYER SPACES

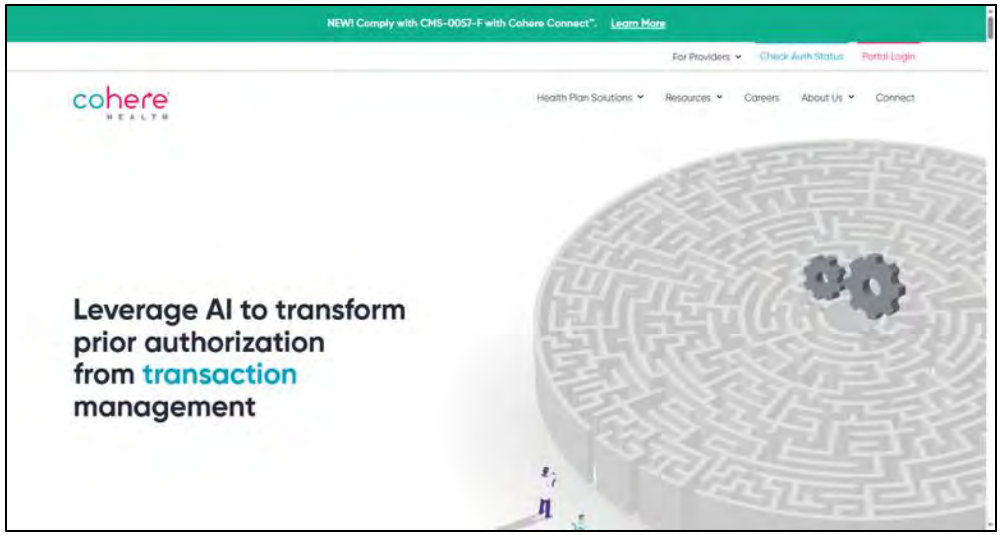
News and Announcements



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.



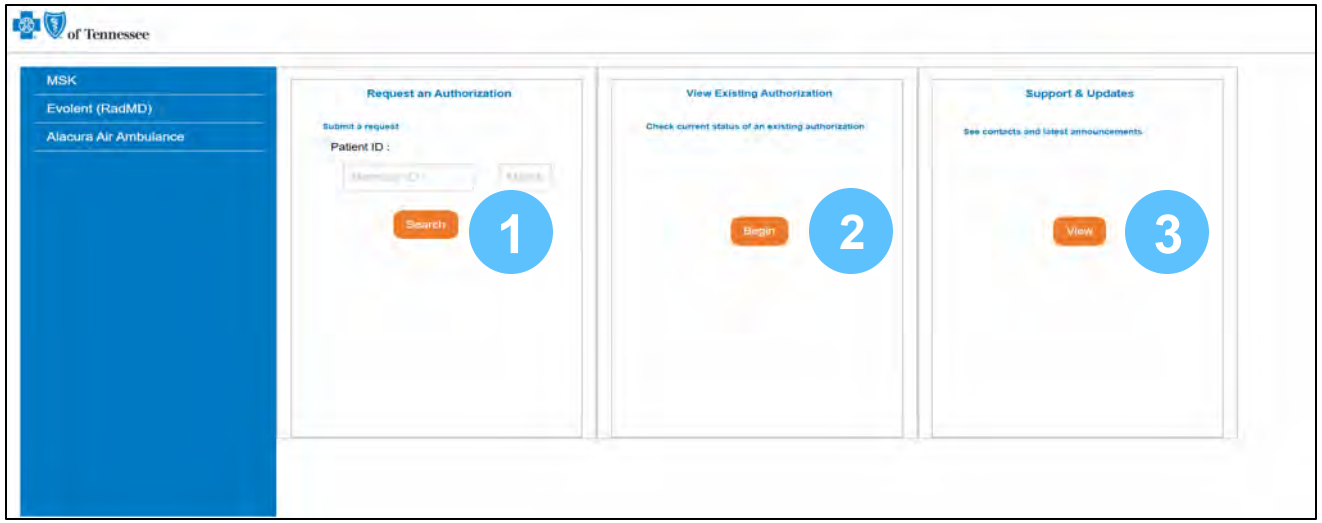
Cohere Health – Commercial Authorizations

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

PAYER SPACES

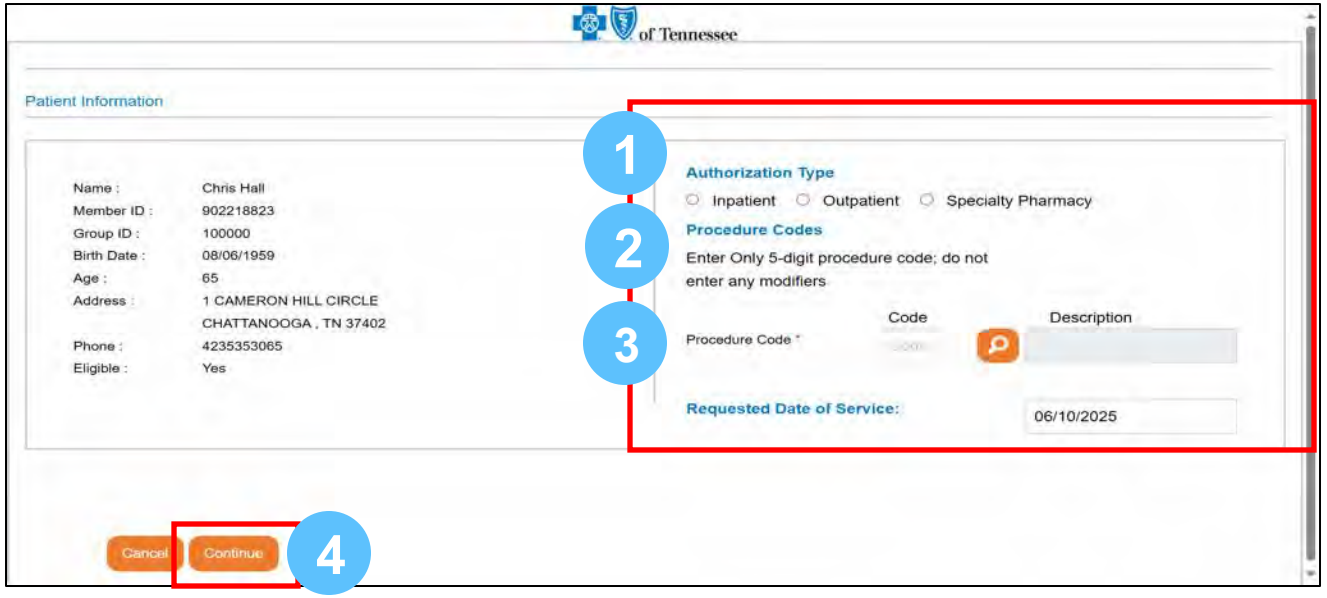
Authorization Submission / Review – New View



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

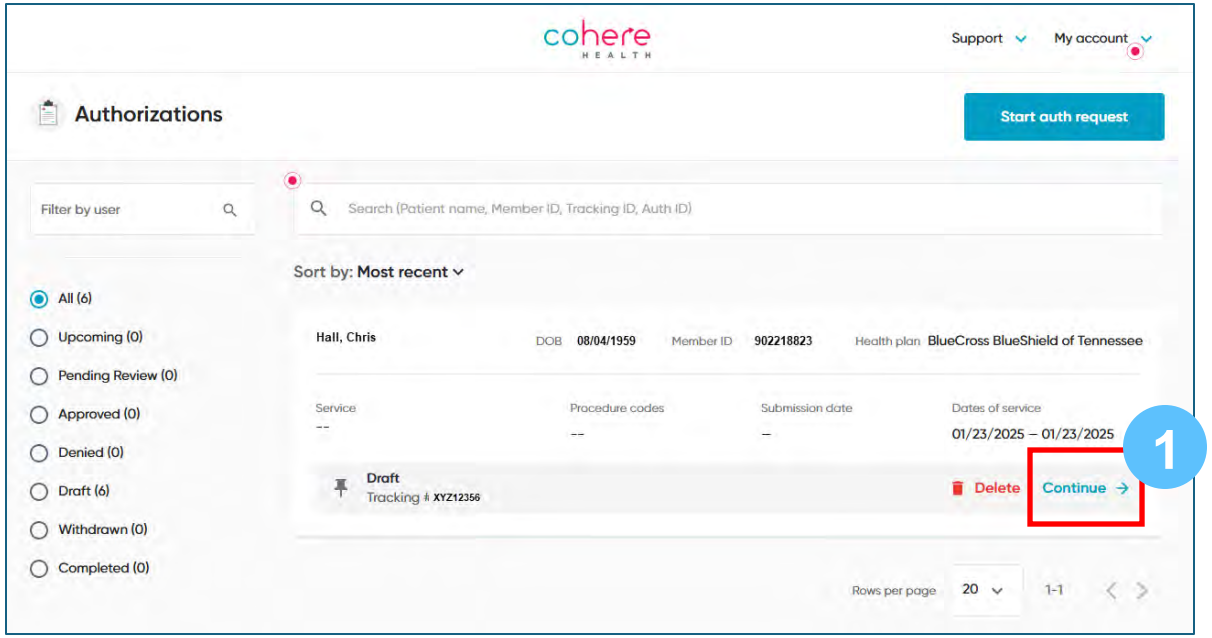
Requesting an Authorization — Commercial Member

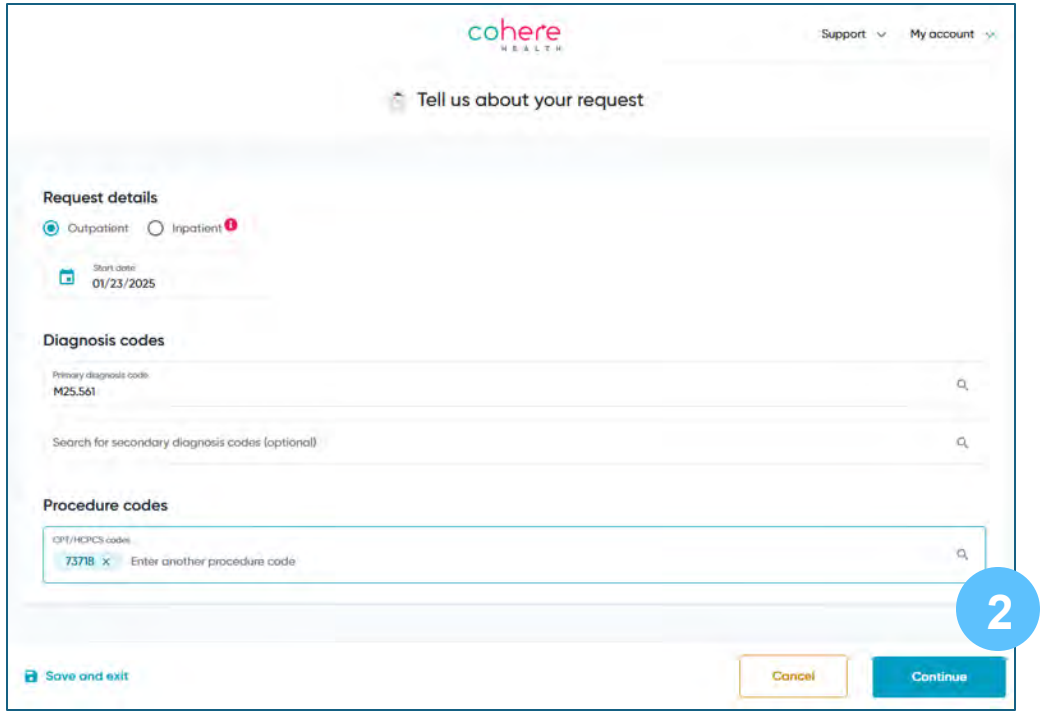
1. **Authorization Type**
   - Inpatient
   - Outpatient
   - Specialty Pharmacy
2. **Procedure Codes**
   - Enter only 5-digit codes, no modifiers
   - Magnifying glass to search
3. **Requested Date of Service**
4. SSO to Cohere after clicking **Continue** button



COHERE HEALTH®

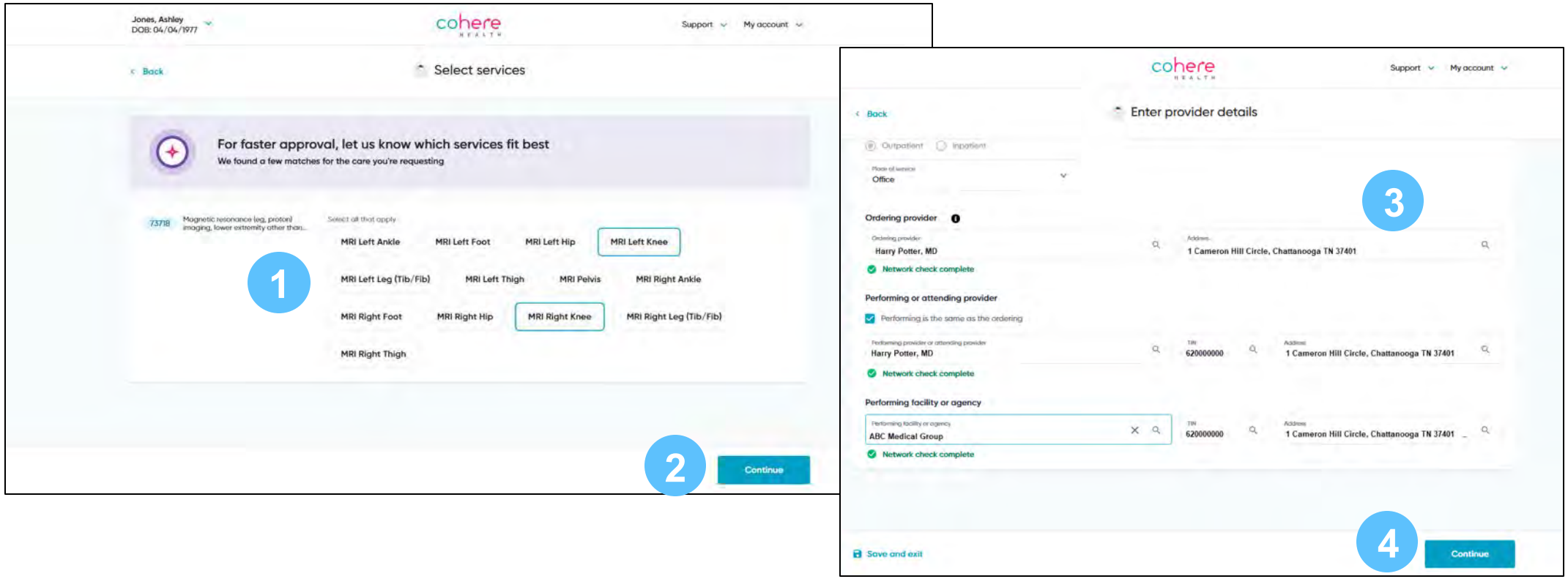
Commercial Authorizations





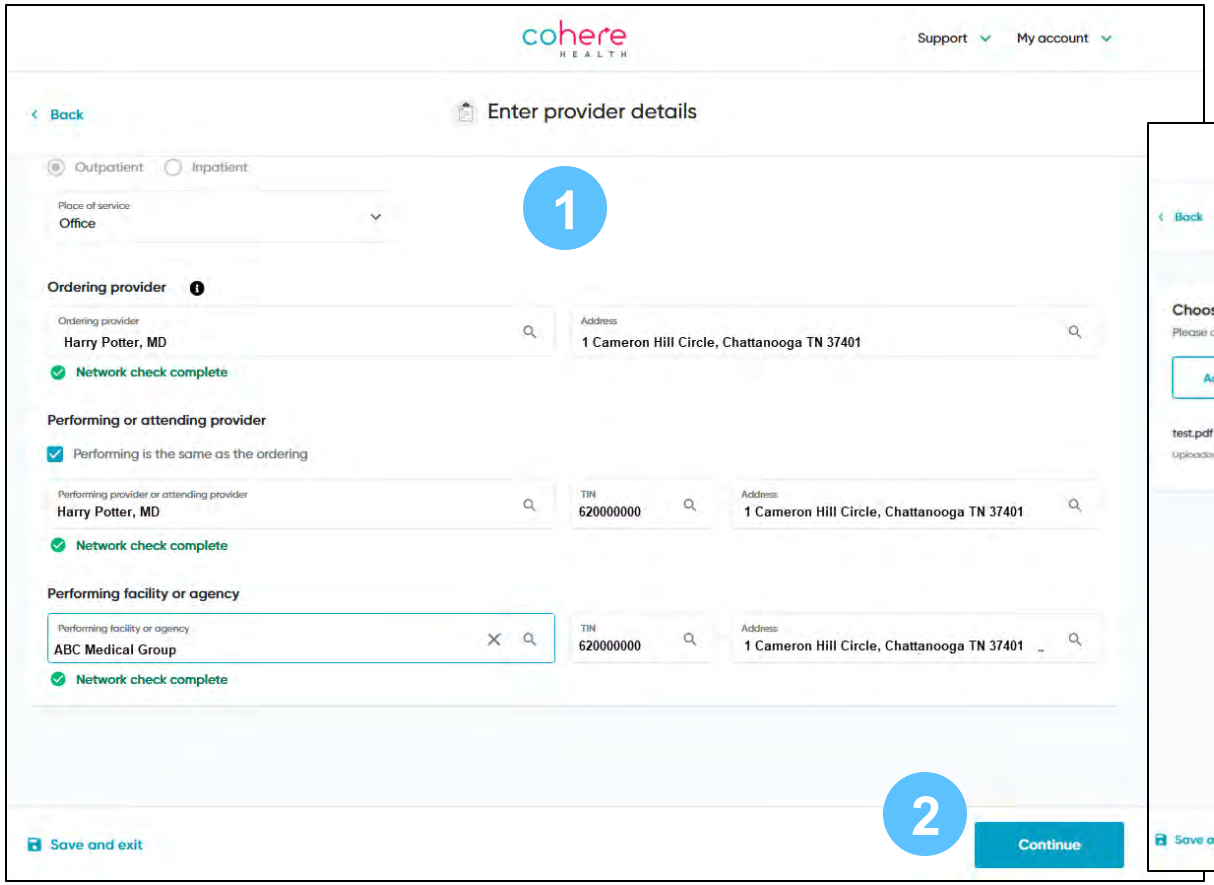
COHERE HEALTH

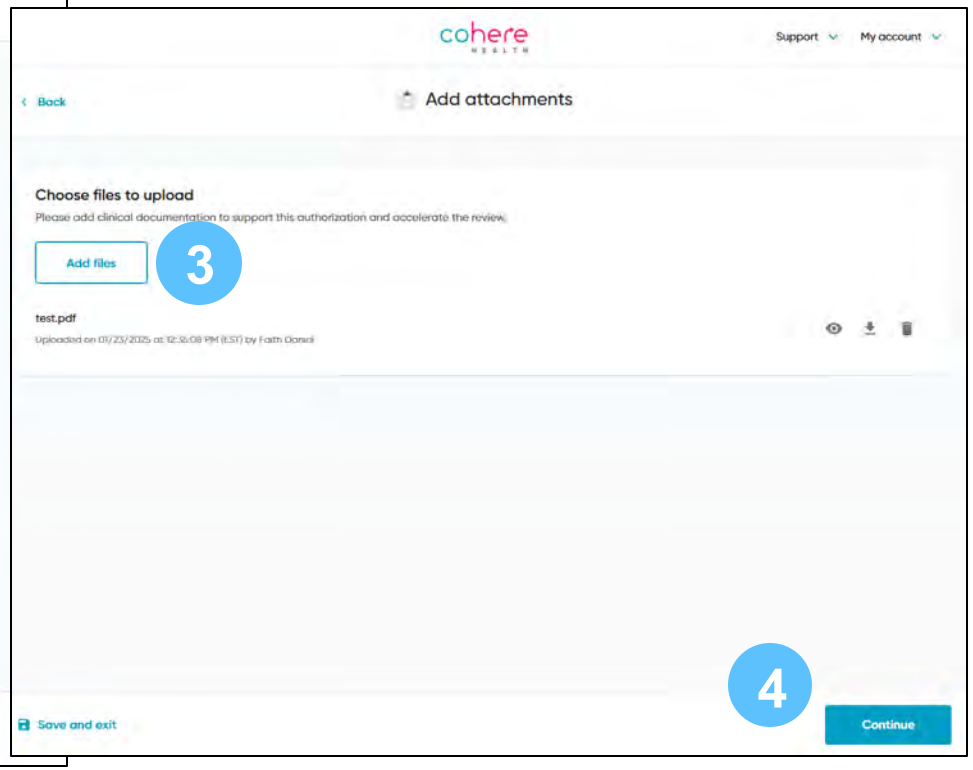
Commercial Authorizations



COHERE HEALTH

Commercial Authorizations

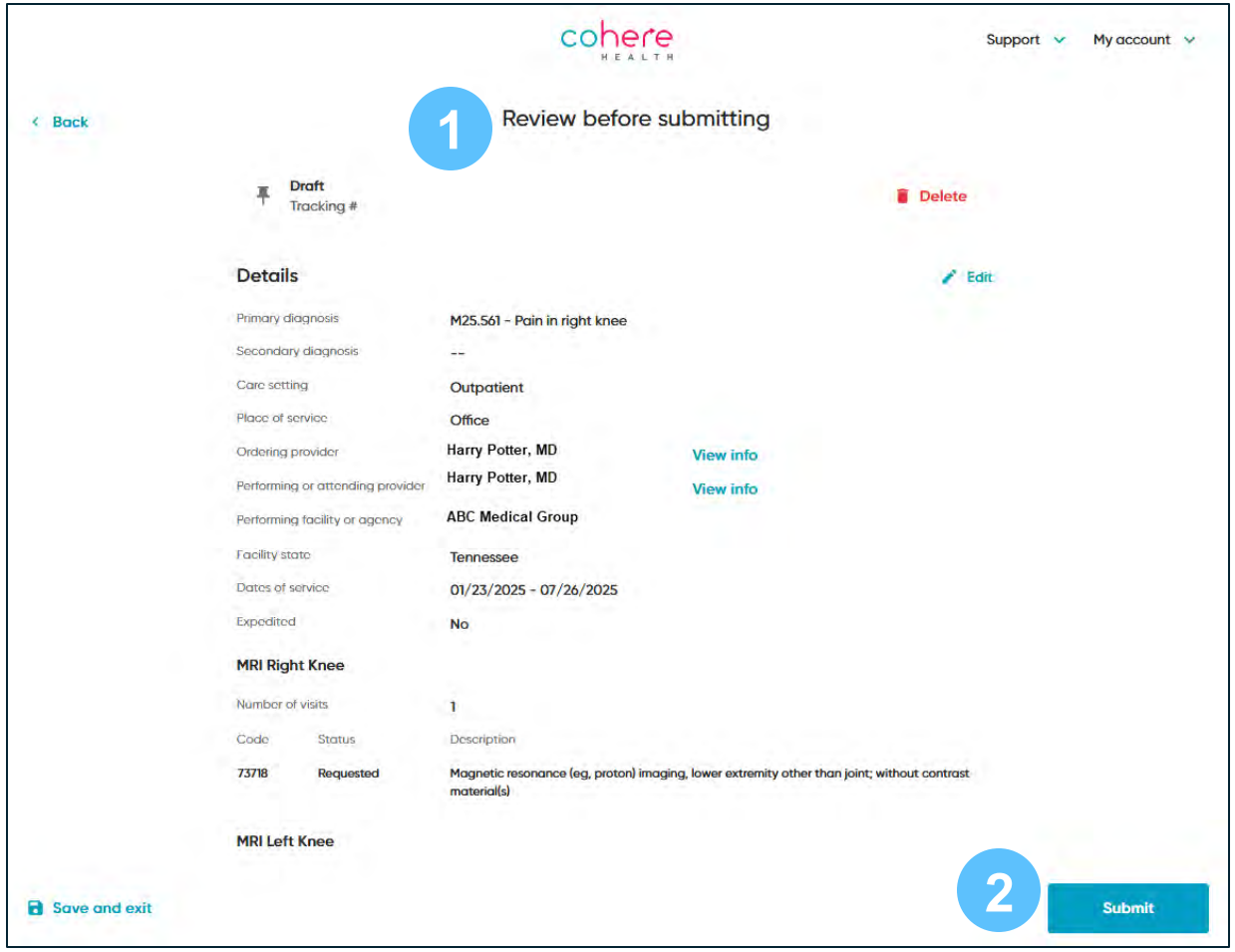




› **Very Important:** Be sure to attach clinical information shown in step 3

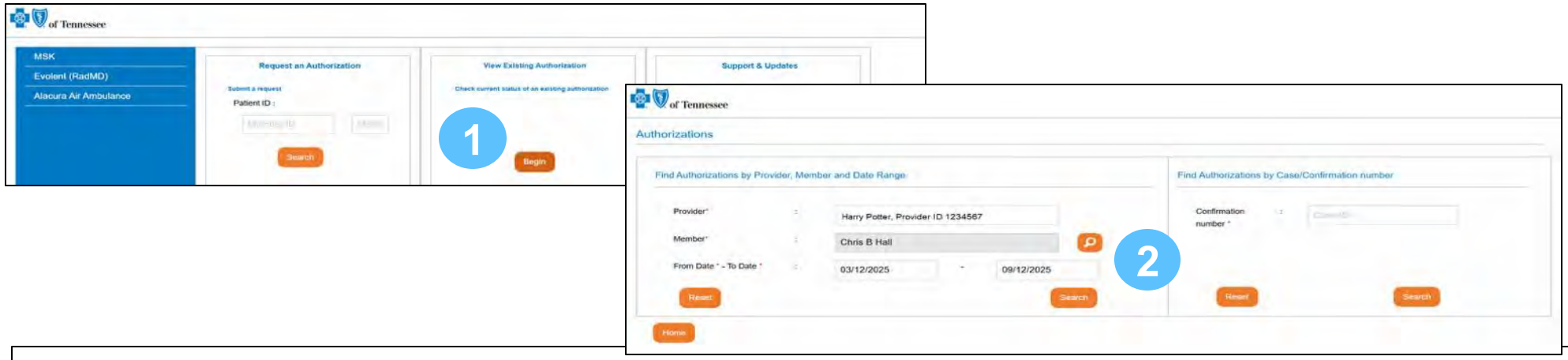
COHERE HEALTH

Commercial Authorizations

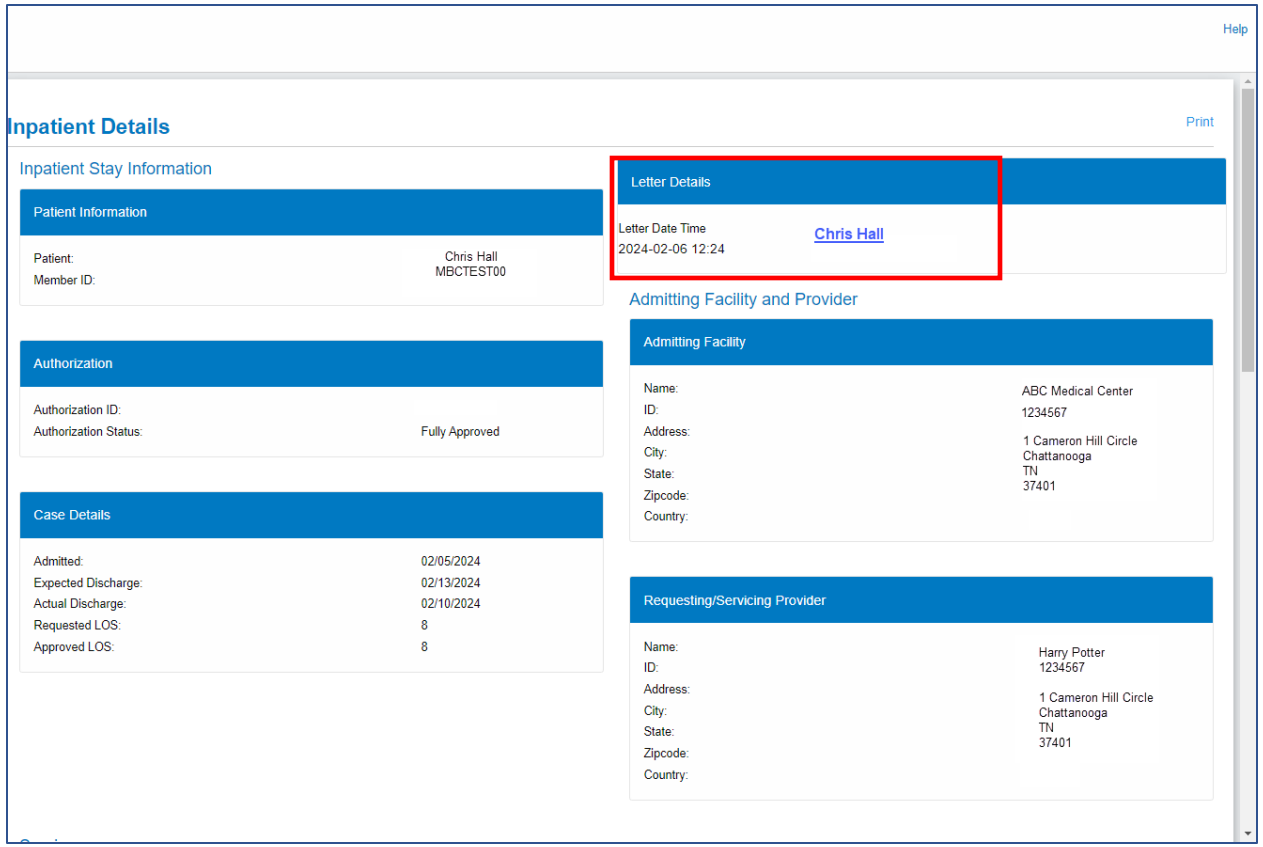


PAYER SPACES

View Existing Authorizations



View / Print Letters

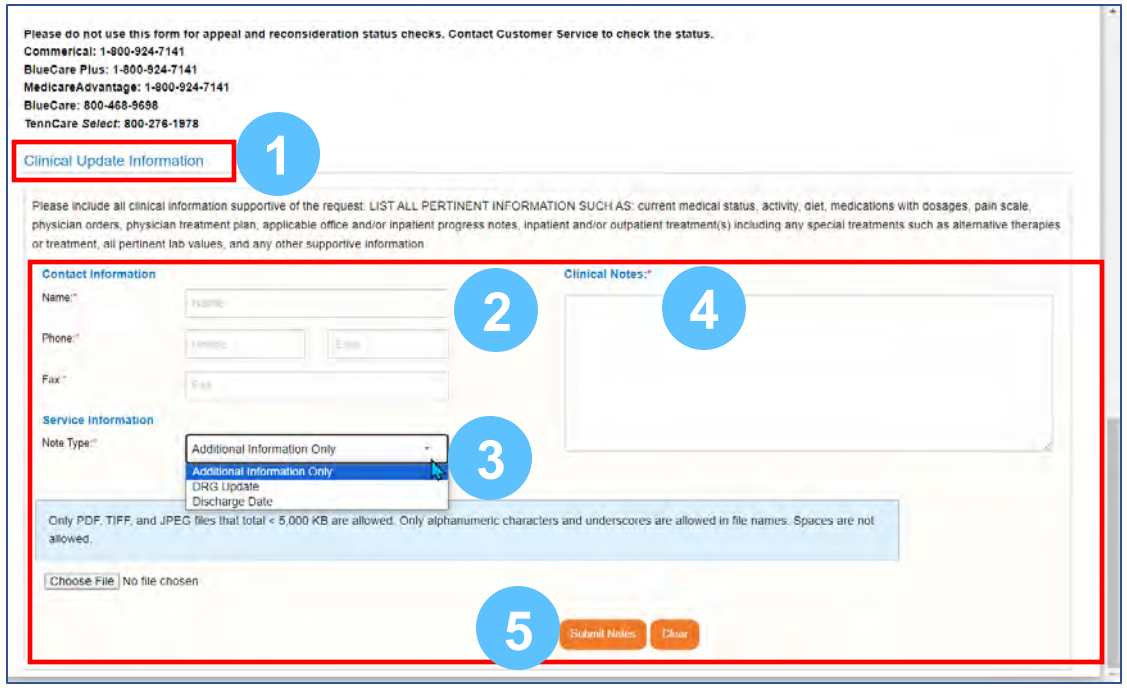


Letter Details

- 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



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

PAYER SPACES

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

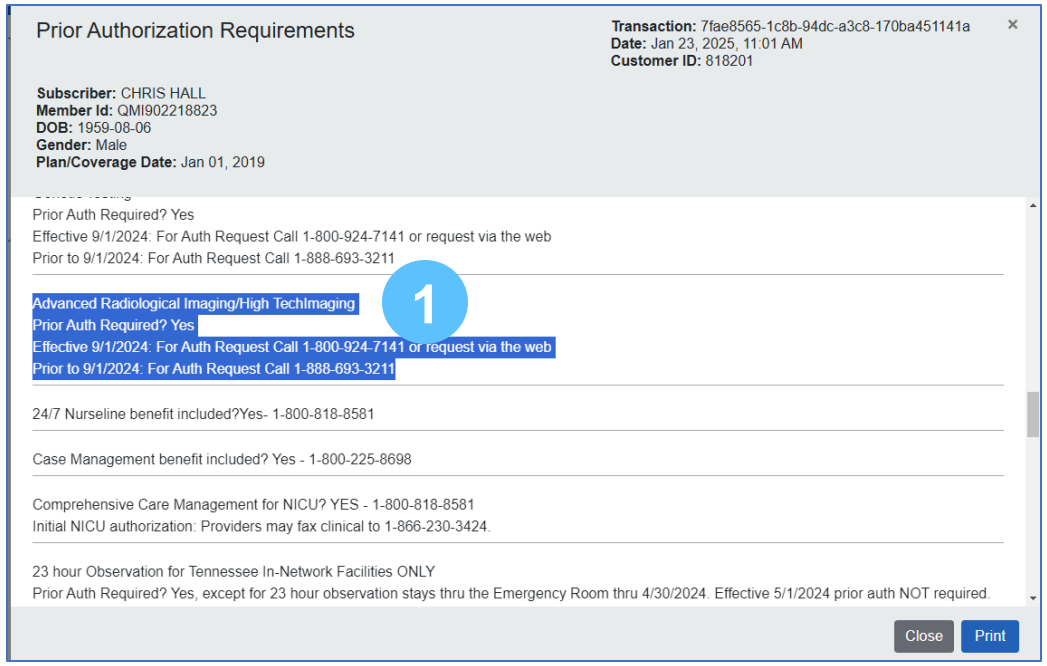
Starting an Authorization

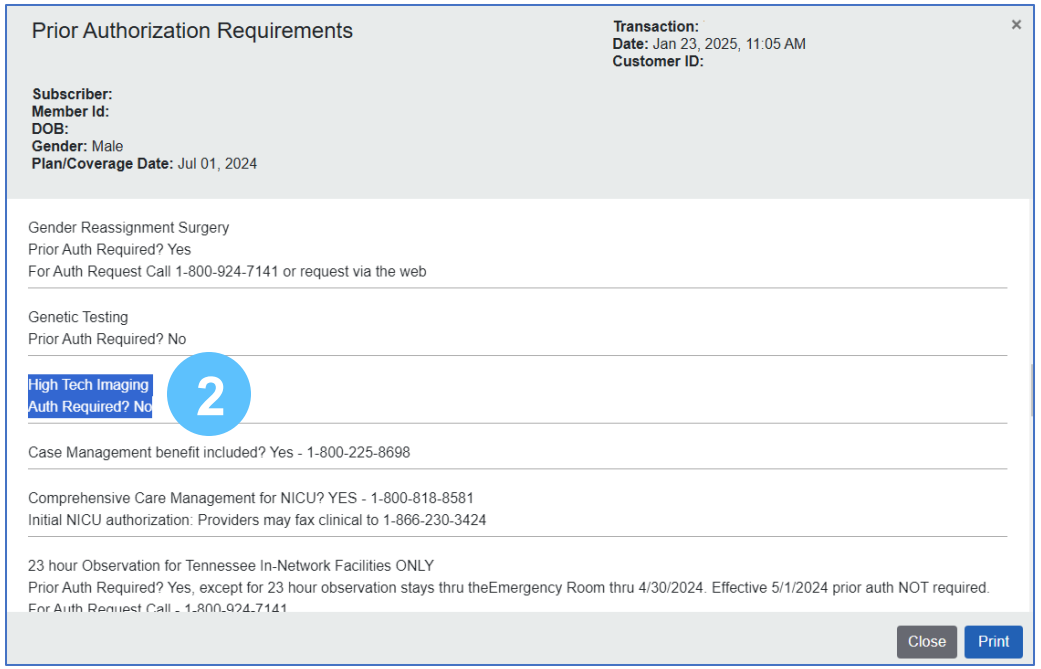
- Start HTI Authorizations for TN Members on Availity Payer Spaces Application
- Start BlueCard Authorizations under Patient Registration / Authorizations & Referrals

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.

PAYER SPACES

High Tech Imaging Authorizations



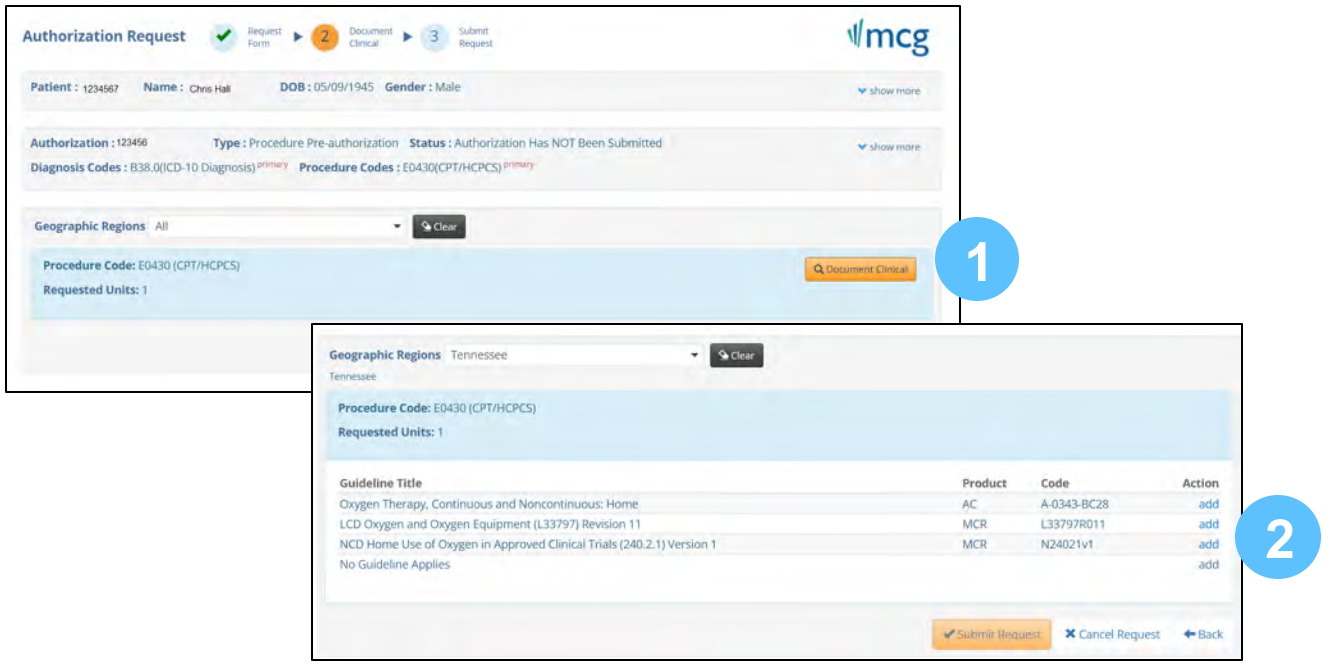


1 Prior authorization **is required** for HTI

2 Prior authorization **is not** required for HTI

Medicare Advantage Authorizations: LCD and NCD Guidelines

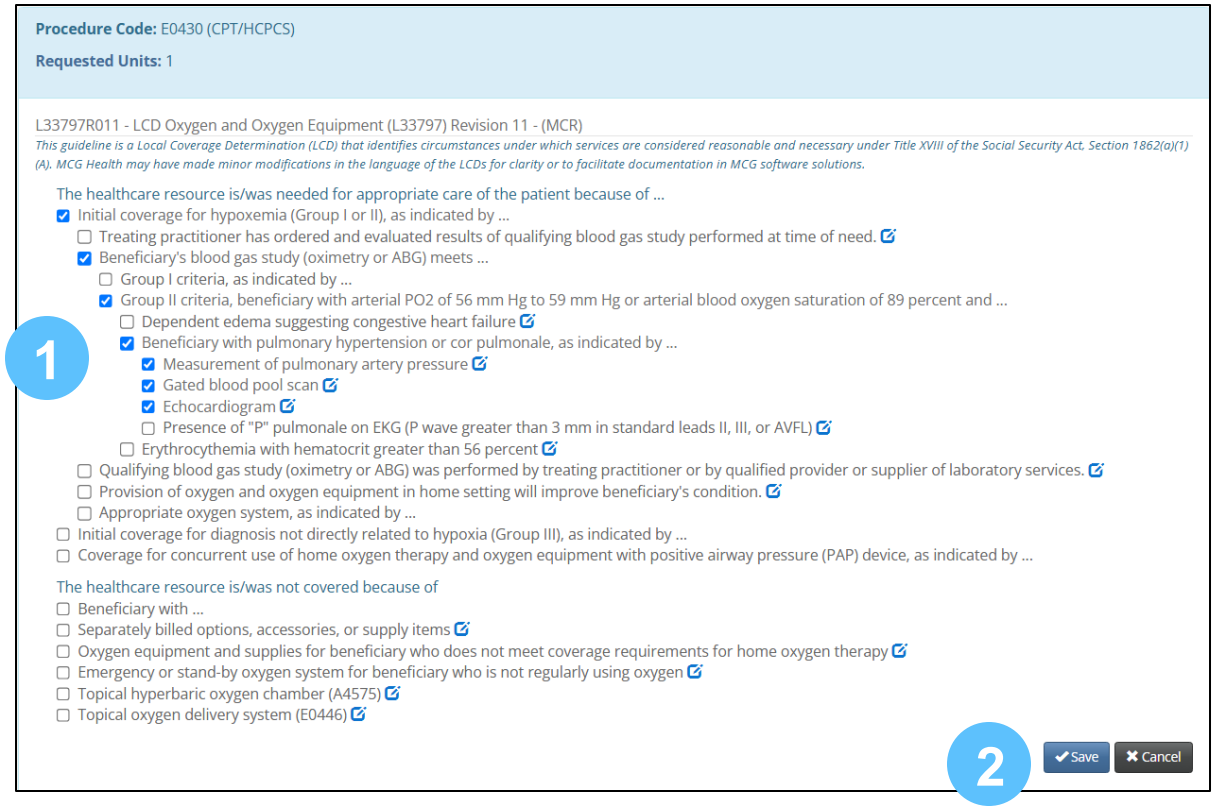
- When submitting Medicare Advantage authorizations, select the most appropriate LCD and/or NCD guideline.
- If the authorization meets the clinical criteria, you may receive instant approval.



MILLIMAN CARE GUIDELINES

LCD/NCD Guidelines

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

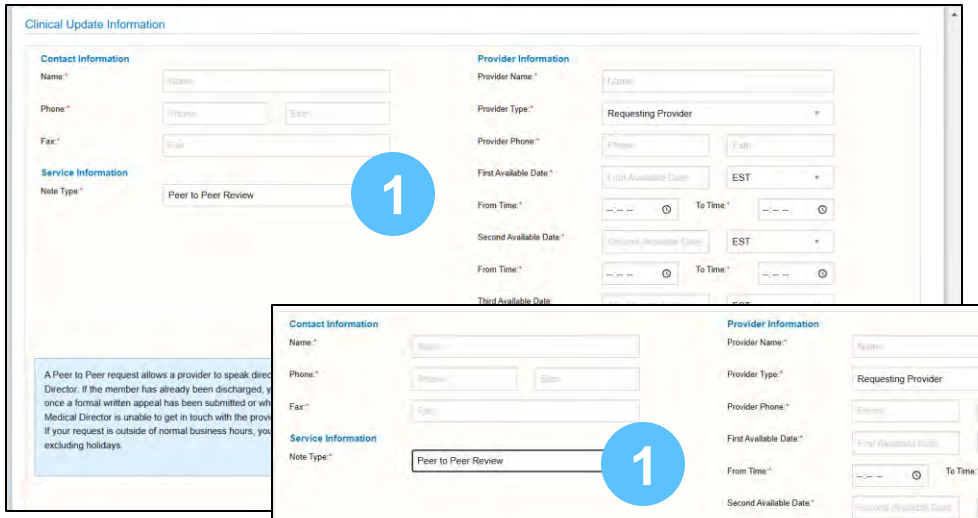


PAYER SPACES

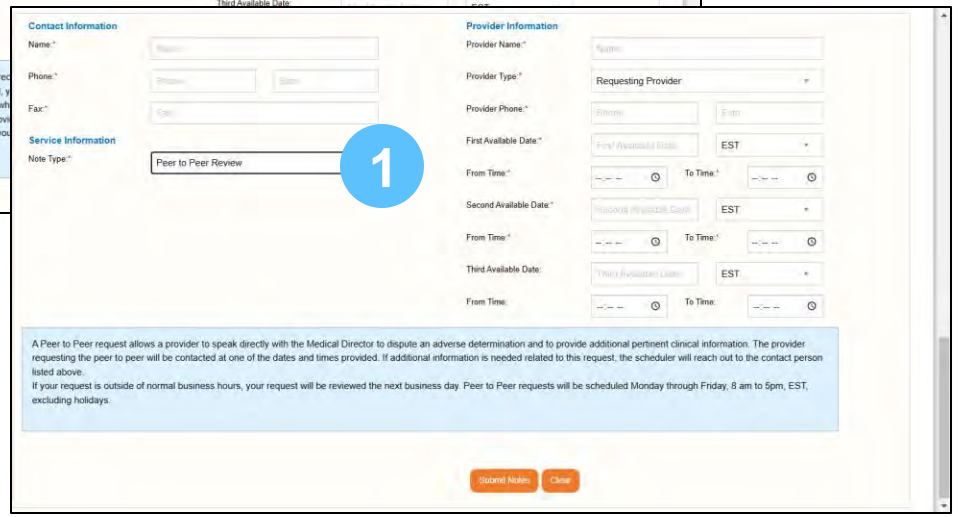
Peer-to-Peer Review

- 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



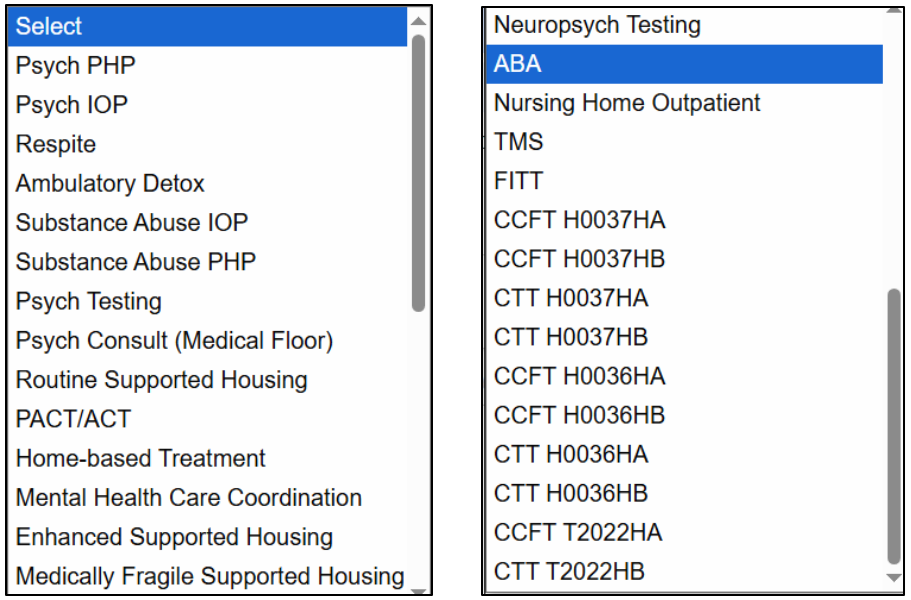
BlueCare



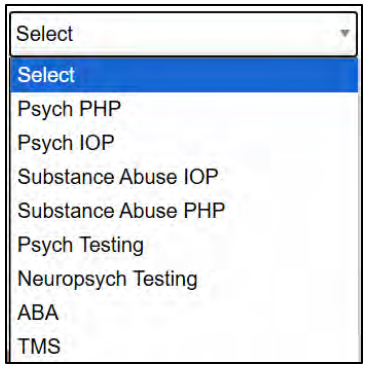
PAYER SPACES

Behavioral Health Outpatient Authorizations: Treatment Types

BlueCare Treatment Types



Commercial Treatment Types



PAYER SPACES

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.

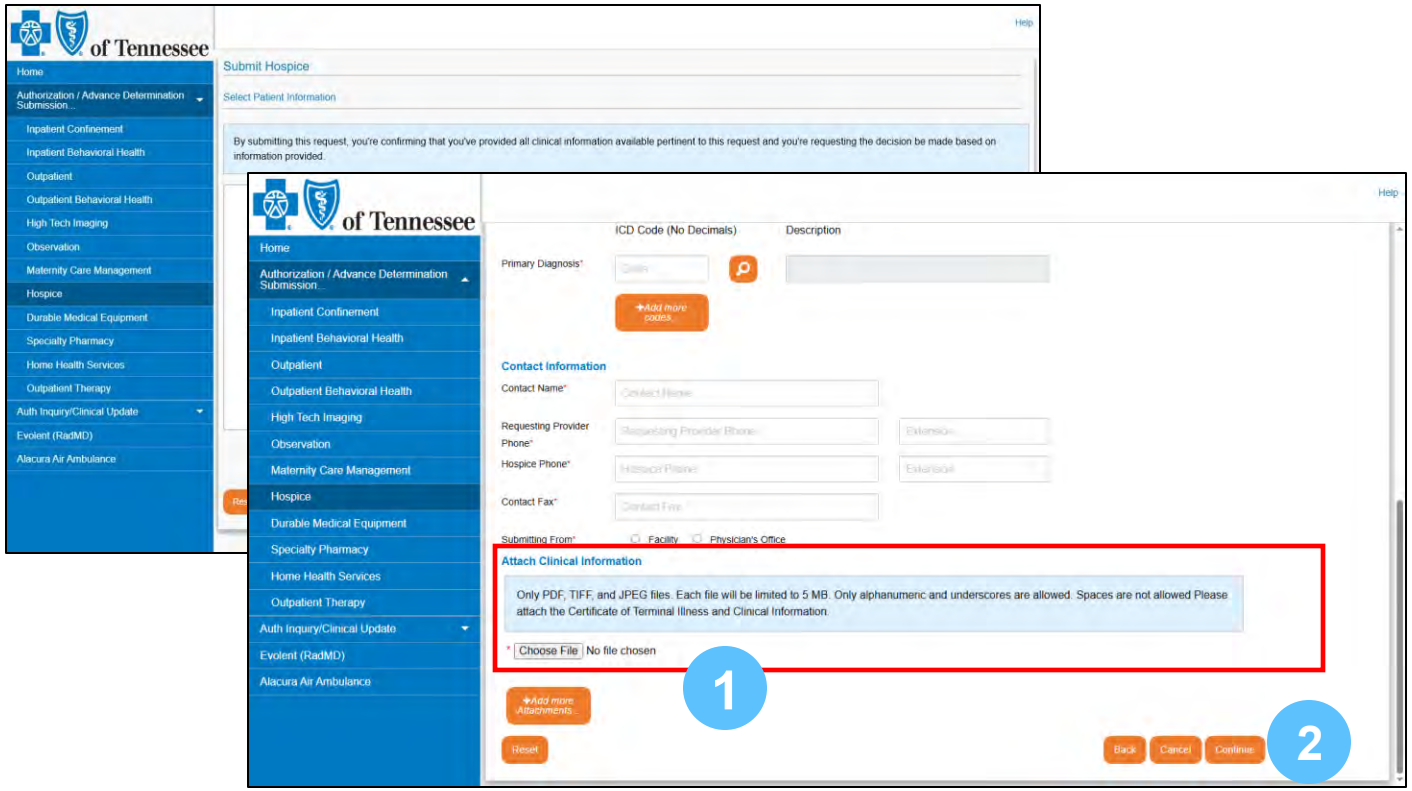
LTAC/SNF/Inpatient Rehab Authorizations

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.



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

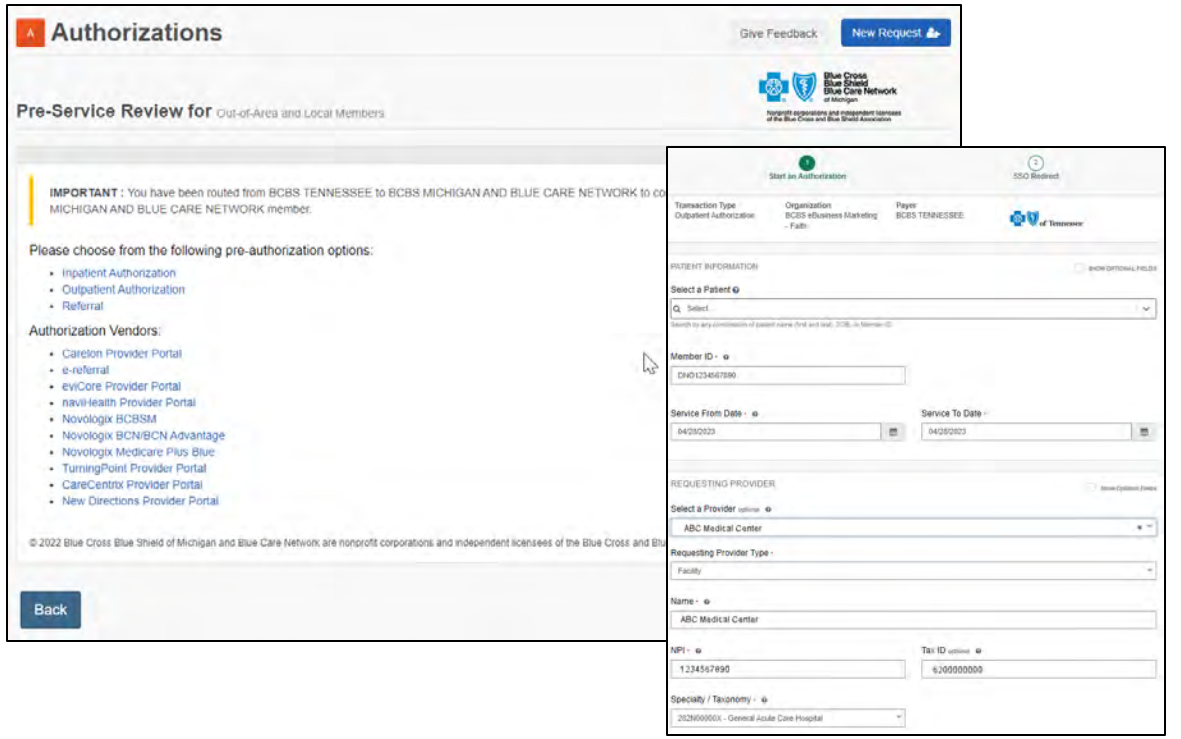
InterPlan Medical Policy and Pre-Certification Application:

- 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.



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.

PAYER SPACES

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

PAYER SPACES

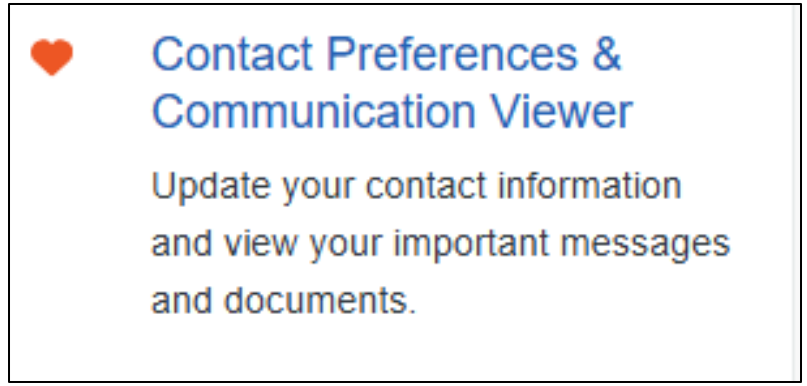
Contact Preferences & Communication Viewer

Contact Preferences

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

View Communications

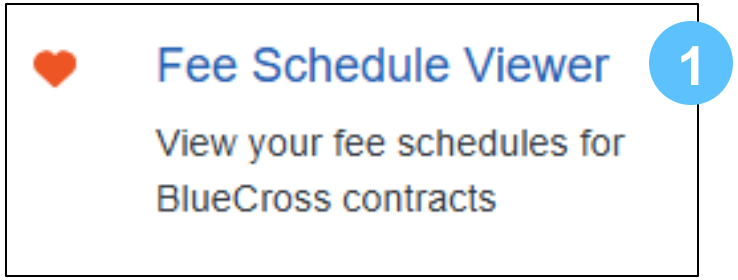
- Online repository of communications

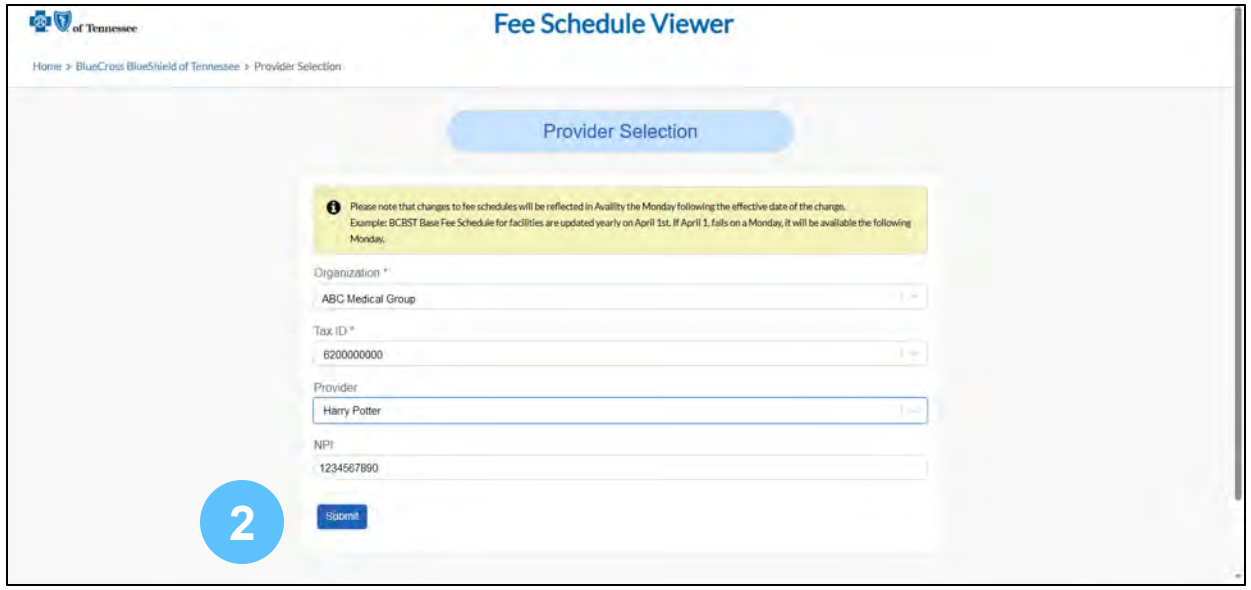


PAYER SPACES

Fee Schedule Viewer

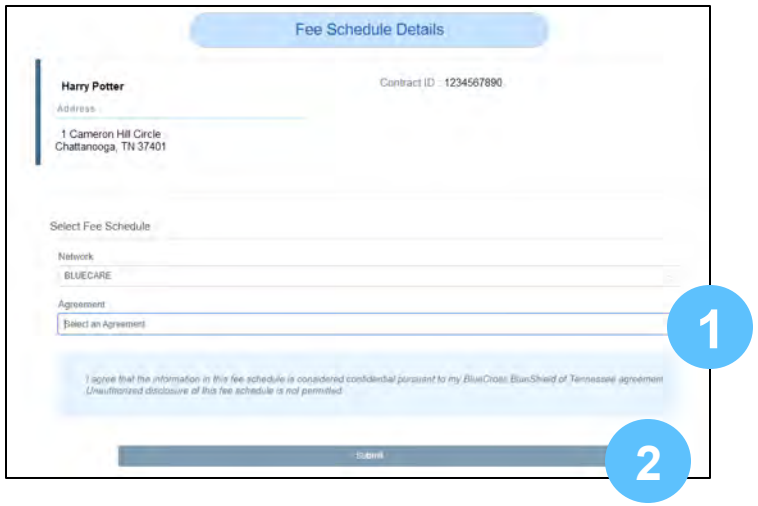
- Provider Enrollment and Contracting User Role is needed
- Provider selection is optional, but often provides a better display inside view application

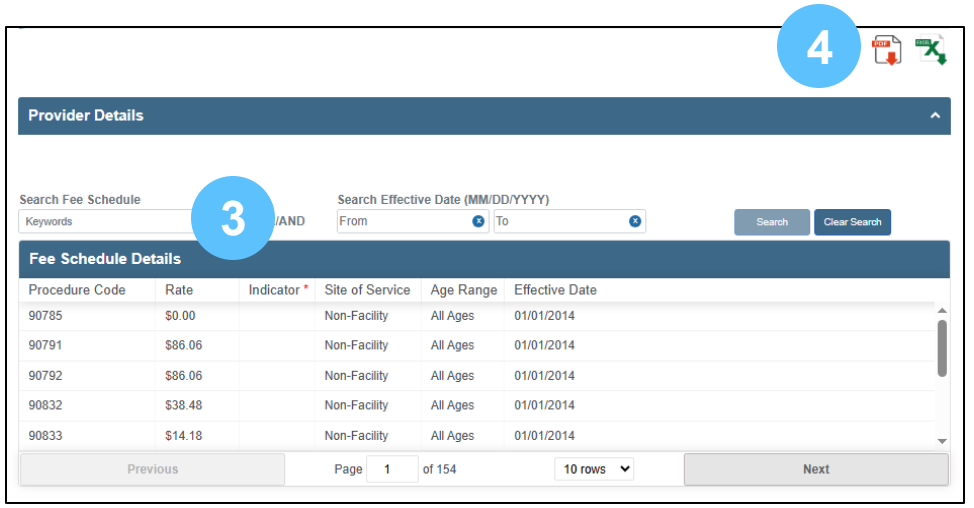




PAYER SPACES

Fee Schedule Viewer





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

BLUECROSS WEBSITE

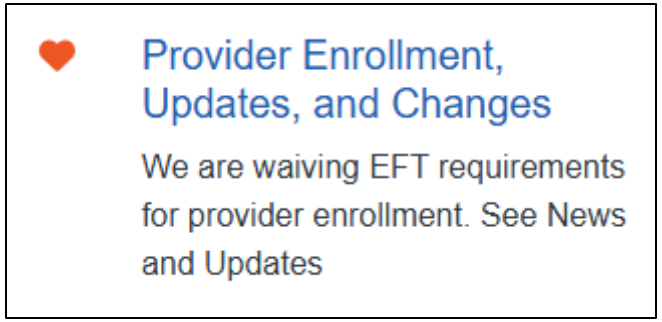
Enroll a Provider

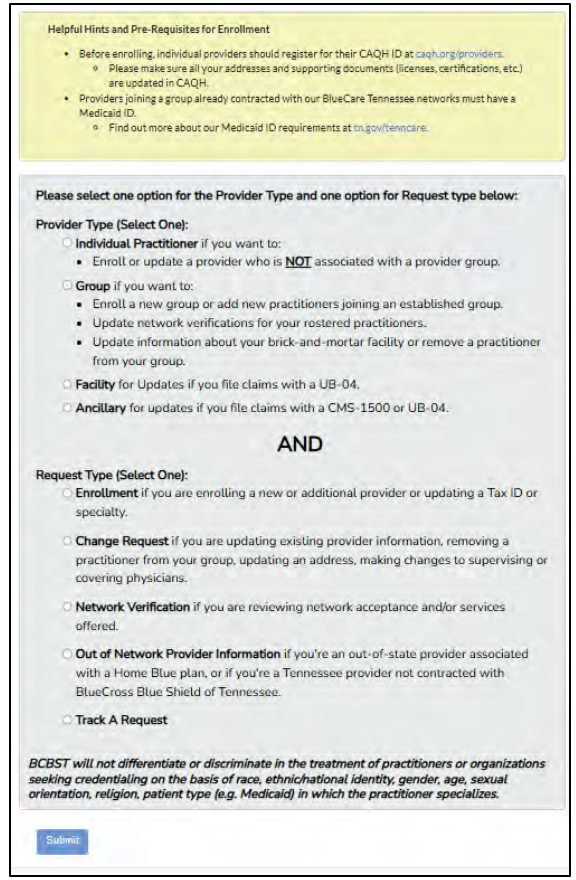
1. Update CAQH CAQH ProView
2. Enter EFT/ERA information on Change HealthCare
3. Availity/Provider Enrollment Updates and Changes Application

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)

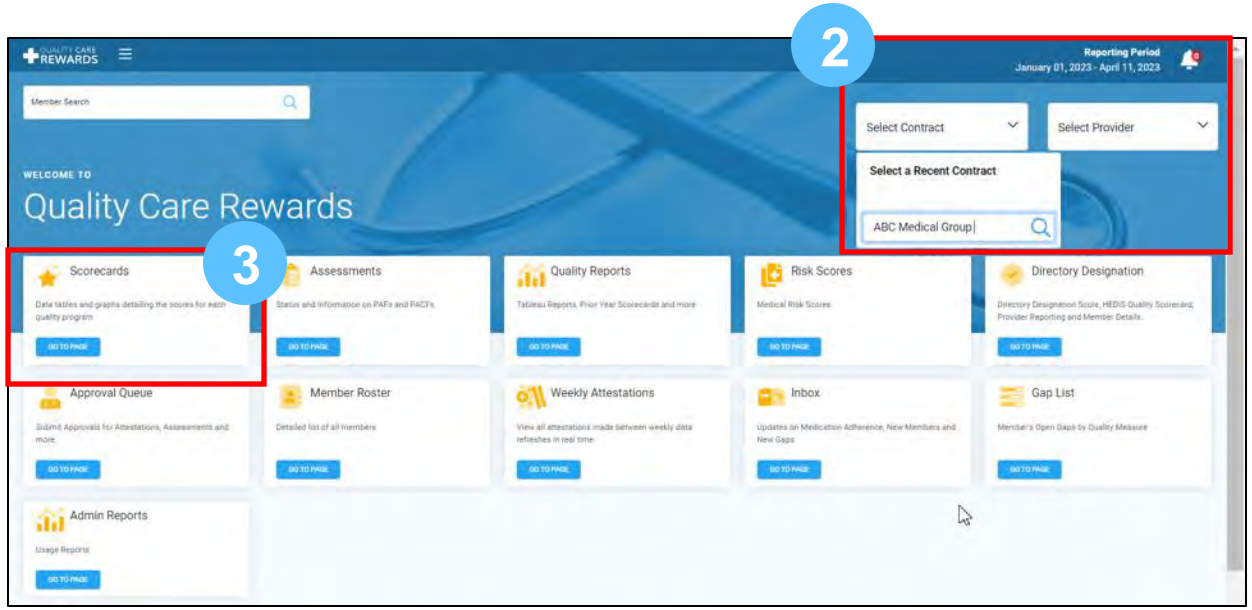


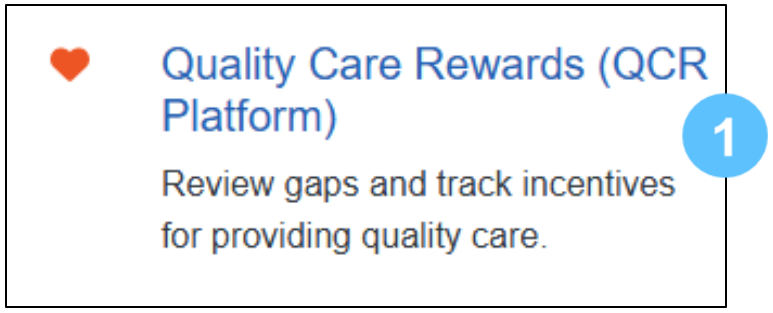


PAYER SPACES

Quality Care Rewards (QCR)

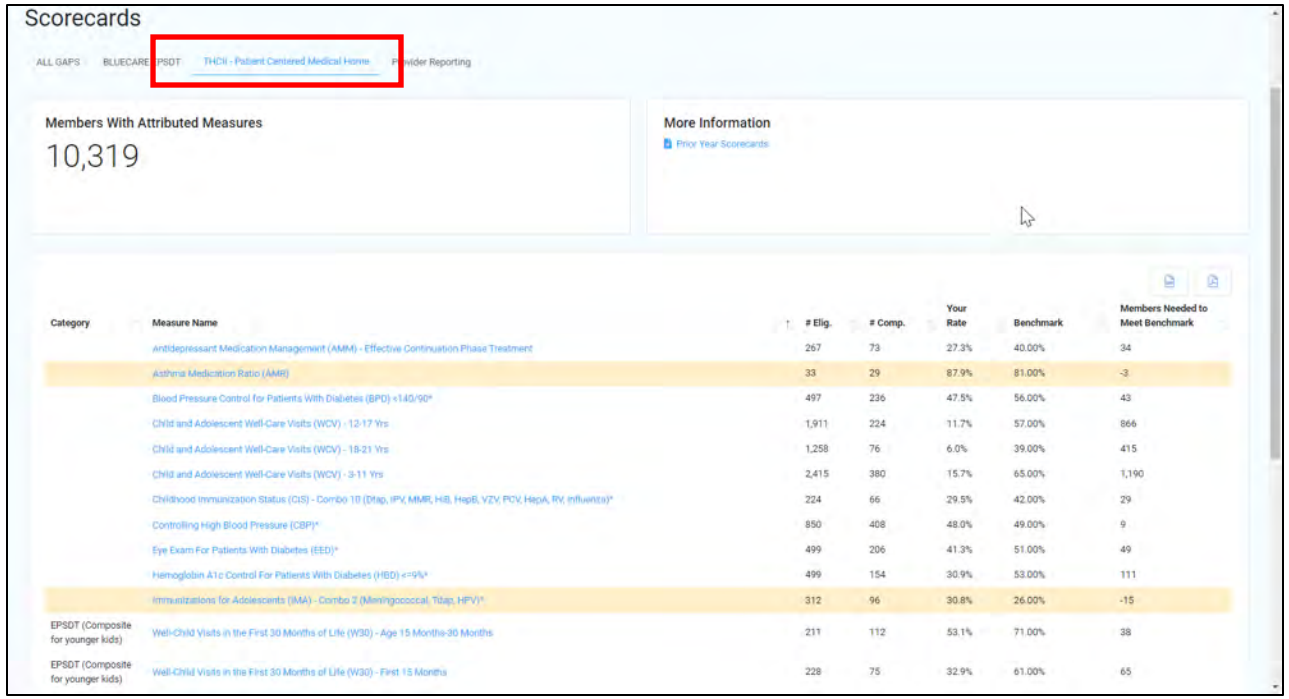
- Search Provider name in Contract Search Field
- Select desired tile to view data or click horizontal lines in upper left corner for navigational menu



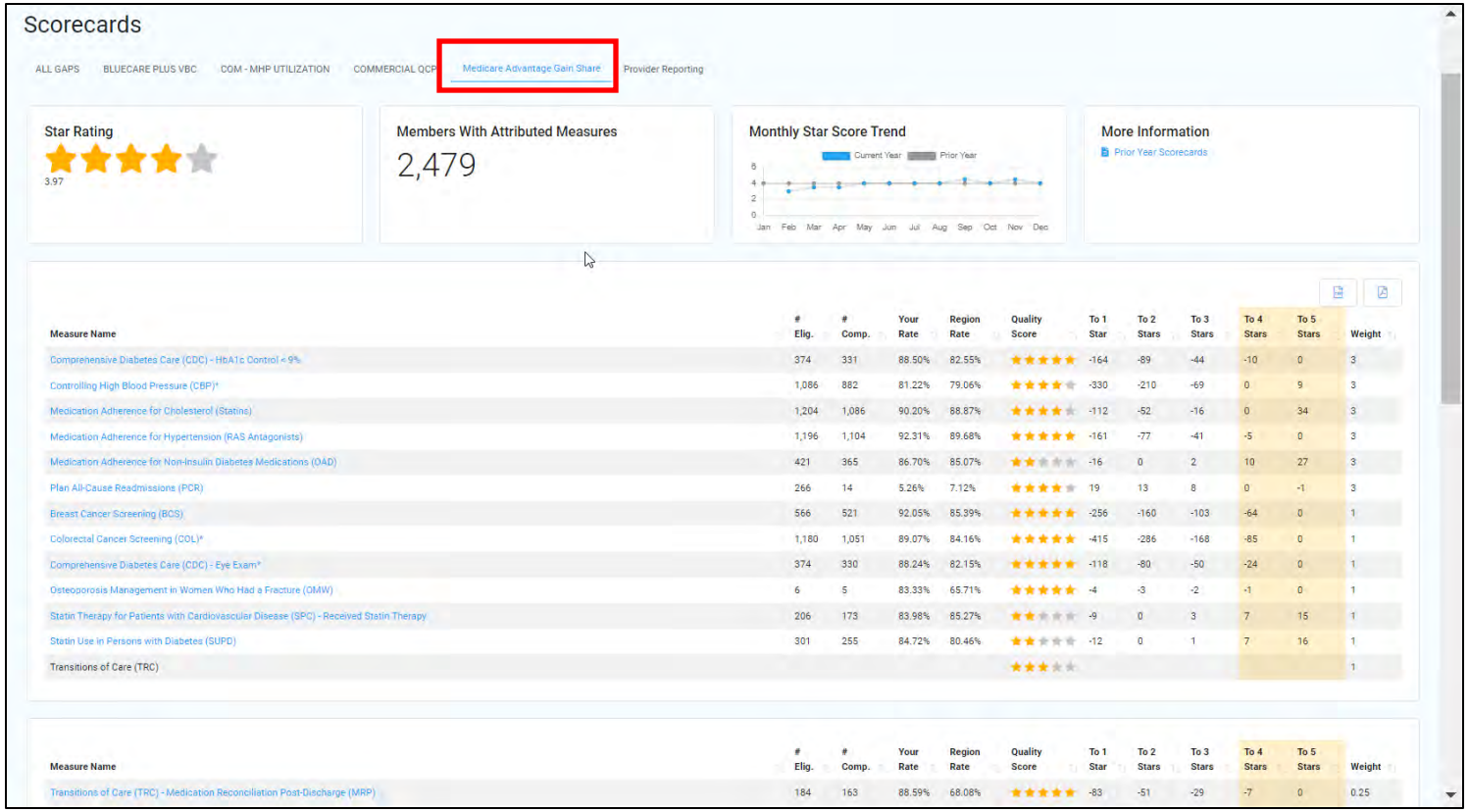


PAYER SPACES

Scorecards: THCII – Patient Centered Medical Home



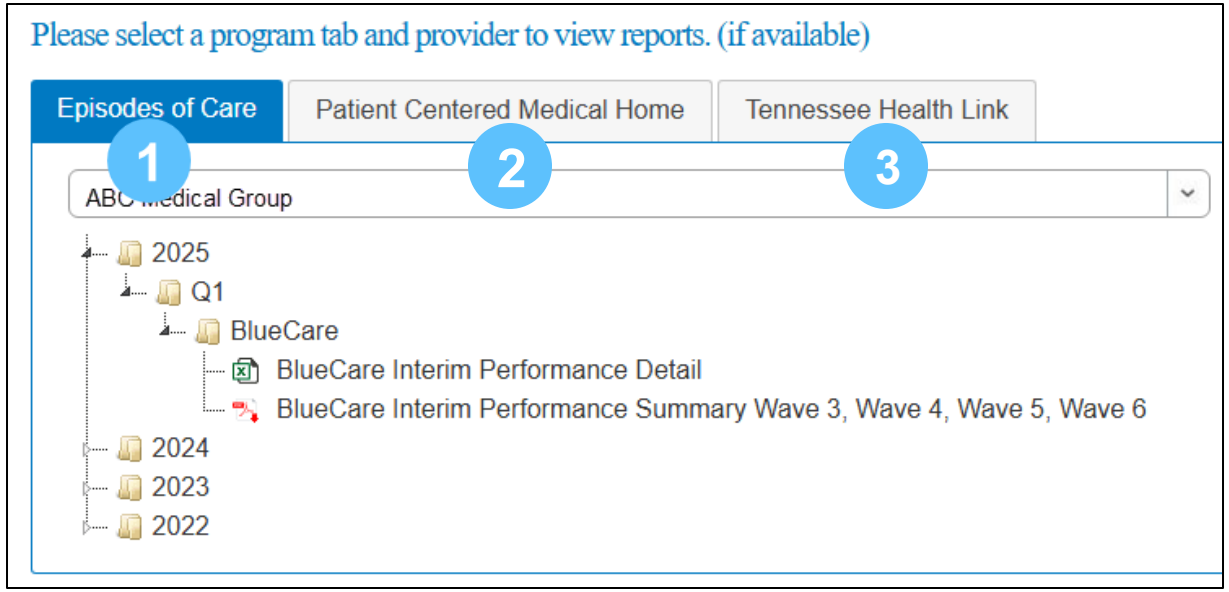
Scorecards: Medicare Advantage Gain Share



Tennessee HealthCare Innovation Initiative (THCII)

THCII Reporting Application

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



BLUECROSS WEBSITE

eBusiness Team Contact Information

› eBusiness Regional Map

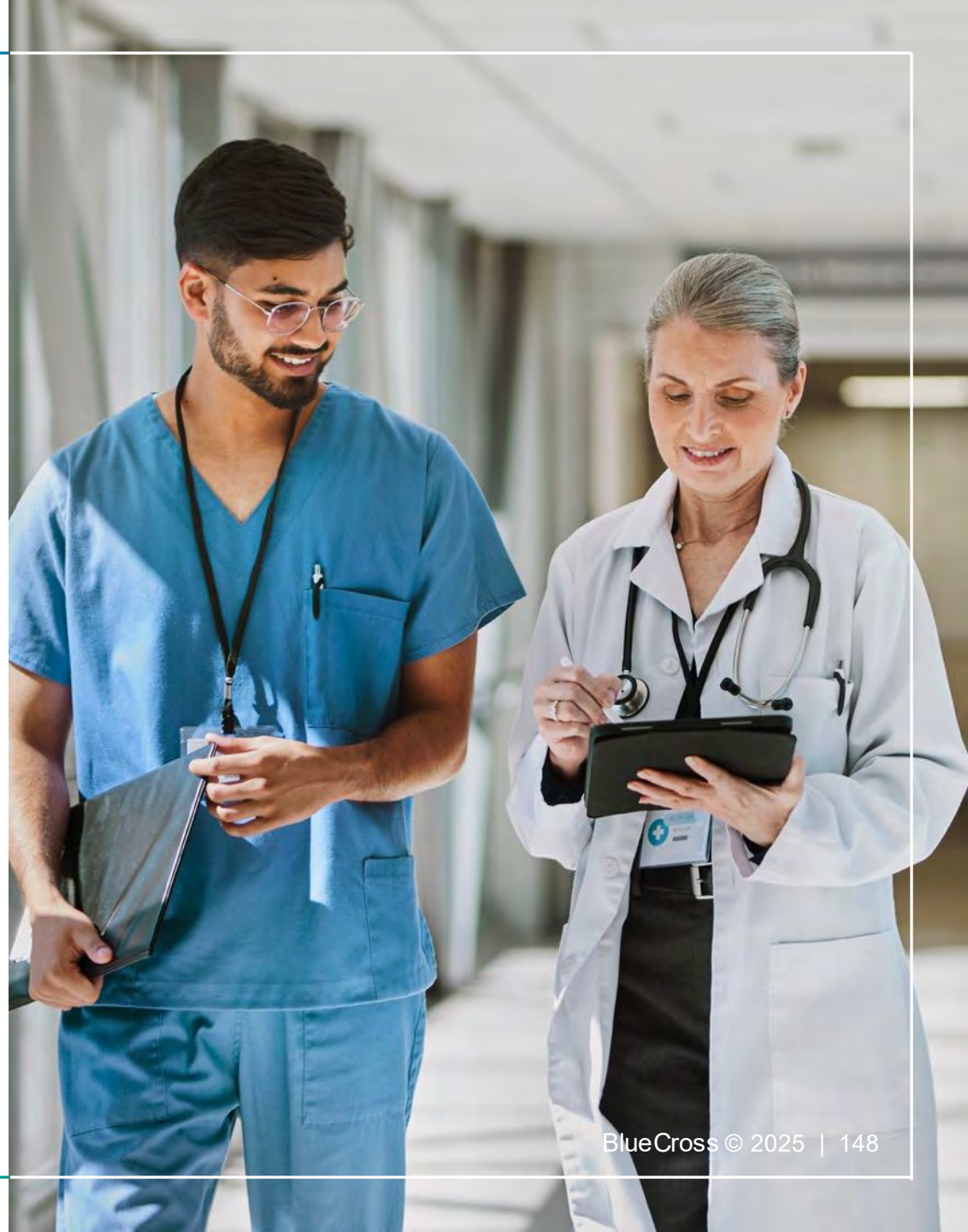
Thank You

Provider Network Operations

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

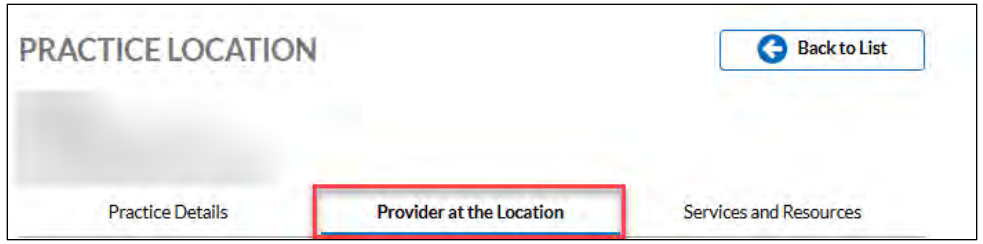


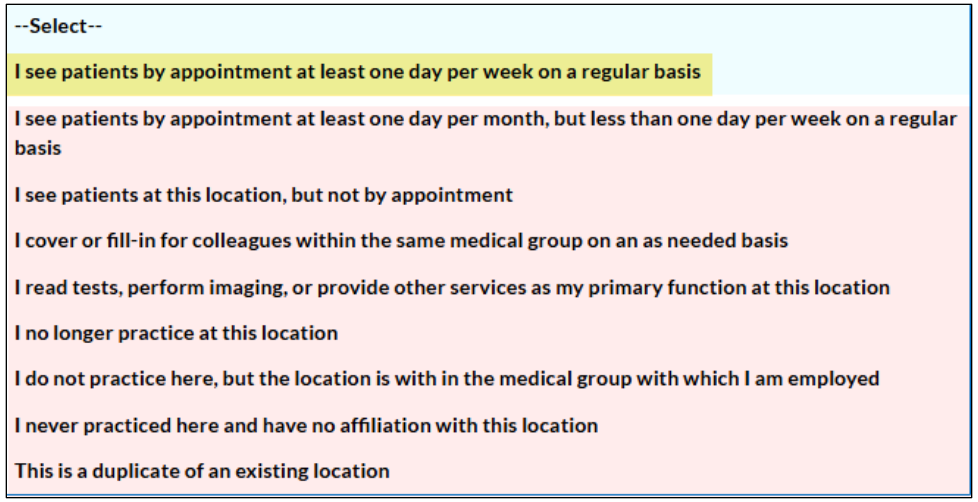
Directory Topics

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

Confirm Affiliation — Address

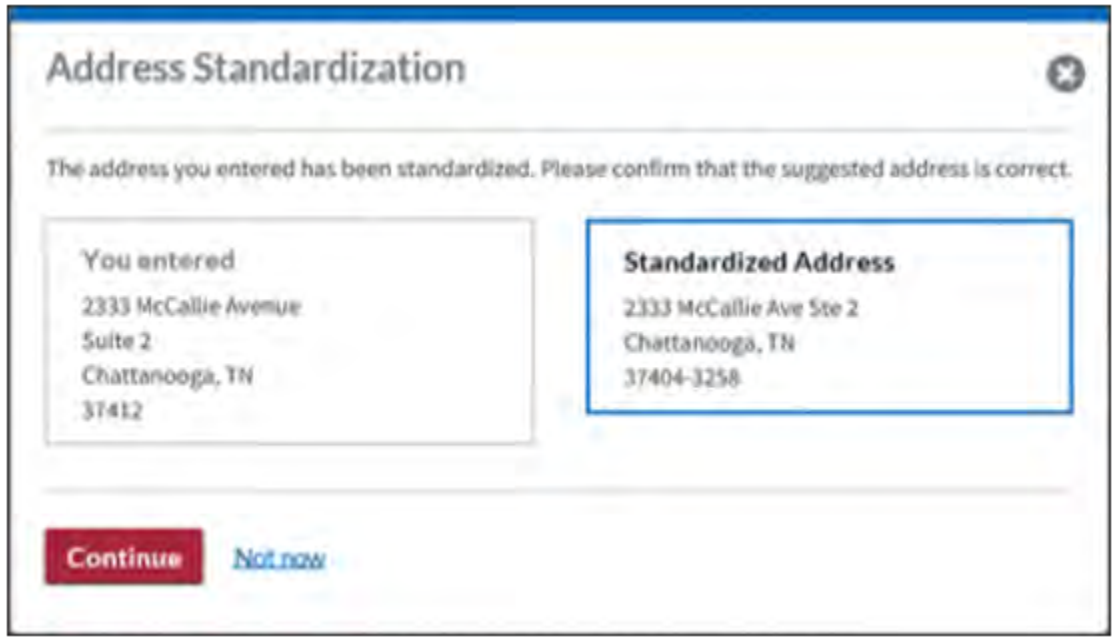
- Review this each time you attest.
- Notice which affiliations display in the directory.
- Notice which affiliations do NOT display in the directory.
- If a provider's address is displayed in the directory, a patient should be able to call that number and make an appointment with that provider at that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





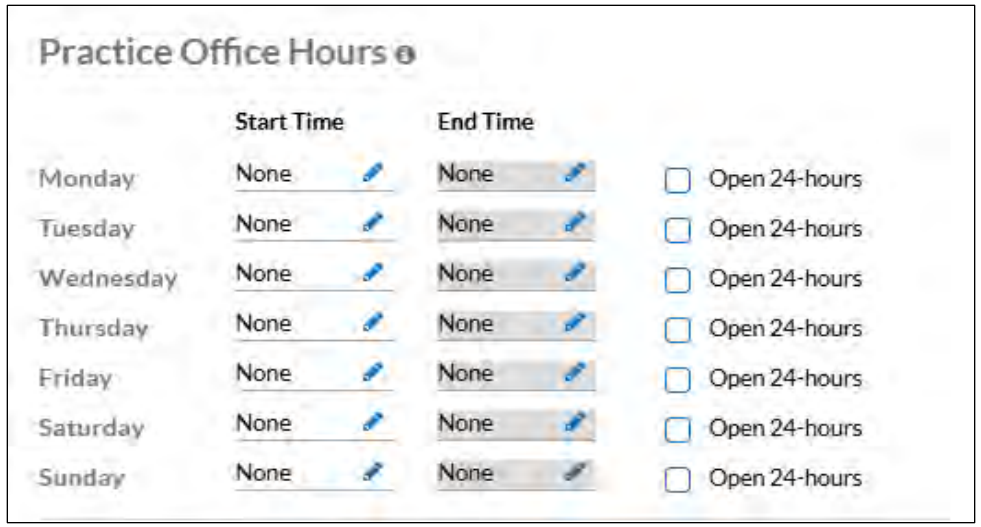
Address Standardization

- 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.



Office Hours

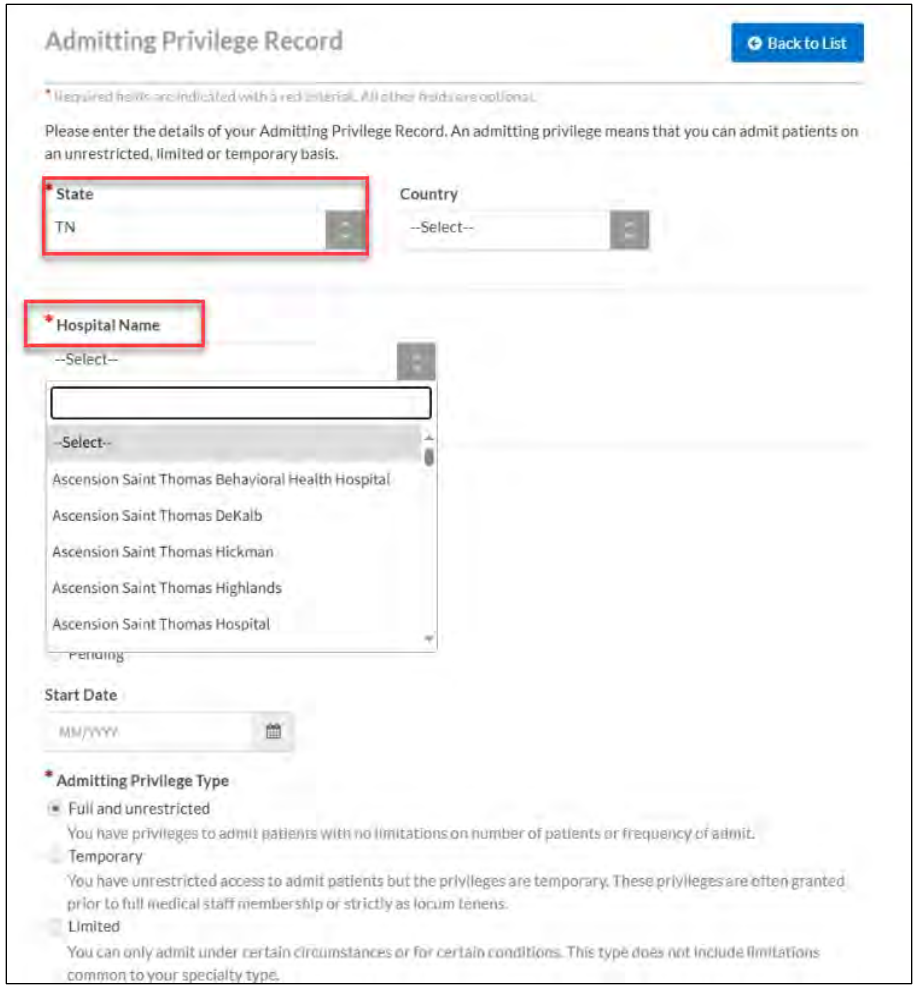
- Review this each time you attest.
- If left blank in CAQH, patients will not see your office hours on our directory.



Hospital Affiliation

Please Review

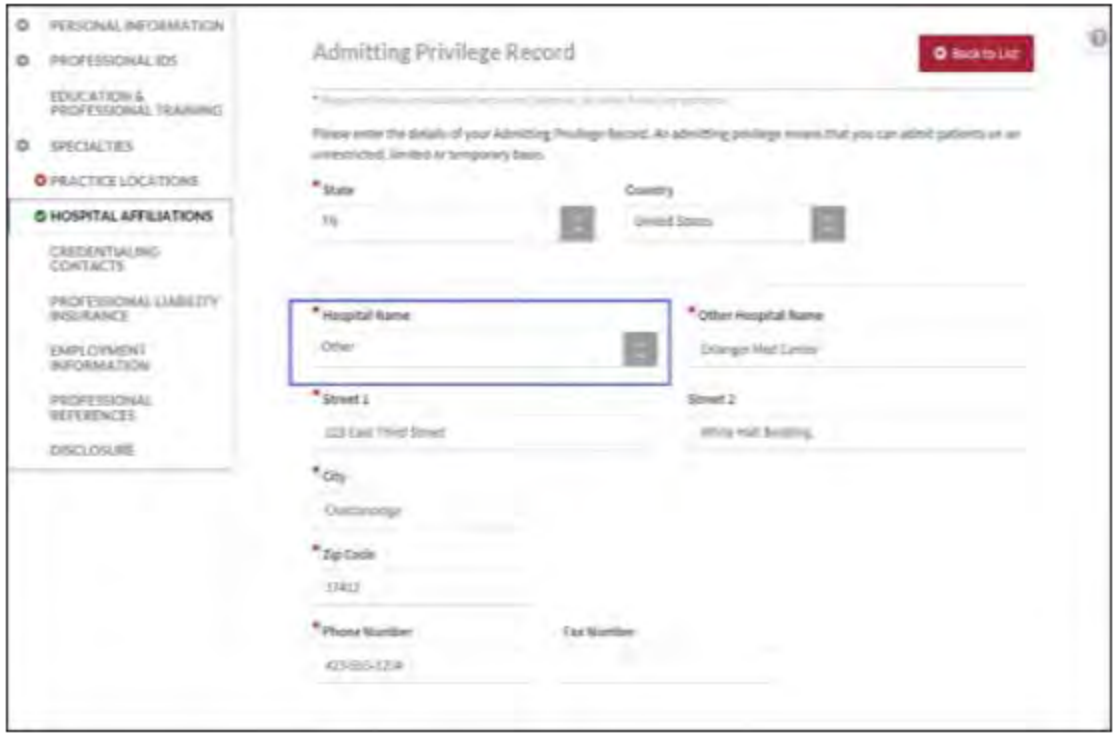
- Review options for Hospital Affiliation and choose the appropriate State selection to drive the dropdown menu options for the accurate Hospital Name selection.
- Hospital names shown in the drop down are as the hospital is registered with the American Hospital Association (AHA)



Hospital Affiliation (cont.)

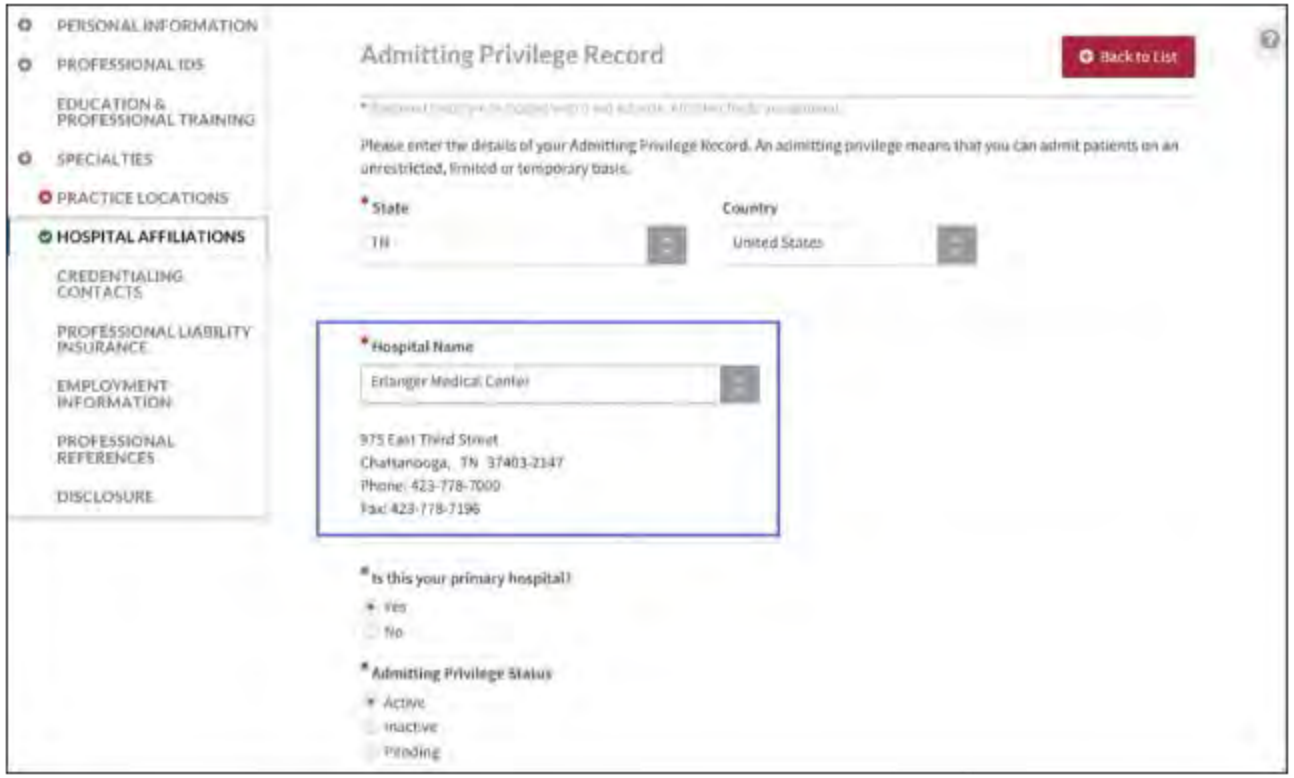
Please Review

- 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.

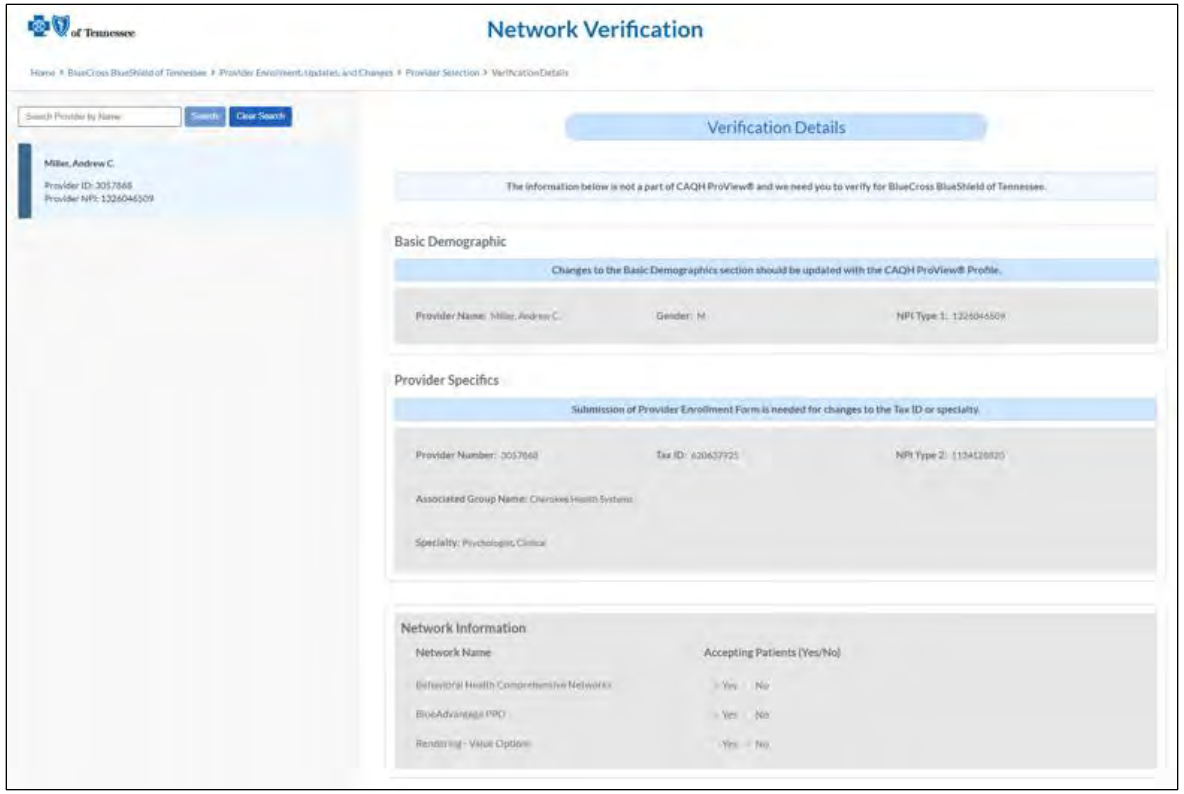


Best Practice

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



Network Verification

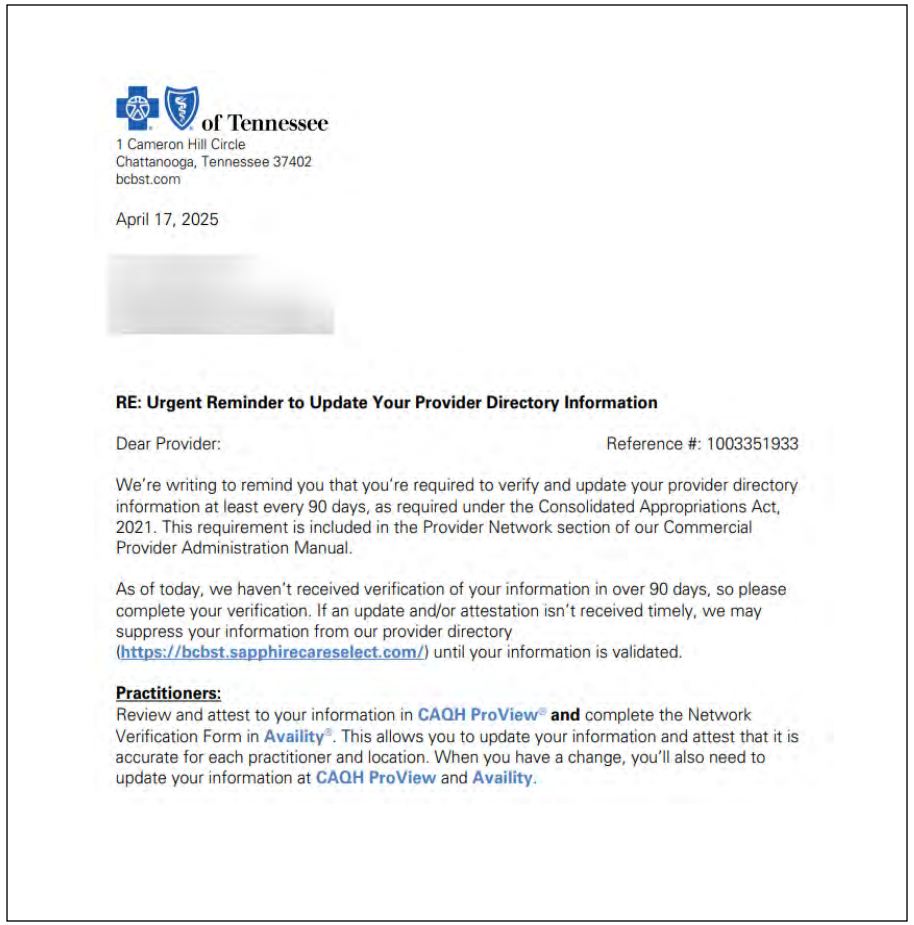


- Information not collected or collected differently than from what BlueCross requires.
- Accepting Patient Status-critical to patients seeking care.
- Billing Address
- New services within your group.
- Quick and easy way to see what BlueCross has and update what's missing.
- An easy way to let us know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



of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbst.com

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 Availity®. 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 Availity.

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

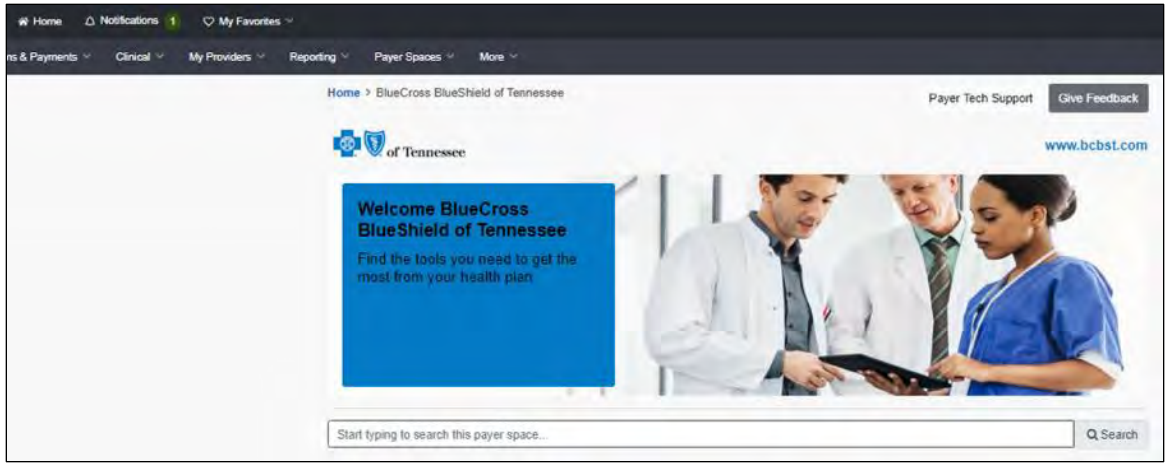
Enrollment, Changes, and Updates

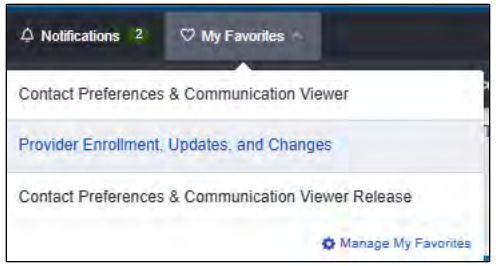
- Navigating the Persona Profile Page and Accessibility
- Enrollment Applications Suite
- Contact Preference
- Enrollment Application Status Tracker
- Reference Page

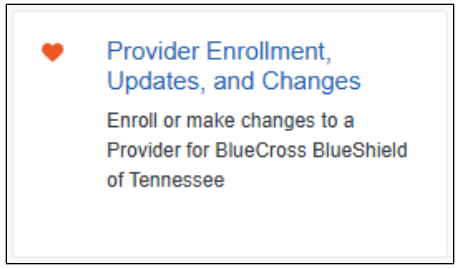
Digital Suite

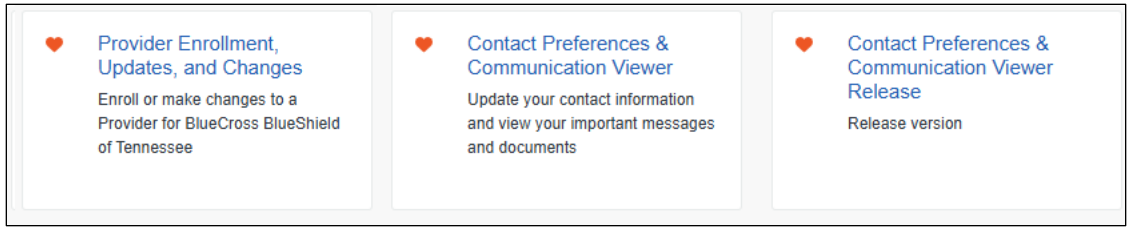
Accessing the Digital Suite

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





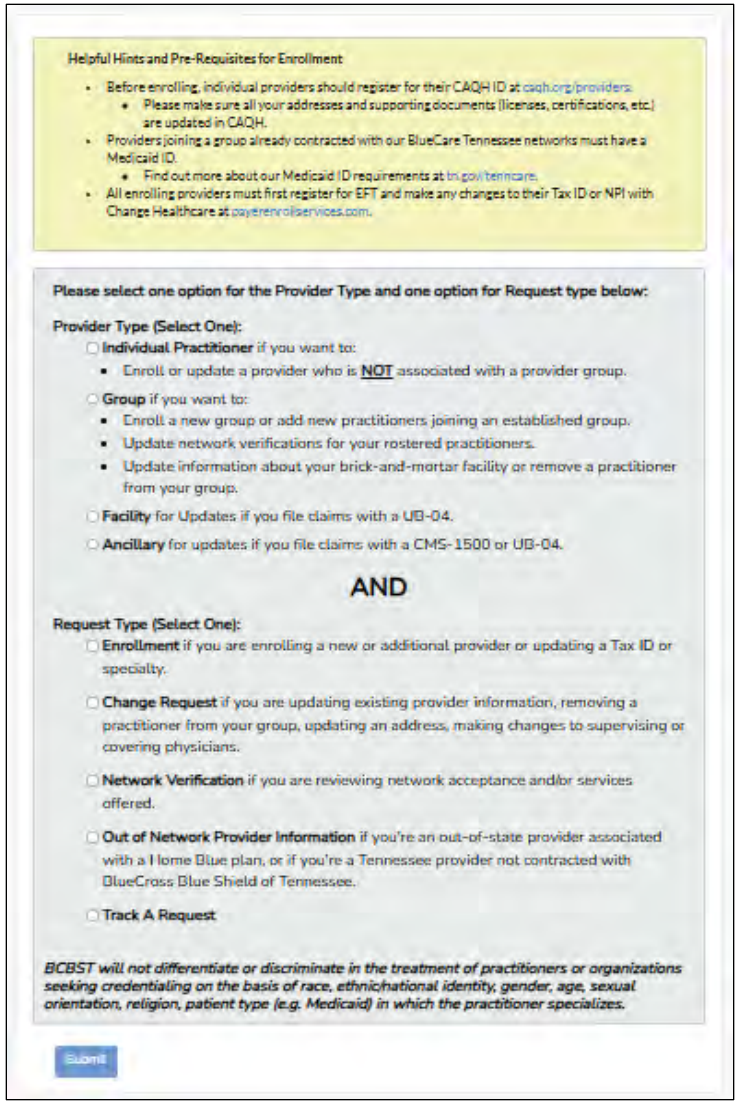




Persona Page

Messaging – Yellow Section

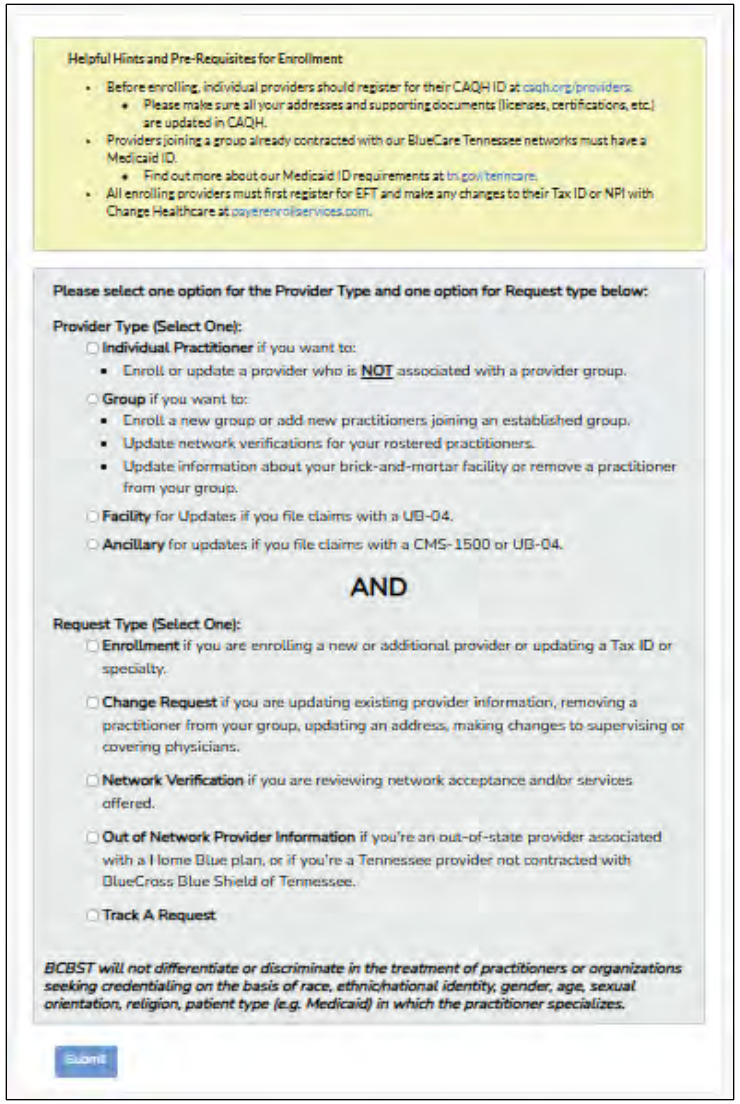
In this section you will find important messaging related to process changes, enhancements, and general details to help guide the submission experience.



Persona Page (cont.)

How to Navigate – Grey Section

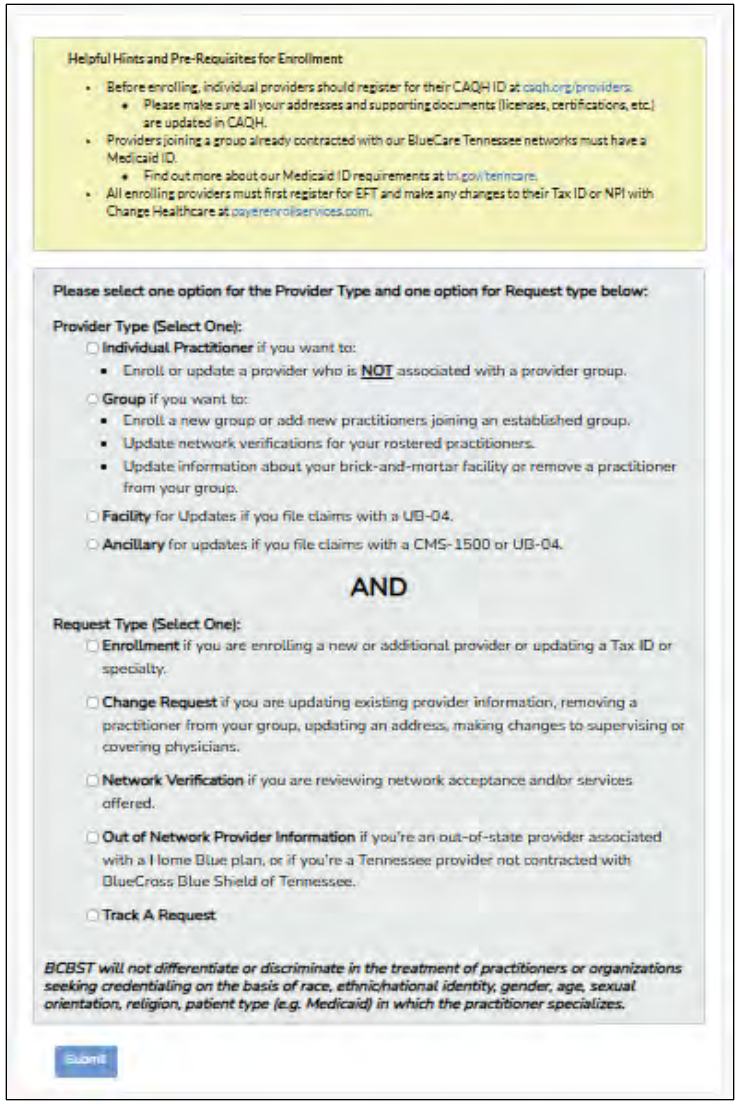
The More Info section in grey will help guide your selection options when navigating the persona page. This self-directed section can help you direct your request to the appropriate application.



Persona Page (cont.)

Persona Navigations

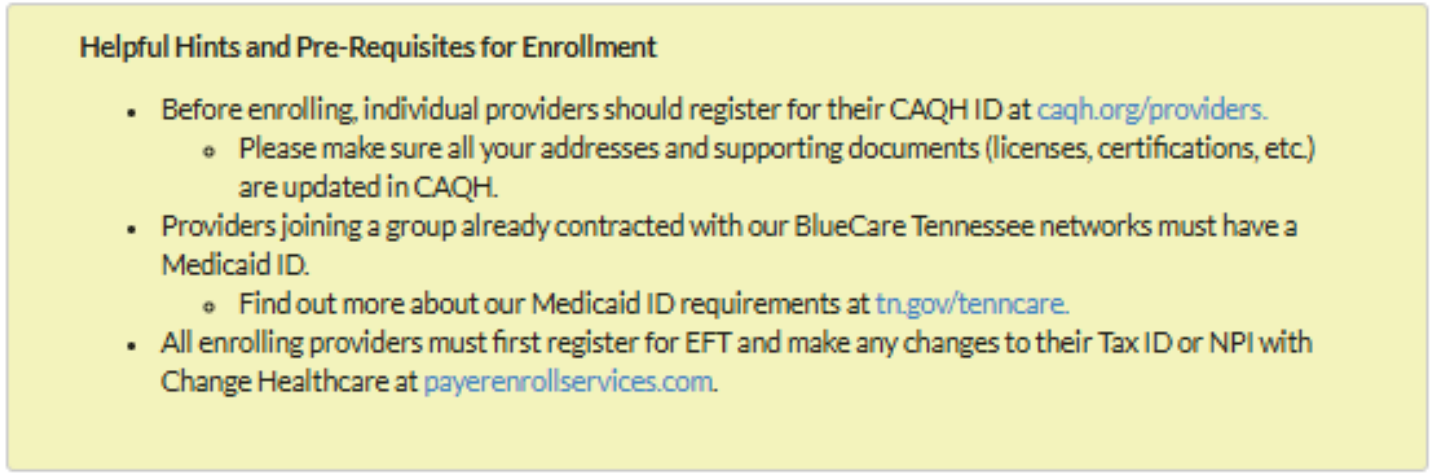
By utilizing a persona, each user can navigate through different scenarios from a single page, accessing our library of applications simply by presenting a few generalized questions.



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.



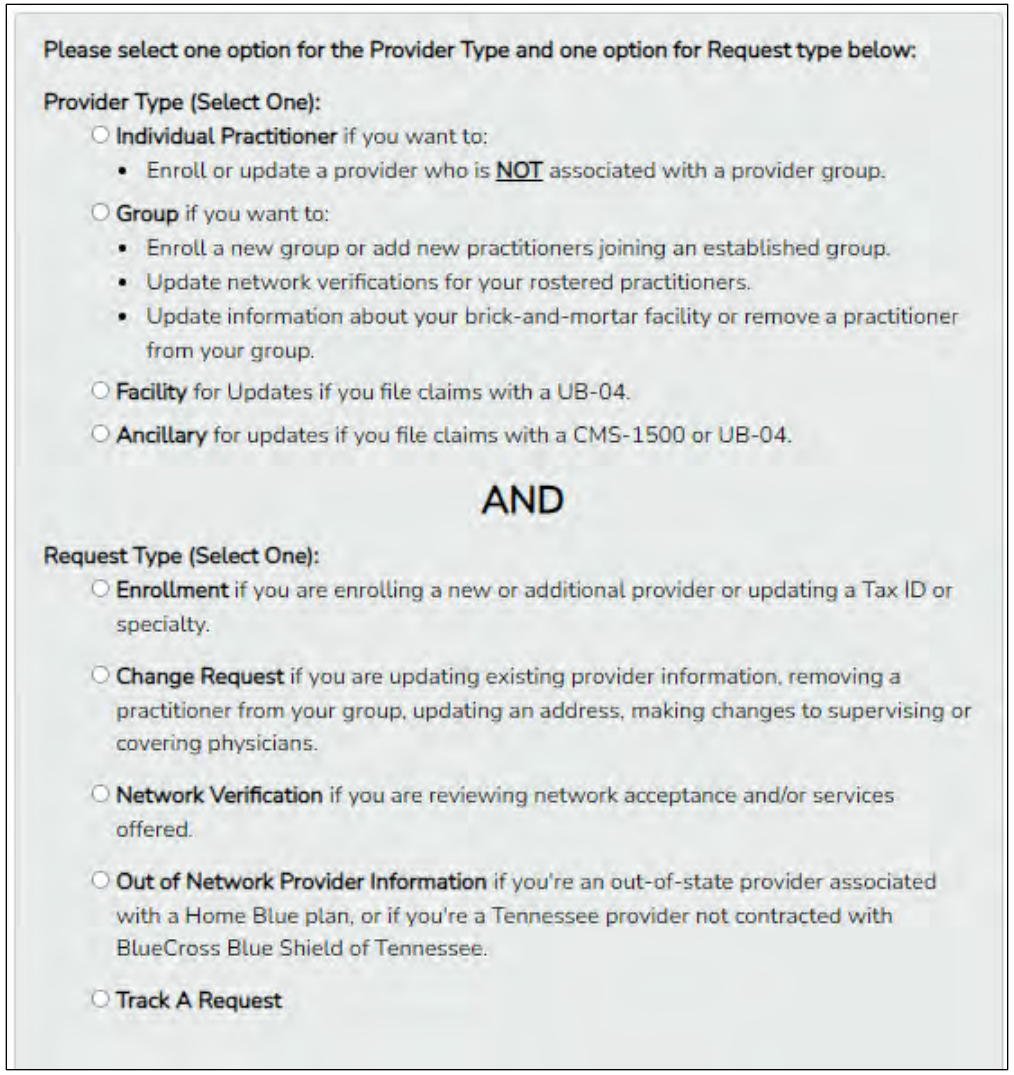
Helpful Hints and Pre-Requisites for Enrollment

- 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

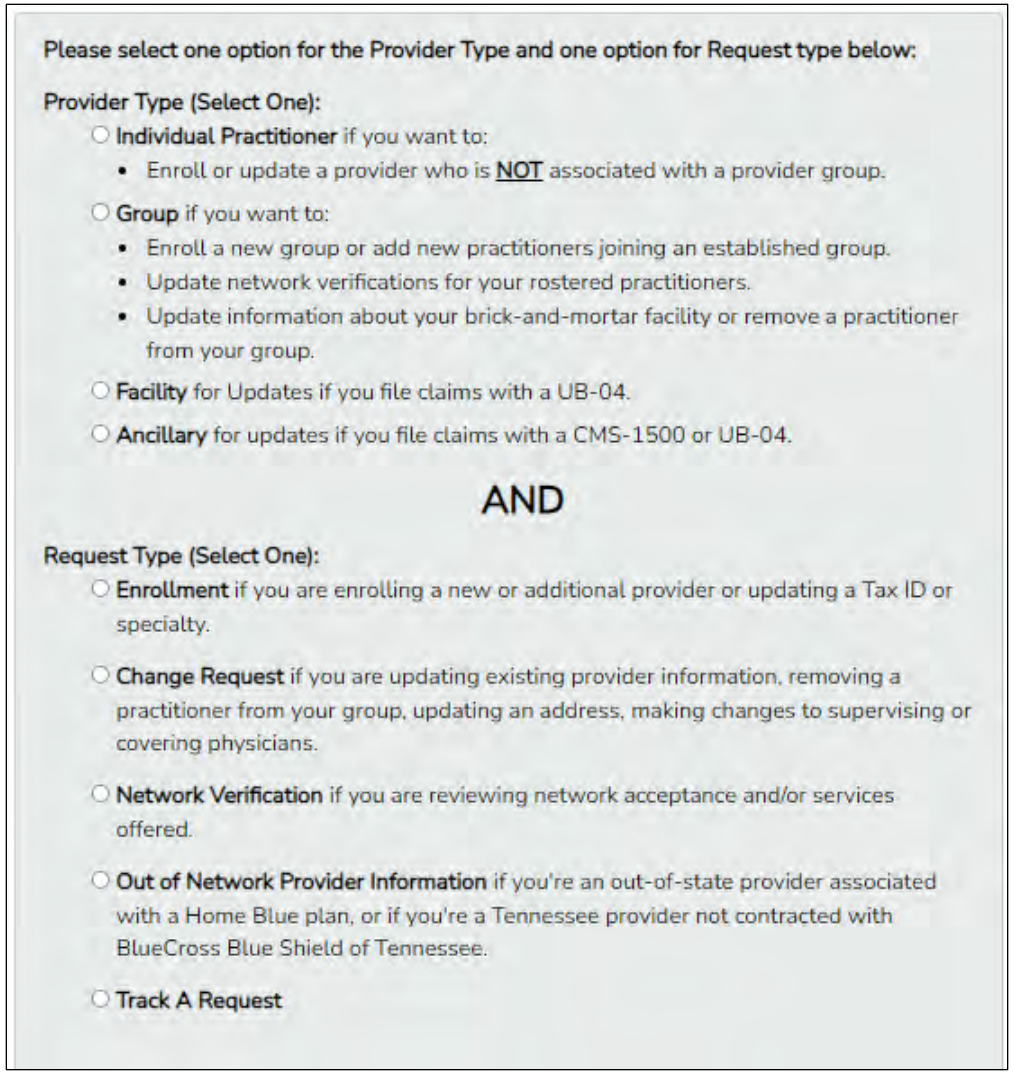
Request Type (Select One):

- ○ **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

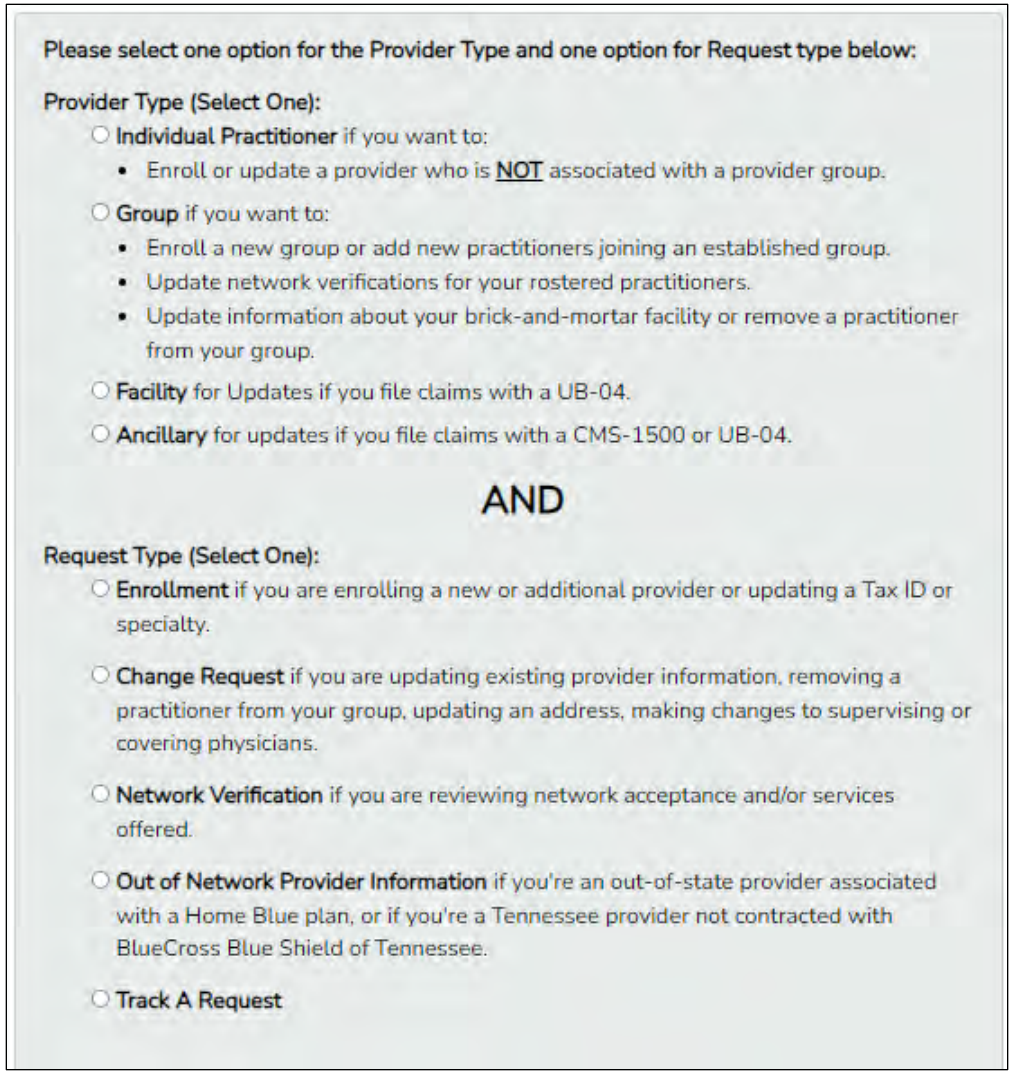
Enroll a new group or add providers to an existing group. Up to 15 providers may be added on a single submission. Type 2 NPI is required for this selection. Individuals with a Type 2 NPI are accepted as well.



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.



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  - Enroll a new group or add new practitioners joining an established group.
  - Update network verifications for your rostered practitioners.
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Request Type (Select One):

- ○ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
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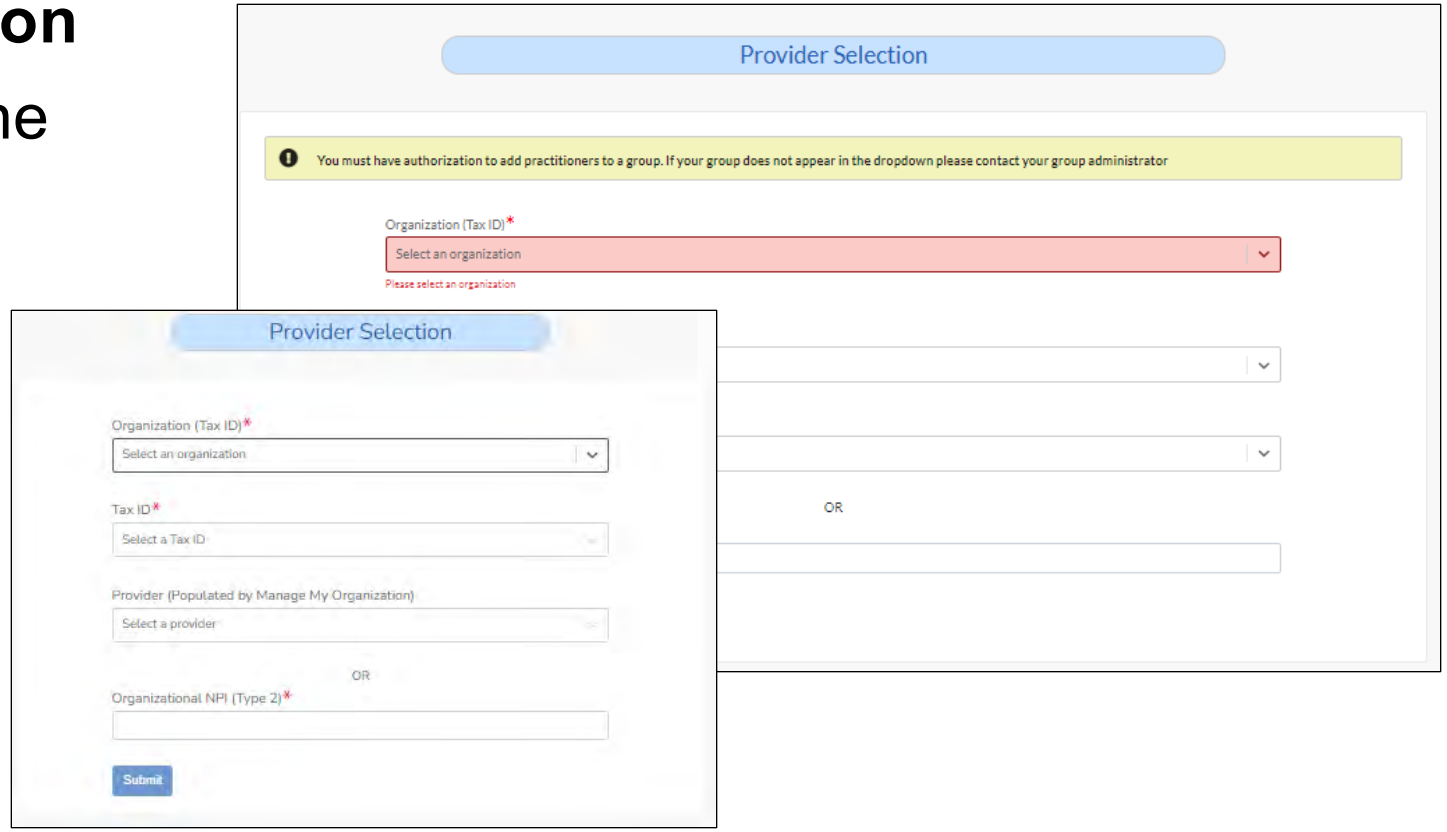
- ○ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ○ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ○ **Track A Request**

Accessing Providers

Accessing Your Organization

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

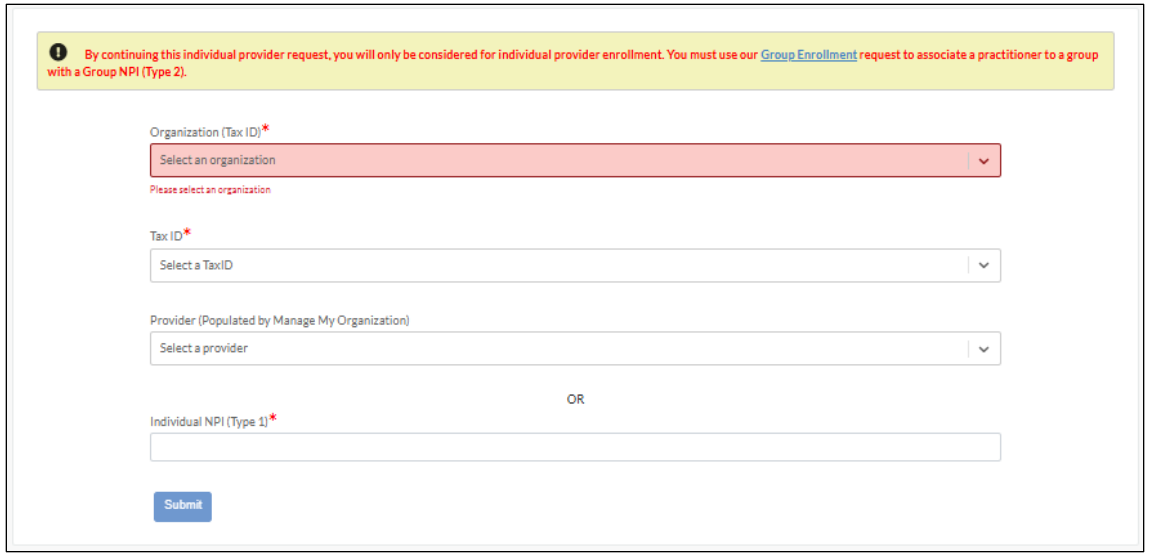


Persona Page — Options (cont.)

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).

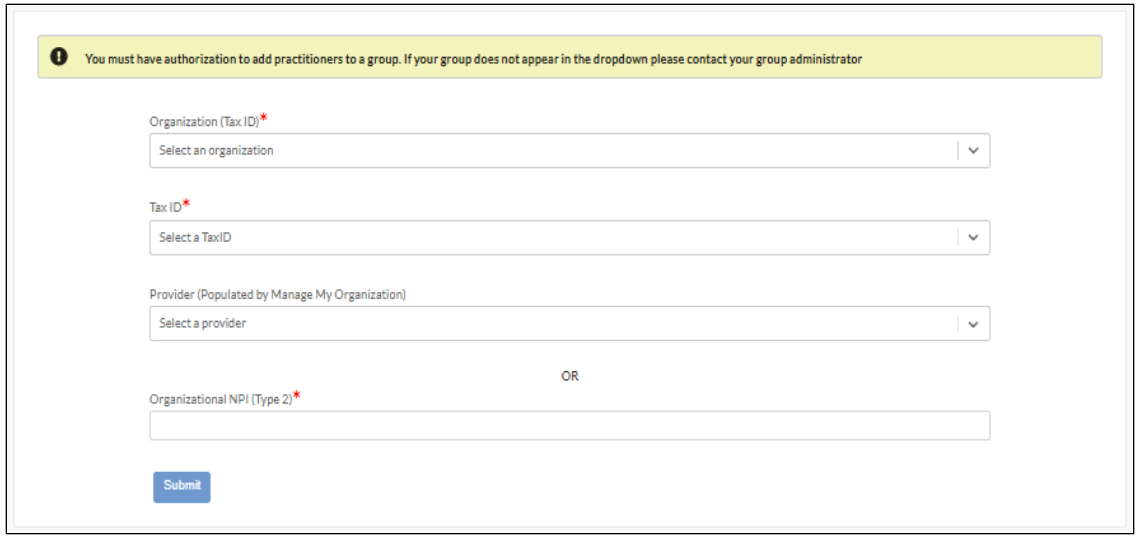


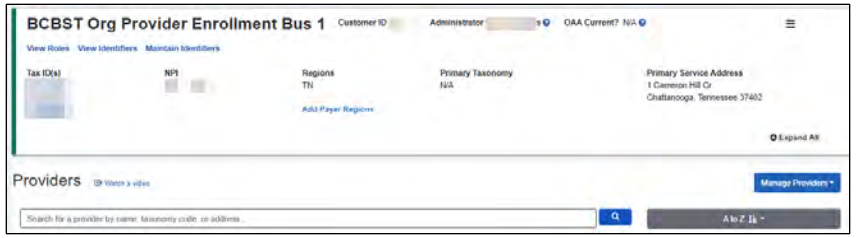
Persona Page — Options (cont.)

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.





Persona Page — Options (cont.)

Ancillary and Facility

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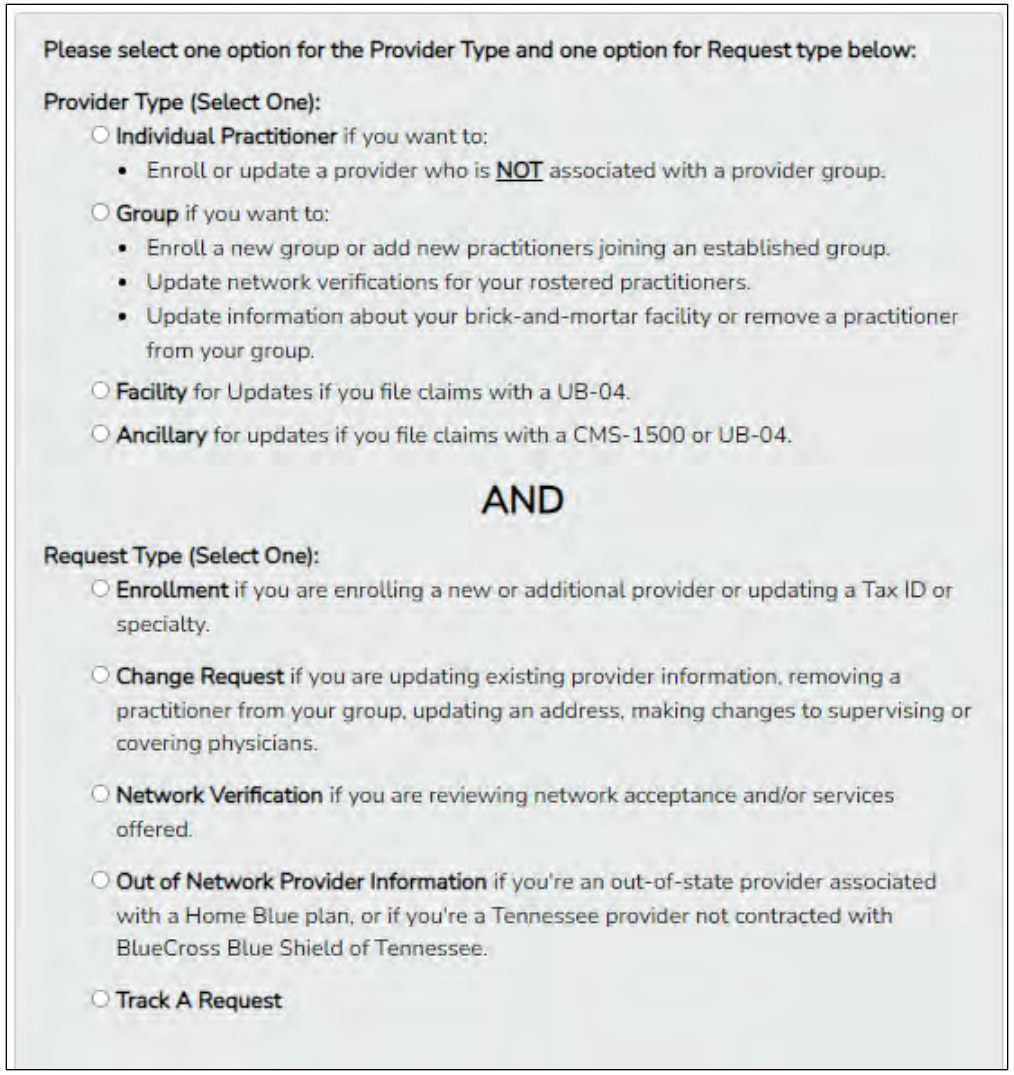

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  - Update network verifications for your rostered practitioners.
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AND

Request Type (Select One):

- ○ **Enrollment** if you are enrolling a new or additional provider or updating a Tax ID or specialty.
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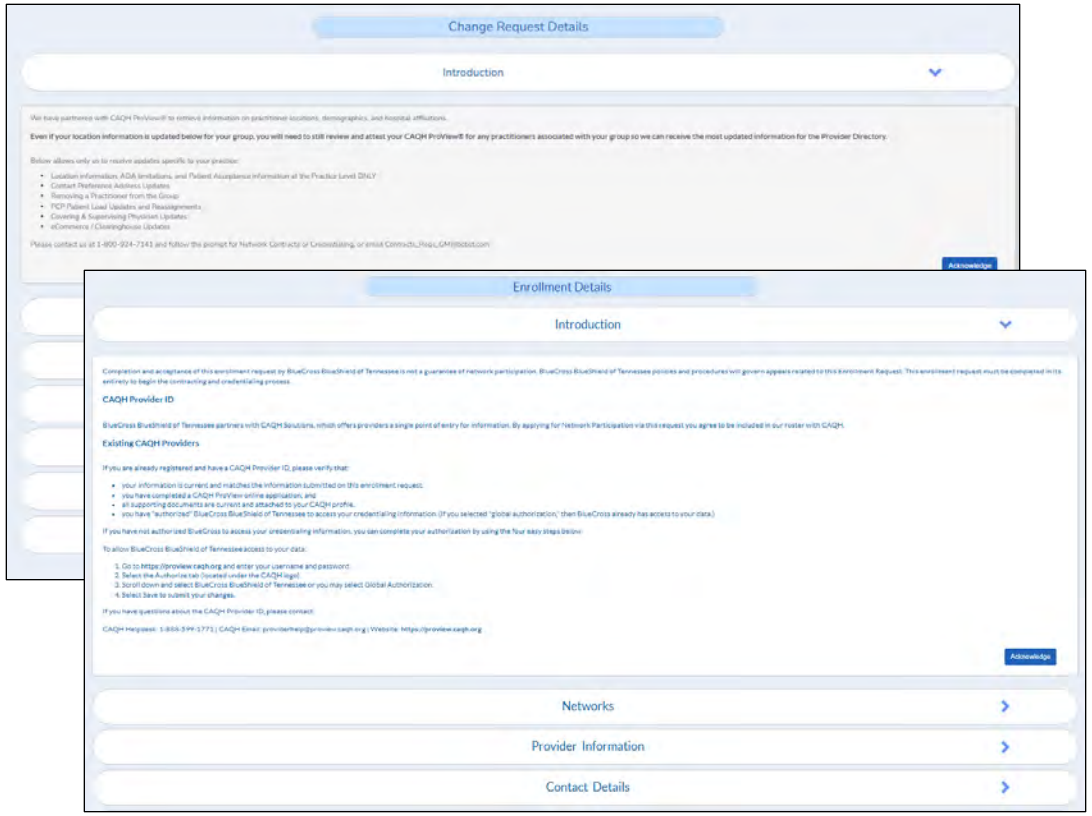
- ○ **Network Verification** if you are reviewing network acceptance and/or services offered.
- ○ **Out of Network Provider Information** if you're an out-of-state provider associated with a Home Blue plan, or if you're a Tennessee provider not contracted with BlueCross Blue Shield of Tennessee.
- ○ **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

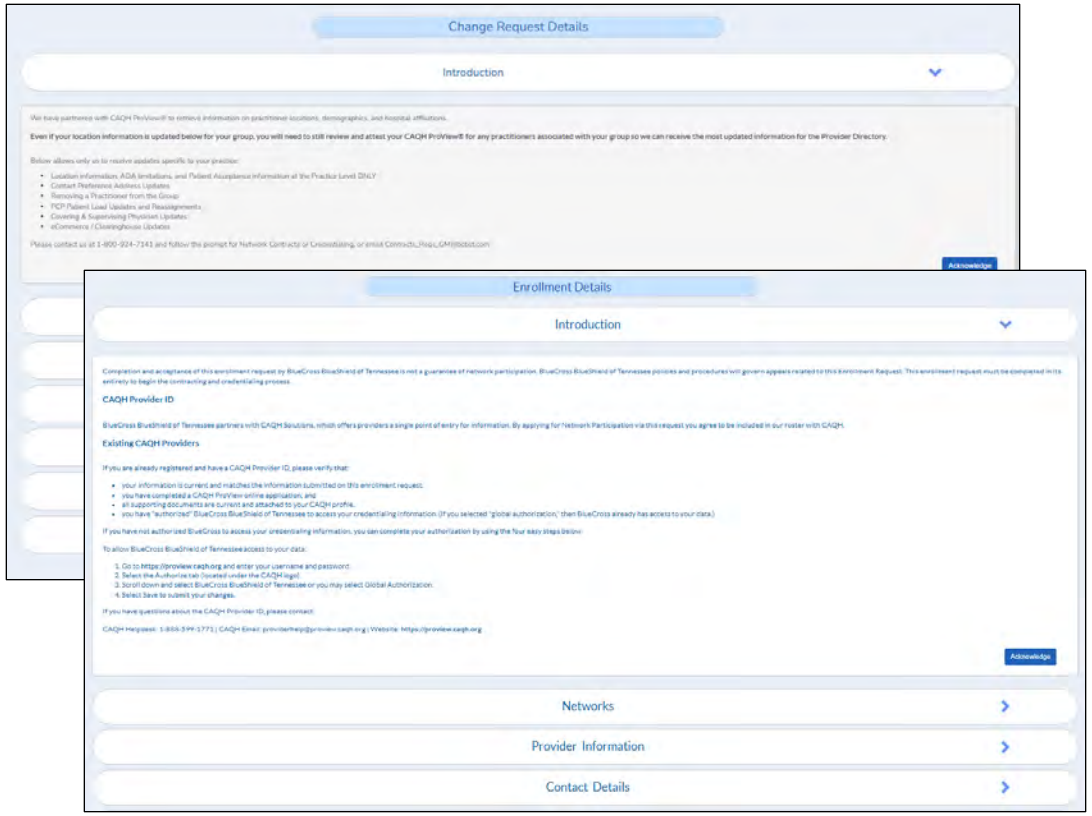


Digital Application — Options (cont.)

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

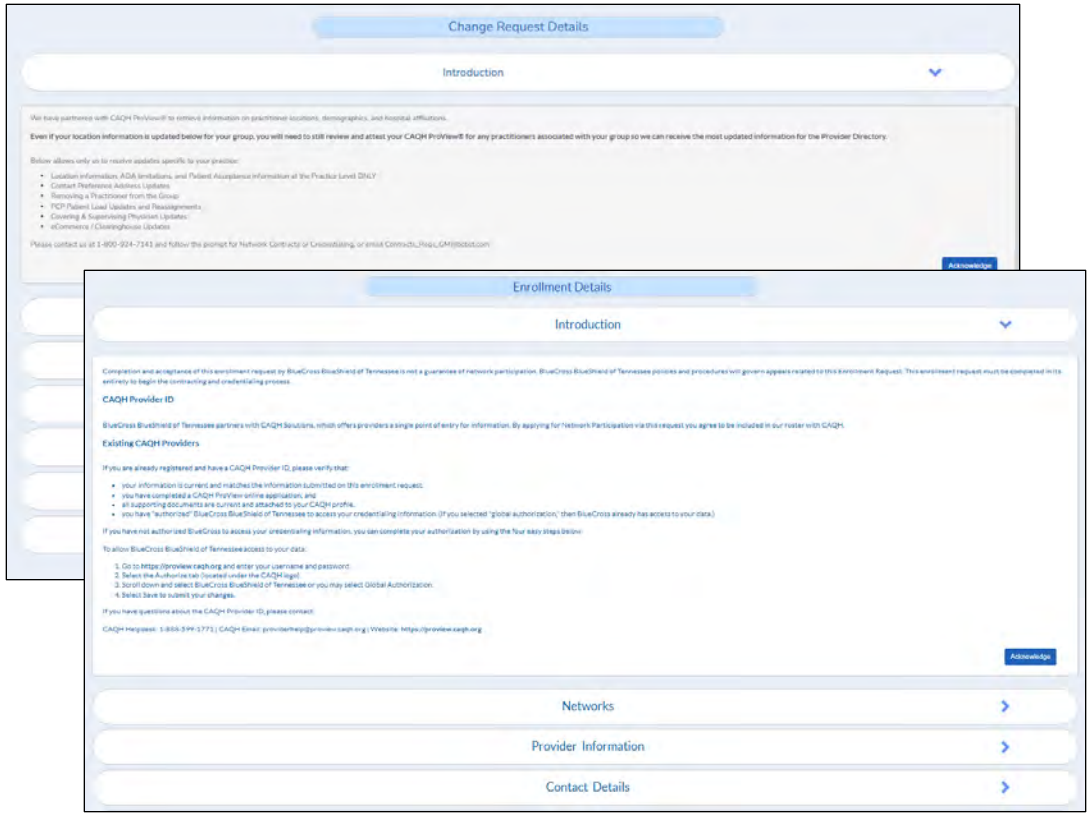


Digital Application – Options (cont.)

Group — Existing

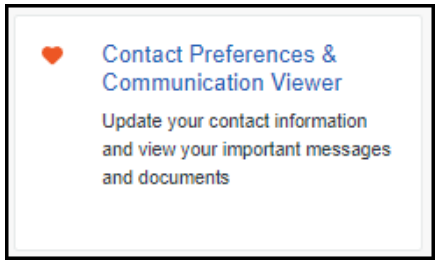
The following options are available:

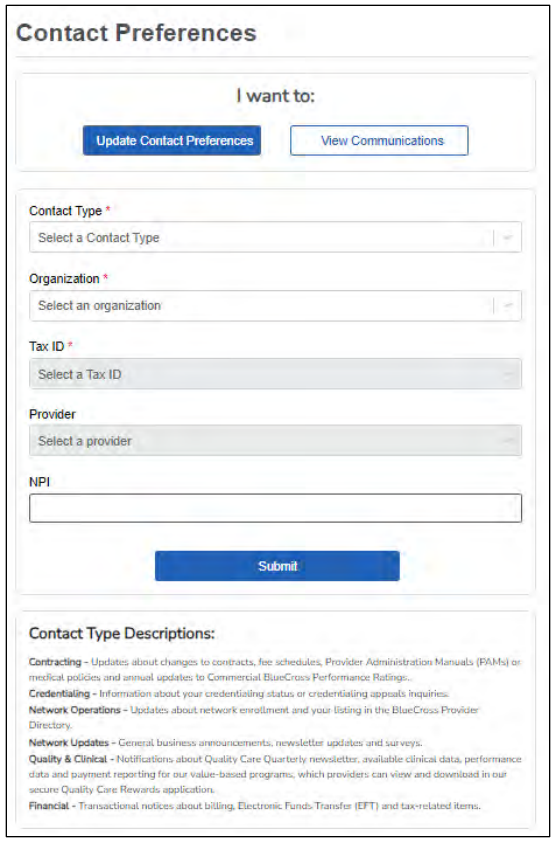
- Update Out-of-Network Enrollment
  - Out-of-Network Enrollment
- Add or Update Tax ID or Specialty
  - Contact Network Manager or Email: Contracts_Reqs_GM@bcbst.com
- Update Network Verification
  - Network Verify Request

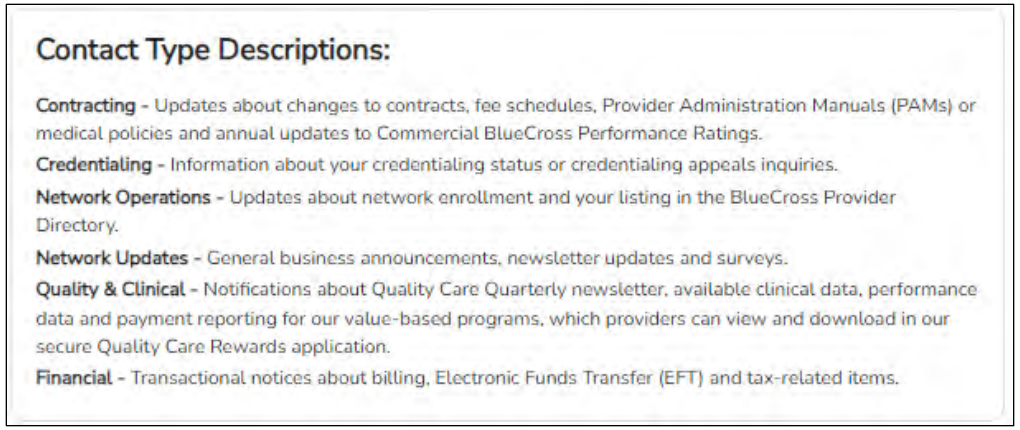


Contact Preferences

Contact Preferences



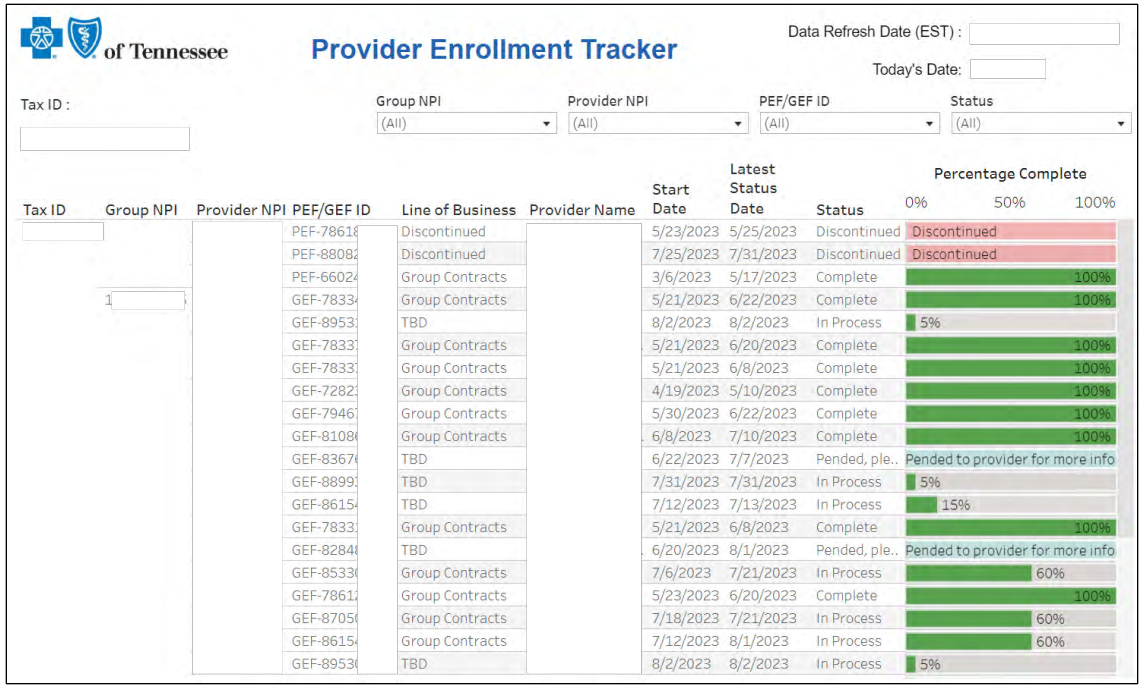




Application Status Tracker

Enrollment Tracker

Self-Service Tracker — Track a Request



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

Medicare Advantage

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

MEDICARE ADVANTAGE

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

MEDICARE ADVANTAGE

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 S**enior 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.

MEDICARE ADVANTAGE

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

QUALITY+ PARTNERSHIPS

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

MEDICARE ADVANTAGE

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

QUALITY+ PARTNERSHIPS

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

ANCILLARY
ALL BLUE WORKSHOP

of Tennessee

ALL Blue 2025

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.

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

Approach to Identify Wheelchair Device	**Use Wheelchair code + MS 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 + MS modifier (No payment)
	Line 2 Billed on Claim – K0739MS (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 + MS modifier (No payment)
	Line 2 Billed on Claim – K0739 + MS 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 + MS Modifier (No payment)
	Line 2 Billed on Claim – K0739 (without modifier) (Indicates Repair; Results in Payment)

Taxonomy

ANCILLARY

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.

Source: Research Resource Credited Here

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.

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

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

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

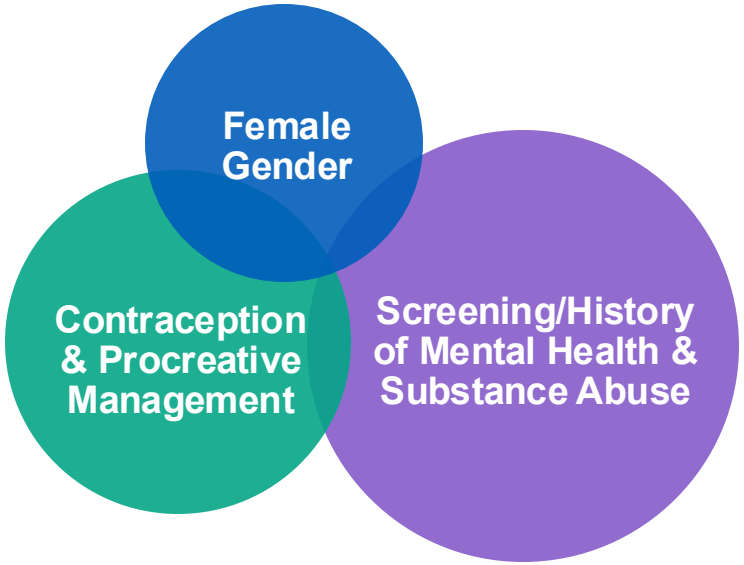
- Risk adjustment is used to fairly compare episode spend across all QBs.
- Based on the number of identified factors in a valid episode, a member risk score is derived.
- A risk score less than 1.0 is considered to have less-than-average risk and adjusts the cost of your episode up; a score greater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

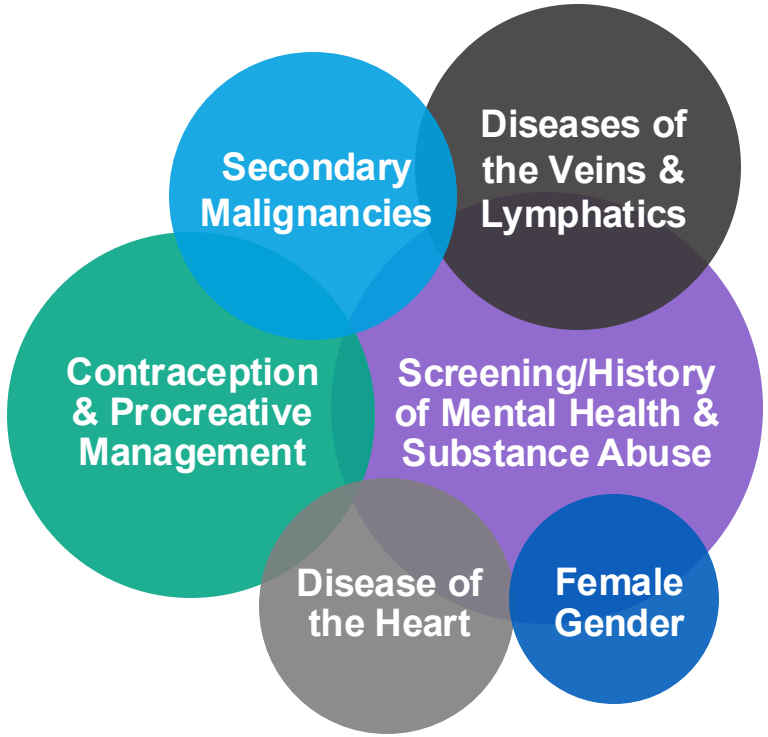
The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

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

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.

Female Gender 0.842 + **Procreative Management** 0.003 + **Hx MH/SA** 0.009 +

Disease of Veins/lymphatics 0.029 + **Secondary Malignancies** 0.638 + **Disease of the Heart** 0.040 = **Episode Risk Score** 1.562

The member's risk adjusted episode cost is $1,676/1.562 = $1,073

*Cost difference of $603

Back & Neck Pain Risk Factors

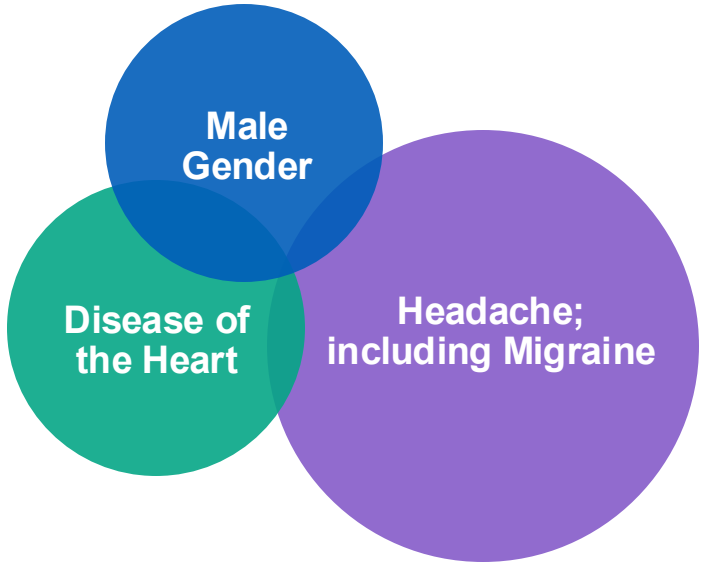
CCS Code	Factor	Weight
—	Female	0.538
—	Male	0.571
3.1	Thyroid Disorders	0.044
3.2	Diabetes mellitus without complication	0.010
6.5	Headache; including migraine	0.059
6.9	Other nervous system disorders	0.166
7.2	Diseases of the heart	0.064
7.5	Diseases of veins and lymphatics	0.059
9.8	Liver disease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

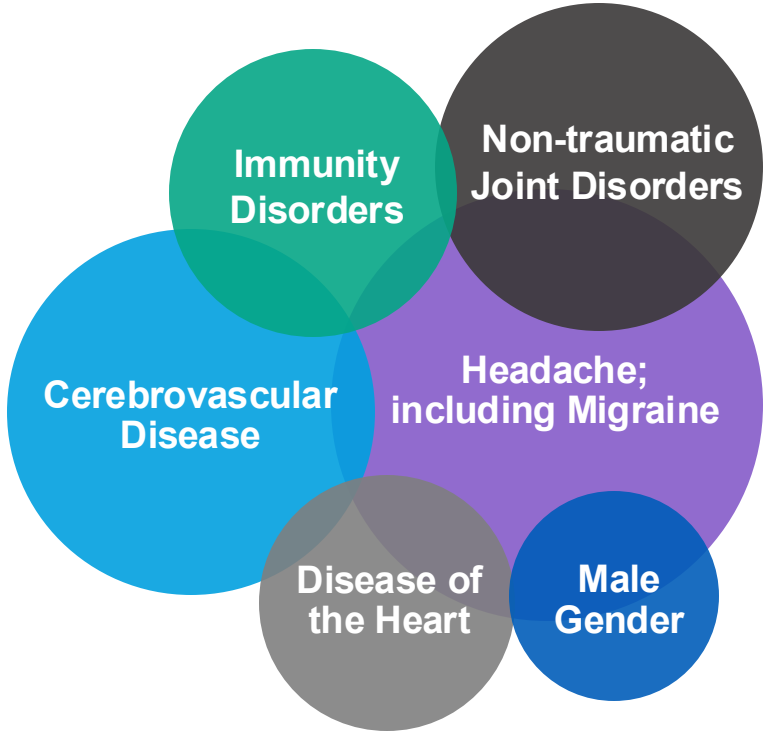
The sum of the risk weights for each documented risk factor the member has, is used to adjust the episode cost.

Male Gender 0.476	+	Disease of the Heart 0.100	+	Headache; including Migraine 0.145	=	Episode Risk Score 0.721

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.

Male Gender 0.476 + **Headache; including Migraine** 0.145 + **Immunity Disorders** 0.134 +

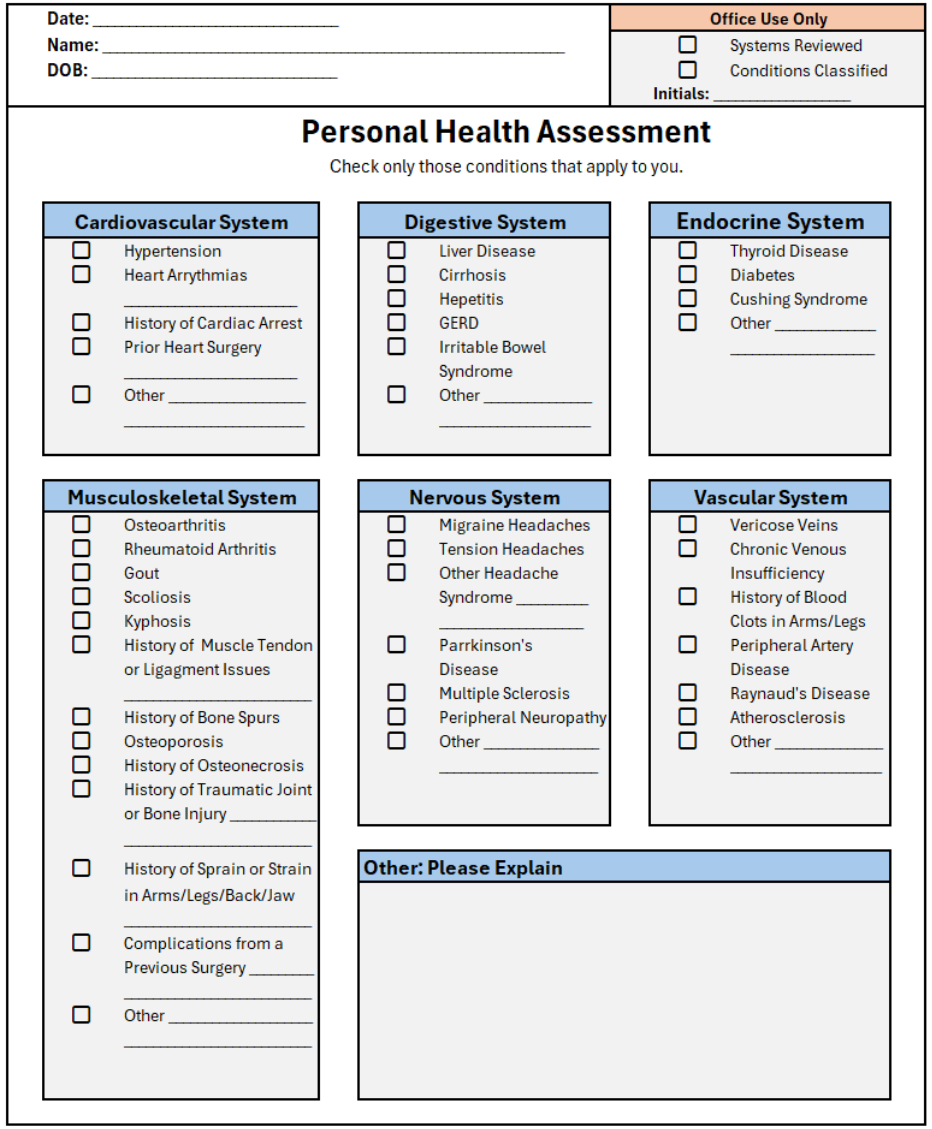
Non-traumatic Joint Disorders 0.140 + **Cerebrovascular Disease** 0.067 + **Disease of the Heart** 0.100 = **Episode Risk Score** 1.062

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
- ☐ Systems Reviewed
- ☐ Conditions Classified

Initials: _____

Personal Health Assessment

Check only those conditions that apply to you.

Cardiovascular System
- ☐ Hypertension
- ☐ Heart Arrythmias _____
- ☐ History of Cardiac Arrest
- ☐ Prior Heart Surgery _____
- ☐ Other _____ _____

Digestive System
- ☐ Liver Disease
- ☐ Cirrhosis
- ☐ Hepetitis
- ☐ GERD
- ☐ Irritable Bowel Syndrome
- ☐ Other _____ _____

Endocrine System
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Cushing Syndrome
- ☐ Other _____ _____

Musculoskeletal System
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Scoliosis
- ☐ Kyphosis
- ☐ History of Muscle Tendon or Ligagment Issues _____
- ☐ History of Bone Spurs
- ☐ Osteoporosis
- ☐ History of Osteonecrosis
- ☐ History of Traumatic Joint or Bone Injury _____ _____
- ☐ History of Sprain or Strain in Arms/Legs/Back/Jaw _____
- ☐ Complications from a Previous Surgery _____ _____
- ☐ Other _____ _____

Nervous System
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Other Headache Syndrome _____ _____
- ☐ Parrkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Other _____ _____

Vascular System
- ☐ Vericose Veins
- ☐ Chronic Venous Insufficiency
- ☐ History of Blood Clots in Arms/Legs
- ☐ Peripheral Artery Disease
- ☐ Raynaud's Disease
- ☐ Atherosclerosis
- ☐ 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 THCII 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)**

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 inconsistancies? 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

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)

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)

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 BlueAlert℠ 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.


of Tennessee

JUNE 2025

BlueAlert℠

of Tennessee Mission driven 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

INSIDE THIS ISSUE

BlueCross BlueShield of Tennessee, Inc.
Provider Enrollment Application Status Tracking
Register for the 2025 All Blue Workshop℠
Check Member Benefits and Eligibility in Availity as Blue Plans Update ID Cards
Coming Soon: New Reconsiderations and Appeals Tool in Availity
Find Your Authorizations Faster
Upcoming Provider Administration Manuals Delayed
More

Commercial
Billing Guidelines for Hospice Services
Out of State (BlueCard) Authorizations
Save Time With High Tech Imaging Prior Authorizations
Upcoming Prior Authorization Changes

BlueCare Tennessee
Transitioning from Pediatric to Adult Care
Join Us for the June 2025 EPSDT Virtual Coding Workshop
Prenatal Vitamin Coverage for BlueCare and TennCare Select Members
Timely Filing Reminders
Psychotropic Medication Monitoring in Children and Young Adults
More

BlueCare Plus Tennessee
Reminder: Complete the 2025 Special Needs Plan Model of Care (MOC) Training

BlueCare Plus Tennessee and Medicare Advantage
Extended Peer-to-Peer Request Deadlines

Medicare Advantage
In-Home Chronic Wound Care Program
Faster Decisions for Medicare Advantage Prior Authorizations

Quality Care Initiatives
Behavioral Health Screening: An Essential Part of Well-Child Care
Low Back Pain Coding Is Key
Changes to Statin Therapy Attestations Start June 1

Pharmacy
Removing Xhance® From Our Preferred Drug List
Nucala® Prior Authorization Requirement
Step Therapy for Additional Medicare Part B Drugs
Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Tips for Coding Professionals
Coding Updates: See the Latest and What Changes Are on the Way

1 | June 2025

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

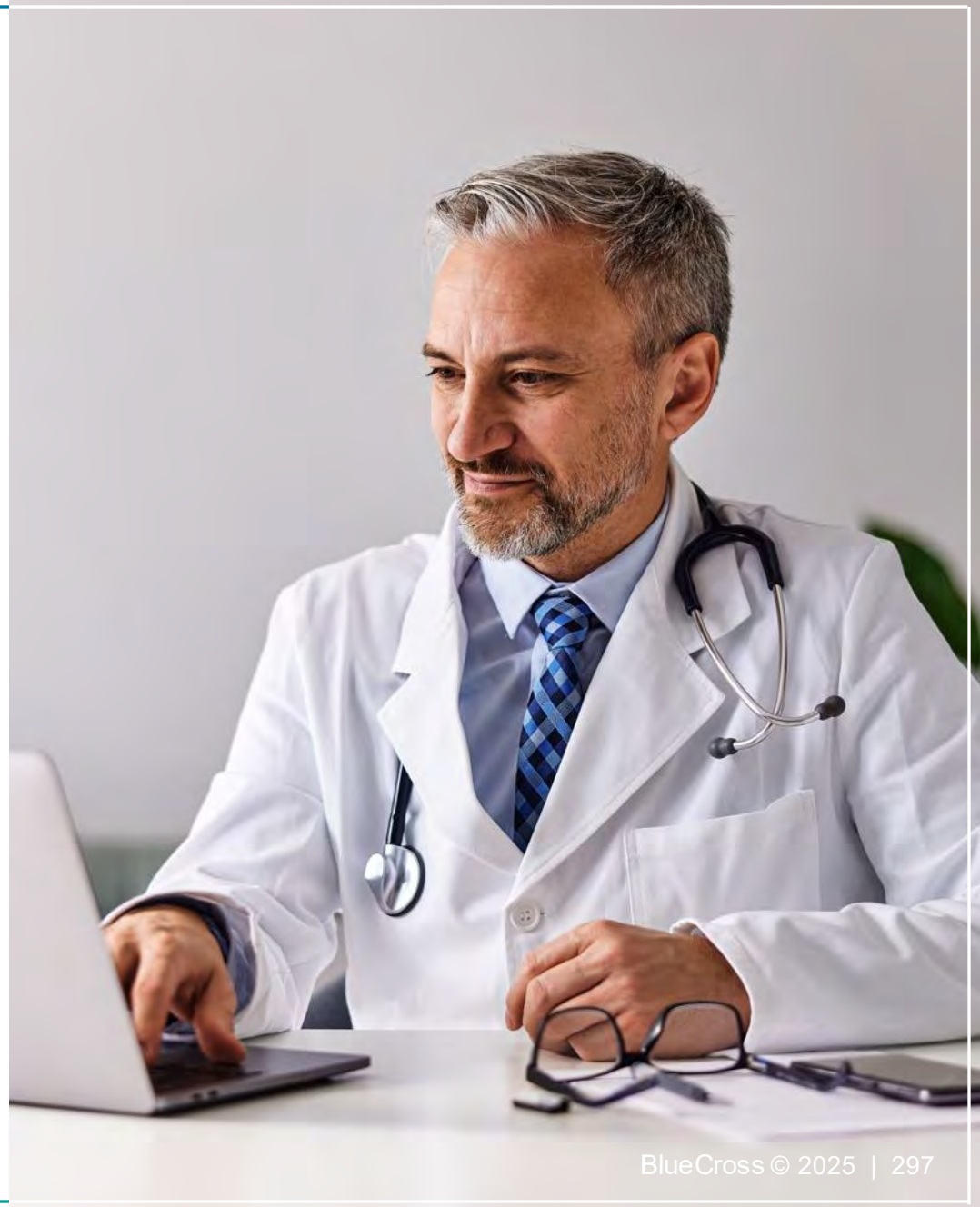
We offer free customized virtual training on HEDIS quality measures. Learn best practice tips for closing gaps in care, keys to coding, yearly specification changes and more.

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