

October 2013

Health Insurance Marketplace

It's a new day in health care

The Health Insurance Marketplace (also known as the Exchange) may have a significant impact on your practice and your patients. For many Tennesseans, it may provide a new opportunity to have more affordable health insurance and greater access to health care services.

The Health Insurance Marketplace is an online market where people can buy standardized health insurance plans, compare and purchase policies – and apply for financial support to help pay for coverage. The new Marketplace is a requirement of the health care law.

If an individual qualifies, the Marketplace provides federal subsidies to help them pay for monthly premiums or lower their health care costs.

BlueCross BlueShield of Tennessee – a not-for-profit company – is the only health plan issuer who has committed to selling plans on the Marketplace in each of Tennessee's eight service regions. No matter where your patients live in Tennessee, BlueCross has an affordable and comprehensive benefit plan for them.

Learn more about the Marketplace at www.bcbst.com/KnowNow or www.healthcare.gov and stay tuned for more updates from us in the near future.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of policies listed below can be accessed at <http://www.bcbst.com/providers/mpm.shtml>

under the "Upcoming Medical Policies" link.

Effective Nov. 5, 2013

- Sleep Disorder Diagnosis and Treatment

Effective Nov. 9, 2013

- Canakinumab
- Interspinous and Interlaminar Stabilization/Distractor Devices (Spacers); Interspinous Fixation (Fusion) Devices
- Proton or Helium Ion Beam (Charged Particle) Radiation Therapy
- Radiotherapy for the Treatment of Prostate Cancer

Note: These effective dates also apply to BlueCare/TennCare *Select* pending State approval.

Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming modifications to select Modified Utilization Management Guidelines. The *Modified Utilization Management Guidelines* can be viewed on the Utilization Management Web page at http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm.

Effective Nov. 13, 2013

The following as relates to Inpatient & Surgical Care:

- Abdominal Aortic Aneurysm, Endovascular Repair
- Ileus
- Newborn Care
- Removal of Posterior Spinal Instrumentation
- Tibial Osteotomy, Child or Adolescent

Changes to commercial drug formulary

Effective Oct. 1, 2013, BlueCross BlueShield of Tennessee's Pharmacy and

Therapeutics Committee will implement the following changes to its commercial drug formulary:

Drugs moving from Tier 3 to Tier 2

Amitiza	Liptruzet
Brilinta	Linzess
Combivent Respimat	Myrbetriq
Effient	Seroquel XR ^{PA}
Eliquis	Zetia
Levemir Pens	

Placed on Tier 3:

Kapvay

No longer requires Prior Authorization (PA):

Butrans	Pradaxa
Eliquis	Xarelto

Remove Quantity Limit (QL):

Brilinta	Xarelto 10mg
Noxafil	

No longer on Step Therapy:

Rapaflo

For additional information regarding the 2013 *Three Tier Formulary* see the company website at www.bcbst.com/pharmacy/pdf_documents/3-tierFormulary.pdf.

New drugs added to commercial specialty pharmacy listing

Effective Oct. 1, 2013, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
Simponi Aria (PA)

Self-administered via pharmacy benefit:
Astagraf XL
Gilotrif
Tivicay

Additional information regarding the 2013 *Three Tier Formulary* is available on the company website at www.bcbst.com/pharmacy/pdf_documents/3-tierFormulary.pdf.

BlueCross BlueShield of Tennessee, Inc. (BCBST)

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CLINICAL (Cont'd)

New TN Law regarding opioids, benzodiazepines effective Oct. 1, 2013

The Addison Sharp Prescription Regulatory Act states that effective Oct. 1, 2013, **no prescription for any opioid or benzodiazepine may be dispensed by a Tennessee licensed pharmacy (including out-of-state Tennessee licensed pharmacies mailing into Tennessee) in quantities greater than a thirty (30) day supply.**

According to the Tennessee Pharmacists Association (TPA) the law applies to any drug pharmacologically classified by the FDA as an opioid or benzodiazepine. The law does not specify a list of drugs, therefore the pharmacist must use professional judgment.

This new law places no limits on quantities of opioids or benzodiazepines that can be *prescribed*. However, if a *prescriber* is also *dispensing*, the *dispensing* limitations of a thirty (30) day supply is applicable.

For additional information about this new law, see the <[Board's September 2013 newsletter](#)>. If you have further questions, please contact the Board of Pharmacy. Additional provisions of this law, require the Tennessee Commissioner of Health to develop recommended treatment guidelines for prescribing of opioids, benzodiazepines, barbiturates and carisoprodol by Jan. 1, 2014.

ADMINISTRATIVE

New drugs added to commercial specialty pharmacy listing

The following provider-administered drug has previously been on our specialty list requiring prior authorization, however, **effective Oct. 1, 2013** this drug no longer requires prior authorization.
Amevive

Providers can obtain prior authorization for:

- Provider-administered drugs that have a valid HCPCS code by logging onto

BlueAccess, the secure area of www.bcbst.com. Select *Service Center* from the main menu, followed by *Authorization/Advance Determination Submission*. Providers not registered with BlueAccess or needing assistance with our website, www.bcbst.com can call eBusiness Technical Support†.

- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.
- Self-administered specialty drugs by calling Express Scripts at 1-877-916-2271.

Note: BCBST updates its Web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be available in the near future.

Reminder: Electronic supplemental claim information

As part of BCBST's goal to offer more robust electronic filing solutions for providers, please review the information below and share the related instructions in the provider administration manuals with your practice management vendor, billing agent, or clearinghouse. By following these guidelines, we can handle electronic claims requiring additional data more efficiently with less need for additional documentation requests to support processing of your claim.

Two common scenarios are listed below:

- DME Invoice data such as product names, descriptions, and other necessary pricing data may be submitted in ANSI 837 NTE segments per the format described in the June *BlueAlert* and the BCBST commercial and BlueCare Tennessee provider administration manuals.
- Per the BCBST Commercial and BlueCare Tennessee provider administration manuals, additional NDC and quantity information is required to support accurate processing of BlueCare claims and not otherwise classified (NOC) drugs. To ensure all required data is submitted on your electronic claim in the ANSI 837 LIN / CTP segments, please refer to the provider administration manuals for

detailed instructions. An industry whitepaper on this topic may also be viewed online at <<http://www.wedi.org/knowledge-center/documents/whitepapers/resources/2013/02/26/whitepaper-the-ndc-reporting-requirements-in-health-care-claims>>.

For information on how to submit claims and additional documents electronically see the company website at <www.bcbst.com/providers/ecom/technical-information.shtm>.

If you have questions regarding this or any electronic filing issue, please contact eBusiness Technical Support†.

ICD-10 Preparation Survey results

Effective Oct. 1, 2014, federal regulations require that ICD-10 codes replace ICD-9 codes, which will require business and system changes throughout the health care industry. In order to determine the preparedness of our providers, we asked you to complete a brief survey and we now have the results.

The majority of survey participants stated they have already started to educate their organization on ICD-10. That's great news! Additionally, a majority of survey participants look to *BlueAlert* and our company website, www.bcbst.com to learn more about ICD-10, however, some survey participants also indicated they do not know when they will begin testing.

In addition to the multiple resources located on our website, here are some suggestions to prepare for testing:

- Inform your staff/colleagues of upcoming changes.
- Identify how ICD-10 will affect your practice/facility.
- Develop and complete an ICD-10 project plan for your organization.
- Identify each task, including a deadline and who is responsible.
- Develop plan for communicating with staff and business partners about ICD-10.
- Estimate and secure budget.

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ADMINISTRATIVE (Cont'd)
ICD-10 Preparation Survey results (Cont'd)

- Select/retain vendor(s).
- Review changes in clinical documentation requirements and educate staff by reviewing frequently used ICD-9 codes and new ICD-10 codes.

For more information regarding ICD-10 implementation and BCBST progress, please see the Provider page of our website, www.bcbst.com by clicking ICD-10 or you can type the following link in your URL <<http://www.bcbst.com/providers/icd-10.shtml>>.

Website changes

If you visit our website often (www.bcbst.com), you'll notice that it has been completely redesigned to better meet your needs and those of our members. The new design is easier to navigate, helping you quickly get to the information you need. We will continue to enhance the site in the coming months, so please let us know how we can make further improvements.

Reminder: Durable medical equipment (DME) and prosthetics and orthotics (DMEPOS) requirements

Providers billing for DME should have a Home Medical Equipment license. The only exceptions are providers billing for non-motorized equipment (e.g. walkers, canes, crutches).

DME and medical supplies should only be billed by a DME provider when the services are purchased in a DME retail store or delivered to the member at their private residence. DME or medical supplies provided in a facility setting or during ambulance transport should not be billed by the DME provider. DME and supply services in these settings are incidental to the services provided by the facility or

ambulance provider. Services billed improperly by DME or medical supply providers for items provided during a facility stay or ambulance transport are subject to recovery.

Providers billing for prosthetics or orthotics should have proper certification or accreditation. The provider is responsible for ensuring all codes billed are valid for the date of service. Information concerning certification and licensing requirements, as well as billing guidelines, is available in the provider administration manuals located on the company website at <http://www.bcbst.com/providers/manuals/>.

Quality focus on women's health

Nationwide, October is known as Breast Cancer Awareness Month. BlueCross would like to extend that focus to **all** women's health, especially breast cancer screening, cervical cancer screening, chlamydia screening and osteoporosis. Prenatal or postpartum visits may also provide a good opportunity for Pap screenings and chlamydia screenings. Encourage and educate parents of preteens on HPV vaccines, and for older women, check for osteoporosis and discuss risks of falling.

BlueCare Tennessee, Cover Tennessee and BlueCross conduct multiple activities focused on increasing patient awareness including:

- Automated telephone calls to members with directed reminders and education on the importance in cervical cancer screenings, breast cancer screenings and chlamydia screening, as well as other preventive testing;
- Health cards are mailed to women during their birthday month with information on Pap tests and mammography encouraging them to discuss with their health care provider whether they should be tested;
- Telephone calls to members identified as not having a current breast cancer screening and assistance with scheduling appointments; and
- Newsletter articles with education on the importance of all preventive tests supporting clinical practice guidelines,

thereby improving the member's quality of life.

Prevention messages are more effective when coming from the member's health care provider. Please encourage your female patients to schedule these important screenings as appropriate.

Requests for authorization

Effective Nov. 1, 2013, requests for authorization of services for members with commercial plans for **DME, Home Health and HIT** must be faxed on the appropriate **BlueCross** form, located on our company website at

<http://www.bcbst.com/providers/forms/>.

Forms should be completed in their entirety to prevent delays. Requests received that are not on BlueCross forms will be returned to you.

For the fastest response, submit requests online 24-hour-per-day, 7-days-per-week via BlueAccess[®]. If you are not a registered user of BlueAccess, contact eBusiness Technical Support[†] at (423) 535-5717 and select Option 2.

Reminder: Duplicate claims handling for Medicare crossover

Effective Oct. 13, 2013, when a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting the claim to BlueCross BlueShield of Tennessee. Medicare primary claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date will be returned or rejected by BlueCross BlueShield of Tennessee.

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt

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ADMINISTRATIVE (Cont'd)

Reminder: Duplicate claims handling for Medicare crossover (Cont'd)

of the remittance advice from Medicare, it may take up to 30 additional calendar days for you to receive payment or instructions from the Blue Plan.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the member's benefit policy to be applied.

To view a list of frequently asked questions, please visit our website at <http://www.bcbst.com/providers/news/> and click on the *Medicare Crossover Duplicate Claims FAQs*.

Cultural disparities analysis

The September *BlueAlert* provided a summary analysis of disparities as indicated by 2012 claims data of top conditions by race/ethnicity for our Commercial and BlueCare Tennessee populations. Please review the results and use as a reminder and perhaps to flag records when our members are seen in your office. The summary has been repeated for your perusal.

Future articles will highlight particulars relative to the disparity.

Thank you for your assistance in closing the gaps!

Asians

- Asian Commercial and TennCare members had lower prevalence for every top condition except Hyperlipidemia and Blood Borne Cancer when compared to all other racial/ethnic groups.
- The prevalence of Obesity for Asian Commercial members was more than half of other racial/ethnic groups.

African Americans

- African American Commercial members had a much lower rate of hyperlipidemia compared to other racial/ethnic groups.
- African American TennCare members had significantly higher rates of STDs compared to other racial/ethnic groups.

American Indian/Alaskan Native

- AI/AN TennCare members had almost double the prevalence of endocrine gland disease or disorder compared to all the other racial/ethnic groups.

Hispanics

- Hispanic Commercial members had low compliance with most preventive measures in the gap measure groups.
- The prevalence of hypertension was significantly lower for Hispanic TennCare members compared to other racial/ethnic groups.

White

- White Commercial members had a significantly higher prevalence of hypertension compared to other racial/ethnic groups.

RationalMed®: Closing Gaps in Patient Safety

BlueCross BlueShield of Tennessee has partnered with Express Scripts to implement RationalMed, a clinical program that identifies and addresses drug therapy-related health risks and gaps in care for all members of clients enrolled in the program.

This program will be implemented for a few select groups in a pilot phase and is designed to deliver:

- Safer use of medications and evidence-based prescribing
- More appropriate, evidence-based patient care
- Fewer avoidable hospitalizations
- Prescription drug savings
- Medical savings
- Insights into the health of a client's population
- Enhanced member care coordination

By leveraging the power of integrated medical claims, pharmacy claims and lab data, RationalMed identifies safety risks and provides patient-specific alerts to physicians and pharmacists.

Key safety risks:

- Adverse drug risk: Interactions between the drug and a patient's disease state or between drugs; excessive dosing; duplicate therapies
- Coordination of care issues: Potential misuse or abuse; poly-pharmacy
- Omission of essential care: Under dosing; omission of essential therapy or drug-related testing/diagnostics; poor adherence

Note: This applies to select commercial and Medicare Part D benefit plans.

SOCRxATES® - A pharmacy quality care initiative

BlueCross and Express Scripts have partnered to launch *SOCRxATES*, a quality care initiative pilot program that delivers electronic alerts regarding clinical opportunities to community pharmacists to enable better health choices, drive patient engagement, improve patient care, and potentially lower health care costs.

Beginning in September, SOCRxATES will be available at participating pharmacies to BlueCross members taking medication to treat cardiovascular, diabetes, pulmonary, immunological, oncological, women's health or neurological conditions. The goal of the program is to improve health for members being treated for these chronic conditions, by improving medication adherence and reducing potential omissions in recommended therapy.

BlueCare Tennessee ADMINISTRATIVE

Certificate of Medical Necessity (CMN) requirement update

Effective Oct. 1, 2013, BlueCare Tennessee durable medical equipment (DME) suppliers are no longer required to submit a CMN with **prior authorization requests** due to timely submission guidelines and the amount of time required to obtain a Medicare CMN. However, the Medicare CMN remains a requirement of Medicare Guidelines and can be subject to claims audit. If post-payment claims audit is performed and the required documentation is not present, the claim will be subject to recovery.

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BlueCare Tennessee

ADMINISTRATIVE (Cont'd)

Updated fax numbers for BlueCare Tennessee *

Please note updates to the following fax numbers:

- Requests for home health (HH) services including skilled and non-skilled with G, S, and T codes, physical therapy, occupational therapy, and speech therapy, should be submitted via fax to 1-865-588-4663.
- Fax *Missed Shifts for Home Health* forms to 1-865-588-4663.
- *SelectCommunity* requests should be faxed to 1-888-255-9175.
- Durable medical equipment (DME) and Orthotic & Prosthetic (O&P) requests should be faxed to 1-866-325-6697.
- Fax all other prior authorization requests to 1-800-292-5311.

Change to Weight Watchers participation with BlueCare Tennessee

Effective Dec. 31, 2013, Weight Watchers will no longer offer BlueCare Tennessee members the opportunity to participate in their program at no cost. Members currently participating will be able to continue attending Weight Watchers meetings until Dec. 31, 2013. After that date members interested in participating in the program must sign up directly with Weight Watchers at their own expense. Please refer any BlueCare Tennessee member interested in weight management support to contact us at 1-800-468-9698.

Reminder: Monthly federal exclusion list screening

BlueCare and TennCareSelect Providers have a **monthly** obligation to screen all employees and contractors against the U.S. Department of Health and Human Services', Office of Inspector General's List of Excluded Individuals/Entities (located at www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (located at

<http://healthcarebackgrounds.com/our-services/general-services-administration>>).

If an employee or contractor is found to be on the list, Medicaid providers must immediately report any exclusion information discovered to BlueCare Tennessee and remove such employee or contractor from responsibility for, or involvement with a provider's operations related to federal health care programs. Appropriate actions must be taken to ensure the responsibilities of such employee or contractor have not or will not adversely affect the quality of care rendered to any BlueCare Tennessee member or any federal health care program.

Additional information may be found in the *BlueCare Tennessee Provider Administration Manual* in the **Highlights of Provider Agreement** section.

New prefix for TennCareSelect members

Effective Nov. 1, 2013, TennCareSelect member identification numbers will have an alpha prefix of ZED. (BlueCare members will continue to utilize the ZEC prefix). New cards will be sent to TennCareSelect members by Nov. 1, 2013.

Coronary stents reimbursement change *

Effective for dates of service Nov. 1, 2013 and after, BlueCare Tennessee will begin reimbursing for coronary stents (when criteria are met) if performed as an outpatient surgical procedure. The reimbursement will be in addition to the procedure rate. BlueCare Tennessee will reimburse for coronary stents at the cost of the device (excluding shipping and handling, and state sales tax) based on the manufacturer's invoice, which is to indicate all discounts and/or rebates. If multiple items are on the manufacturer's invoice, the correct item(s) must be clearly indicated. See the *BlueCare Tennessee Provider Administration Manual* (PAM) for more details in the fourth quarter PAM update.

Reminder: DME reimbursement

DME providers are reminded that reimbursement for equipment and supplies not requiring prior authorization is based on the associated fee schedules as well as your provider contract.

BlueAdvantageSM

ADMINISTRATIVE

Reminder: Home health therapy authorization requirements

As previously communicated, home health physical therapy (PT) and occupational therapy (OT) services are included in our Musculoskeletal Program. Authorization requests are reviewed by TRIAD Healthcare for these services. Although the evaluation does NOT require authorization the evaluation date and number of requested visits **must be** increased to include the evaluation date. Home health is contracted to bill by revenue code in order for the PT and OT evaluation to process and reimburse correctly, therefore the date of the evaluation is required.

Note: Should the requested visits following the evaluation be denied for medical necessity, TRIAD will send BlueAdvantage an approval for the evaluation date. The updated form can be accessed under Home Health via the following link <http://www.triadhealthcareinc.com/bcbst/>.

Health assessments for Medicare Advantage members

BlueAdvantage is pleased to announce two new programs to improve the quality of care for our members, your patients. The first includes voluntary in-home, in-depth health risk assessments conducted by clinicians.

The second program involves the creation of a provider assessment form (PAF) to assist you with the coordination and documentation of health care of your senior members. PCPs received a letter with a list of your BlueAdvantage members to help you identify patients eligible to receive the assessment. BlueAdvantage will provide

BlueAdvantageSM

ADMINISTRATIVE (Cont'd)

Health assessments for Medicare Advantage members (Cont'd)

additional compensation for the completion of this form.

Additional information about both programs and the form are located on the company website at bcbst.com/providers/BlueAdvantage-PPO.

BlueCard

ADMINISTRATIVE

Electronic Provider Access improves prior authorization review process

Effective Jan. 1, 2014, a new tool, Electronic Provider Access (EPA), makes it easier for providers to conduct prior authorization review for out-of-state members electronically. Currently, providers who want to conduct prior authorization review for out-of-state members generally have to call the member's Home Plan directly for authorization or use the 1-800-676-BLUE number.

EPA will be added to the current BlueCard/FEP application (currently used for out-of-state eligibility and claim status) in BlueAccess. This will allow providers to enter the alpha prefix from the member's ID card and be automatically routed to that plan's homepage to conduct prior authorizations. If no electronic option is available for that plan, providers will be given specific instructions on how to obtain an authorization.

Please look for future *BlueAlert* articles with more information on EPA.

If you have any questions about this process, please contact **eBusiness Technical Support†** at **423-535-5717** and **select option 2**.

Cover Tennessee

ADMINISTRATIVE

Upcoming changes to Cover Tennessee program *

As a result of State of Tennessee budget reductions and changes due to the new federal health care law, changes are being made to the Cover Tennessee programs during the coming months. Members have been notified of these changes via letter within the past few weeks. The letters are available on the company website at <http://www.bcbst.com/health-plans/cover-tennessee/>. The following are some changes to both the CoverKids and the CoverTN programs.

CoverKids

Effective Oct. 1, 2013, CoverKids and HealthyTNBabies members will be served through the TennCareSelect Network of providers.

- Member benefits remain the same.
- Value Options will administer behavioral health benefits.
- Reimbursement for pregnant women in their second or third trimester will be based on contracted Network S rates.
- National Drug Code (NDC) is required for all charges for provider administered drugs.
- "CoverKids" will appear on the top right corner of the member ID card. The network name (TennCareSelect) will appear in the bottom left corner.
- This is only a network change, CoverKids members will not become part of the TennCareSelect Network

Beginning Jan. 1, 2014, CoverKids will no longer offer the buy-in program to families with incomes over 250 percent of the Federal Poverty Level.

CoverTN

Because the federal health law will no longer allow health plans with annual caps, effective Jan. 1, 2014, CoverTN coverage will no longer be available. These members are being notified via letter, which will also be available on the website. These members are being advised that they may obtain

coverage through an employer group or through the new Health Insurance Marketplace.

Providers with questions may call Provider Service†.

*These changes will be included in the appropriate, 4Q 2013 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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†Provider Service lines

Featuring "Touchtone" or "Voice Activated" Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "Network Contracts or Credentialing" when prompted, to easily update your information.

Commercial Lines 1-800-924-7141 (includes CoverTN; CoverKids & AccessTN)

Operation Hours

Monday-Friday, 8 a.m. to 5:15 p.m. (ET)

Medical Management Hours

Monday-Friday, 9 a.m. to 6 p.m. (ET)

BlueCare 1-800-468-9736

TennCareSelect 1-800-276-1978

CHOICES 1-888-747-8955

SelectCommunity 1-800-292-8196

Monday - Friday, 8 a.m. to 6 p.m. (ET)

BlueCare/TennCareSelect Medical

Management Hours

Monday-Friday, 8 a.m. to 6 p.m. (ET)

BlueCard

Benefits & Eligibility 1-800-676-2583

All other inquiries 1-800-705-0391

Monday - Friday, 8 a.m. to 5:15 p.m. (ET)

BlueAdvantage 1-800-841-7434

Monday - Friday, 8 a.m. to 5 p.m. (ET)

eBusiness Technical Support

Phone: Select Option 2 at 423-535-5717

e-mail: eBusiness_service@bcbst.com

Monday - Thursday, 8 a.m. to 5:15 p.m. (ET)

Friday, 9 a.m. to 5:15 p.m. (ET)

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